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BY
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DISSERTATION SUBMITTED 2018

AALBORG UNIVERSITY
DENMARK

GUIDED IMAGERY AND MUSIC WITH MILITARY WOMEN AND TRAUMA: A CONTINUUM APPROACH TO MUSIC AND HEALING

by

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Dissertation submitted

CV

Maya began her clinical work in Music Therapy in 1995 after obtaining her degree at University of Miami and interning at Langley Porter Psychiatric Institute in San Francisco. Her Master of Science degree in Music Therapy is from Indiana University through IUPUI where her research focus was on the use of Virtual Learning Environments and role-playing for pre-clinical training. She has worked in hospitals, mental health facilities, Universities and in private practice. She is a part time lecturer for Eastern Michigan University and maintains a private practice in Northern Michigan. She is a fellow of the Association for Music and Imagery and served as President for that organization from 2013-2015.

ENGLISH SUMMARY

Women are the fastest growing demographic among veterans in the United States. In response, the Veterans Hospital Administration (VA) has increased attention to the care and research of female veterans. Military Sexual Trauma (MST) is an issue among returning veterans that causes a significant amount of distress with a high occurrence of Post-Traumatic Stress Disorder (PTSD). There is a need to evaluate and develop treatment protocols for MST related PTSD. This study sought to evaluate Guided Imagery and Music (GIM) and its modifications as a treatment modality for female veterans with MST related PTSD.

The thesis describes five components that comprised the PhD study. A systematic literature review details issues that women encounter in the military and on return to civilian life, including impact of MST, and current services available to them. Conclusions from the literature reviews led to a conceptual framework for the research and initial research questions. A feasibility study was implemented that gathered qualitative and quantitative data to explore five female veterans' experiences with a continuum model of music and imagery and GIM (MI/GIM Continuum) sessions. Research questions sought to explore the participants' experience of components of the MI/ GIM sessions, including: music, imagery, guiding and creative processing. Identified themes from transcribed sessions and a focus group interview revealed that the participants found music helpful in regulating emotions, decreasing arousal, expressing feelings and as a means to connect with others. Imagery was experienced as a new resource for grounding, a reminder of goals and a mediator to insights. Participants experienced the guiding as supportive, structuring and empowering. Initially resistant to the creative processing, all participants found it helpful as a manner of self-expression and a way to continue processing between sessions. Overall, participants found the sessions to be a means for increased coping skills, increased self-awareness and empowerment. Completed PCL-5 scales demonstrated a decrease in PTSD symptoms, and data related to compliance and attrition demonstrated positive results. The feasibility study is detailed in a peer-reviewed journal article, published during the course of this study and included as a link in the thesis.

The feasibility study helped to refine the protocol for a proposed Randomised Controlled Trial (RCT). For the purpose of improving therapy fidelity in the clinical trial, a therapy manual was created that used a MI/GIM Continuum Model for working with clients who have experienced trauma. The manual details a flexible protocol for adapting the MI and/or GIM method to three different working levels: resource-oriented, issue-oriented and transformation-oriented. The levels are meant to support the various stages of trauma work, beginning with the strengthening of

trust and inner-resources before progressing to issues related to trauma and its symptoms, and finally exploring the re-integration of a new sense of self into society.

In order to further examine benefits from the MI/GIM sessions, a collaborative inquiry with one participant utilized an Arts Based Research process to investigate the musical and personal growth that followed participation in the sessions. A short documentary was filmed, edited and released through a collaboration between the participant and researcher. The inquiry used a transformative framework and sought to empower the participant to tell her story in her own manner, to engage in an equal creative collaboration and to raise awareness beyond academia. Portraiture was the method that guided the data collection and presentation of her story through film and creative writing. A link to the film is included in the thesis.

This timely and original study aims to make an impact by adding to the small body of research on female veterans and raising awareness in the greater community, specifically in the understanding of female veterans with MST related PTSD and their experience with MI/GIM as a treatment modality for MST related PTSD.

DANSK RESUME

Kvinder er den hurtigst voksende gruppe blandt veteraner i USA. Veterans Hospital Administration (VA) har som respons på dette sat øget fokus på omsorg for og forskning i kvindelige veteraner. Militært seksuelt trauma (MST) er et særligt belastende problem blandt hjemvendte veteraner som medfører en høj forekomst af posttraumatisk stress syndrom (PTSD). Der er behov for at evaluere og udvikle behandlingsprotokoller for MTS-relateret PTSD. Dette studie har søgt at evaluere Guided Imagery and Music (GIM) samt modifikationer som en behandlingsmodel for kvindelige veteraner med MST-relateret PTSD.

Afhandlingen beskriver fem komponenter af PhD-studiet. (1) En systematisk litteraturgennemgang går i detaljer med de problemer, som kvinder møder i militæret og ved tilbagevenden til det civile liv, inklusive følger af MST, samt de aktuelle behandlingstilbud der er til rådighed for dem. Konklusioner fra litteraturgennemgangen førte til dannelsen af en ramme for forskningsprojektet og formuleringen af indledende forskningsspørgsmål.

(2) Et feasibility-studie med 5 deltagere blev gennemført hvori der blev indsamlet kvalitative og kvantitative data, således at kvindelige veteraners oplevelser af sessioner indenfor en kontinuumsmodel af musik og billeddannelse (MI) og GIM (MI/GIM kontinuum) kunne undersøges. Forskningsspørgsmålene søgte at udforske deltagernes oplevelse af komponenter i MI/GIM sessionerne, inkluderende musik, billeddannelse, og kreativ processering. Fremfundne temaer fra transkriberede sessioner og et fokusgruppeinterview viste at deltagerne fandt musikken hjælpsom i forhold til at regulere følelser, sænke arousal, udtrykke følelser og som en måde at forbinde sig med andre. Billeddannelse blev oplevet som en ny ressource for jordforbindelse, en måde at minde sig selv om målsætninger, og en mediator for indsigt. Deltagerne oplevede guidningen som støttende, strukturerende og som et bidrag til empowerment. Selvom flere havde modstand mod kreativ processering (tegning) i begyndelsen, fandt alle deltagere den hjælpsom som selvudtryk og som en måde at fortsætte processen mellem sessionerne. Overordnet oplevede deltagerne sessionerne som en hjælp til at få flere mestringsstrategier, større opmærksomhed på sig selv og mere empowerment. Spørgeskemaet PCL-5 blev udfyldt før og efter terapiforløbene og viste en nedgang i PTSD-symptomer, og data relateret til fremmøde og dropout demonstrerede positive resultater. Feasibility studiet er beskrevet i en peer-reviewet artikel som blev publiceret under studiet (link kan findes i afhandlingen).

Feasibility-studiet hjalp med at forfine protokollen for et foreslået randomiseret kontrolleret studie (RCT) (3). Med det formål at forbedre terapeuternes overholdelse af protokollen (fidelity) blev der udviklet en manual der anvendte en MI/GIM kontinuum model til at arbejde med traumatiserede klienter (4). Manualen beskriver detaljeret en fleksibel anvendelse af MI og/eller GIM på tre forskellige niveauer: ressourceorienteret, temaorienteret og transformationsorienteret. Opdelingen i niveauer skal støtte de forskellige stadier i traumebearbejdning, begyndende med styrkelse af tillid og indre ressourcer, derefter arbejdet med temaer relateret til traumet og dets symptomer, og sluttelig udforskningen af tilbagevenden til samfundet med en ny selvoplevelse.

(5) For at gå mere i dybden med at udforske gavnlige virkninger af MI/GIM sessionerne, blev der udført en "collaborative inquiry" med en deltager, hvor der blev anvendt en arts-based research proces til at undersøge den musikalske og personlige vækst som fulgte efter terapiforløbet. En kort dokumentarfilm blev optaget, redigeret og udgivet i et samarbejde mellem deltager og forsker. Projektet blev foretaget med en "transformativ" tilgang, hvor deltageren blev støttet til at fortælle sin historie på sin egen måde og at engagere sig i et ligestillet kreativt samarbejde med forskeren, og der var fokus på at øge opmærksomheden på temaet udenfor akademiske sammenhænge. Portraiture-metoden guidede dataindsamlingen og præsentationen af deltagerens historie gennem video-optagelse og kreativ skrivning. En link til filmen er inkluderet i afhandlingen.

Dette studie søger at skabe en forskel gennem at bidrage til den begrænsede forskning i kvindelige veteraner og gennem at skabe øget viden i det omgivende samfund, specifikt i forhold til forståelsen for kvindelige veteraner med MST-relateret PTSD og deres oplevelse af MI/GIM som behandlingsmodel.

ACKNOWLEDGEMENTS

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TABLE OF ABBREVIATIONS USED

ABR	Arts Based research
CAM	Complementary and Alternative Medicine
CPT	Cognitive Processing Therapy
DoD	Department of Defense
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EMDR	Eye Movement Desensitization and Reprocessing
GIM	Guided Imagery and Music
MB	Music Breathing
MER	Music Entrainment and Reprocessing
MI	Music and Imagery
MST	Military Sexual Trauma
PCL-5	Posttraumatic Stress Disorder Checklist
PE	Prolonged Exposure therapy
PSS	Performative Social Science
RCT	Randomized Controlled Trial
TBI	Traumatic Brain Injury
US	United States
VA	United States Veterans Administration

CHAPTER 1. INTRODUCTION

The gender studies scholar Nina Lykke (2010) refers to the author as a guide who holds the responsibility of leading the reader through the written landscape, providing tools to ground and orient the reader. This introduction chapter serves as such a tool, particularly in the forms of a map to the structure of the thesis and a description of the landscape that will be surveyed. Lykke also states that ultimately the traveler will connect to the parts of the vast landscape with which they resonate. This thesis used multiple methodologies and thus multiple types of landscapes, which some readers may find disorienting while others may enjoy. Through this thesis, you will be guided through the landscape and stories of female veterans, their experiences with music and of the intersection through my process as a researcher.

Embedded in all research is the process of the researcher, but not always in a transparent manner. Likewise, in this research there were times when I was more objectively in the background or very subjectively interacting in the process. Attention is drawn to this from the beginning because it highlights the different landscapes of research and thus styles of writing.

1.1. OVERVIEW OF THE THESIS

The thesis begins with theoretical foundations and a systematic review of literature, leading to a research design including a protocol for a randomized controlled trial (RCT), the summary of a feasibility study, and an explanation of the Continuum Model of Music Imagery and Guided Imagery and Music (MI/GIM Continuum). At that point in the thesis, there is an interlude (Chapter Seven) bridging to the Arts Based research phase, where the rationale for a shift of methodology will be presented. Following that are details of a collaborative inquiry with one of the research participants where in essence, she becomes a co-researcher and I become a co-participant. Finally, there is a discussion chapter that synthesizes the research and draws attention to salient points.

The five different components that made up the PhD studies are shown in Figure 1-1, including the purpose of each and where they are located in the thesis.
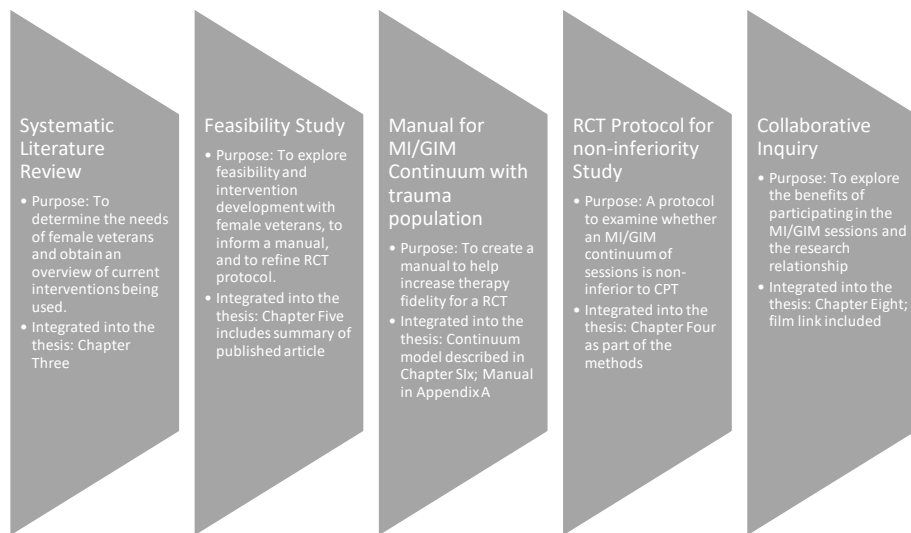
Figure 1-1: Components of the PhD

(abbreviations: RCT- randomized controlled trial, MI- music and imagery, GIM- guided imagery and music, CPT- cognitive processing therapy)
Thesis Type

This PhD course of study began as an article-based thesis. The research proposal had delineated phases leading to a RCT with proposed articles aligned with each phase. After the first study was accepted for publication, the research plan changed, as described in Chapter Seven. Due to the ethnographic nature and arts based component of the new project, there were challenges to continue in an article-based manner. A large part of the arts-based study involved filming and producing a short documentary. At the time, arts-based research was quickly emerging in the literature, but there was not a strong platform for peer evaluation and publication of the artistic artifacts. Narrative and story had become so pivotal to the process that I could not imagine a clear presentation through articles. Thus, the decision was made to shift to a monograph-type thesis conducted in a hybrid format that includes a published article detailing the first phase of research and subsequent study. The article is summarized in the monograph at the point in which it occurred in the research process. In that way, the monograph unfolds in the manner that the research process occurred. The film is also submitted in consideration of incorporating arts based artifacts as rigorous data collection and dissemination of the research process in their own right.

Also embedded, is a parallel process of my research identity and the identity of women in the military, a colliding and attempt to balance the masculine and feminine characteristics inherent in the social and political dynamics surrounding the issue. In this way of panning out and focusing in, you will be guided through the larger picture

of female veterans before gradually honing in on the life and story of one particular woman who described herself as living in a box and how she used music to get out.

1.2. BACKGROUND: FEMALE VETERANS

Though women have served in military institutions for many years, the roles have traditionally been that of a caregiver or administrative support. The United States recruitment campaigns during the Vietnam War stressed that women could serve and still maintain their feminine identity: "the ideal army nurse then was outwardly feminine, sought traditional ways to serve their country by providing a psychological boost to soldiers, and they might even find a husband in the process" (Crompvoets, 2011, p. 26). As women's roles changed in society, more integration occurred in the military. In 1994 the United States (US) banned women from combat roles, but the ban was reversed in 2013. Through serving in the US armed forces, The National Guard, or Reserves, women represent 16.5% of the total military force. In 2015, two million women in the US and Puerto Rico constituted 9.4% of total veteran population and the total population of women veterans is estimated to increase at a rate of 18,000 women per year for the next ten years (US Department of Veterans Affairs, 2017a).

An increase of numbers of women in the military is occurring in other countries as well. In 2000 the percentage of female soldiers in France was 9.1%, compared to 15.15% in 2010. A larger increase is seen in Germany where female soldiers comprised 2.4% of the military in 2000 and 9.1% in 2010 (Eulriet, 2012). Norway and Sweden recently began to require military service for women in addition to men (Olsen, 2017), which will increase the numbers of women significantly.

Men and women return from active military service with challenges connected to re-integration in civilian life and military experiences during deployment, but there has been increased attention to the needs of women as their numbers grow and services have been lacking (Crompvoets, 2011; Middleton & Craig, 2012). Female veterans have identified stressful experiences in the military from combat, military sexual trauma, and separation from family and support resources (Mattocks et al., 2012). Military Sexual Trauma (MST), defined in US federal law, Title 38 U.S. Code 1720D, is a term the US Veterans Administration (VA) uses to describe sexual assault or repeated sexual harassment encountered during time in the military (Koo & Maguen, 2013). Though predominantly an issue for women, men in the military also encounter MST and have a unique set of challenges in their recovery. Increased services for men and women are extremely important, but this project will address MST as connected to women in the military.

The National Center for Posttraumatic Stress Disorder (PTSD) indicates that approximately one in every four women have screened positive for MST, based on those who received treatment through the VA Hospital (US Department of Veterans Affairs, 2018). However, there is a wide range of reported prevalence with published

MST rates of up to 45% (Allard, Nunnink, Gregory, Klest, & Platt, 2011). Actual numbers are thought to be much higher due to female veterans not accessing the VA for services and veterans not reporting harassment and assault. Possible barriers to care and a lack of reporting are due to: fear or shame, veterans' beliefs about mental health care, difficulty navigating the VA system, concern regarding not fitting in at the VA as a woman, military culture of power differentials, and loyalty to unit (Koo & Maguen, 2013). The Department of Defense (DoD) (2017) released data that showed a 15% increase in number of sexual assault incidences reported between 2013 and 2016. The increase in reports may be due to the increased attention to the issue in the media, empowering more individuals to come forward.

The most common forms of distress associated with MST are PTSD, depression, anxiety, and poor functioning (Allard et al., 2011). The numbers of US women veterans who received compensation for PTSD in 2015 was 47,931, making it the most prevalent disability compensated to women by the VA (Department of Veterans Affairs, 2017). Distress symptoms from MST mirror other documented symptoms of adult sexual trauma including PTSD, suicidal behaviors, anxiety, depression, substance abuse, and repeated sexual victimization (Campbell, 2008; Resick, 1993; WHO, 2002).

There are qualitative differences when PTSD is connected to MST, compared to civilian sexual trauma. The hierarchy of the military system and insistence of unit loyalty effects the reporting of cases, and thus the ability to seek help. Because the trauma has occurred where the individual lives and works, multiple identities in their personal and professional environments are impacted, leaving no perceived safe space. There is an increased rate of re-victimization and a decreased sense of power and hope due to not being in control. Issues connected to social functioning are particularly salient (Steward, 2013). Despite growing integration, women in the US Military experience gender stereotyping that contributes to inequality and a lack of community with male peers during service (Archer, 2013). Deployed women in the military report greater difficulties in social relationships than men in the military and conflicts in relationships are more likely to result in divorce or separation (Gibbons, Hickling, Barnett, Herbig-Wall, & Watts, 2012).

Even with high exposure to trauma, some individuals develop PTSD and others do not, perhaps due to resilience. Researchers interested in trauma and outcomes have found that components of well-being of veterans that led to better outcomes were resilience, coping skills, sense of identity and community (Crompvoets, 2011; Feczer & Bjorklund, 2009; Kelly, Skelton, Patel & Bradley, 2011; Tsai, Harpaz-Rotem, Pietrzak & Southwick, 2012). In sexual abuse literature, resilience is also found to be a predictor of better outcomes (Zraly, & Nyirazinyoye, 2010).

1.3. INTERNATIONAL COMPONENT

Although there are some reports of sexual trauma, there is less evidence published from other democratic countries aside from the US. Canadian military forces report rates of sexual misconduct of women at 27.3% among regular force members (Cotter, 2016) and military-related sexual assault at 15.5% (Watkins, Bennett, Zamorski, & Richer, 2017). The British Army released data from a 2014 survey that details rates of sexual misconduct toward women from the previous 12 months that ranged from 2% for sexual assault to 39% for unwanted comments related to appearance, body or sexual activities (British Crown Ministry of Defence, 2015). The Israel Defense found that in 2016 one out of six female soldiers reported sexual harassment during their required service time, but only 19% of those who reported, filed a formal complaint (Middle East Monitor, 2017). A survey of the Australian Armed forces detailed that one in four women experienced sexual harassment in the previous five years (Australian Human Rights Commission, 2012). These reports demonstrate incidence in other countries, however the literature is far less than what is published related to the US Military. Based on the lack of data, one might conclude that in other countries where women are integrated into the military: sexual trauma is not an issue, not garnering as much attention, or not being reported. However, in International articles that address greater inclusion of women in the military, sexual harassment is repeatedly identified as a possible outcome and concern of gender integration, which demonstrates global awareness of the issue (Carreiras, 2013; Kummel, 2002).

The explanation for lack of reported incidences in other countries may be due to a smaller number of women serving in their forces. In 2000, women comprised 12.7% or 282,673 of the NATO forces. The US accounted for 198,452 (70%) of that total, compared to Denmark for instance, which reported 1,033 (.4%) of the total NATO number (Carreiras, 2013). Sexual trauma may become more prevalent as numbers of women in the military increase internationally. The US serves as an example (perhaps not a positive one) for how issues are being handled, but other countries will need to increase attention to problems that arise from gender integration. Cultural considerations regarding gender dynamics differ between cultures and from country to country, which may be a strong determinant of successful gender integration.

Though this study examined sexual trauma within the military, there is a connection to the larger culture of sexual assault in war. Sexual assault on female civilians by men in the military has been a longstanding practice with examples from Burma, Egypt, Mexico, and Libya (Women's Media Center, n.d.). An increase in female military enrollment may be one way to change military culture (Kummel, 2002), which extends outside of how women are treated *within* the military, to how women living in places of conflict are treated *by* the military.

1.4. BACKGROUND OF INTERVENTION

1.4.1. GUIDED IMAGERY AND MUSIC

Guided Imagery and Music (GIM) is a method of individual music psychotherapy that uses carefully selected classical music to elicit imagery responses that with verbal processing can lead to therapeutic resolution (Bonny, 2001). Helen Bonny, a music therapist, initially developed the Bonny Method of GIM (here after referred to as The Bonny Method) for use with normal functioning adults as a method of greater self-awareness and transformation. The Bonny Method uses specifically programmed classical music (Western Art Music) approximately 35-55 minutes in length during which time the client is encouraged to be open to the music and to exploration of conscious and unconscious material in an altered state of consciousness. An average Bonny Method session lasts from 90-120 minutes.

Bonny (1999) described a GIM session as consisting of four parts, the preliminary conversation/ prelude, induction, music-listening, and post-session integration/ postlude.

Prelude
The purpose of the prelude is to establish rapport and to assess the client in order to better choose music and relaxation method for the session. This is accomplished through a verbal check in regarding client's current emotional, physical and mental state, as well as therapist observation of client's demeanor and energy level. The prelude is also a time to share insights or work that has been explored as follow-up from the previous session. Some therapists incorporate a creative process such as drawing as part of the prelude assessment.

Induction
The induction includes the two elements of physical relaxation through initiating a relaxation technique, followed by a focusing of attention in order to mask distraction from other stimuli. This focus becomes the suggested place to begin the imagery and unlike other imagery methods, is the only time specific imagery is suggested. Subsequent imagery unfolds as generated by the music and specific to the client's imagination, allowing the experiences in the music to be specific to the client's needs (Bonny, 2001).

Music-listening
The music-listening period involves listening to music, verbal sharing of elicited images by the client and guiding by the therapist. At the end of the induction the chosen music is played. The client verbally shares her experiences in the music as the therapist supports and helps to deepen the experience through guiding with verbal reflection, introjection and empathy. During this time, the therapist is also observing the client for non-verbal responses, such as posture, breathing and affect. Again,

guiding by the therapist is structured in order to *support* or *deepen* the client's experience. In some instances, more directive guiding is indicated, but generally the therapist is careful not to influence the client's experience in the music.

Postlude

The postlude is structured to support the client in returning to a regular state of consciousness and to process content that emerged during the session. Because clients are in a slightly altered state, many times the processing of content may occur later through a client's journaling during the week and shared at the beginning of the following session. Verbal processing and processing through creative arts modalities assists in making the imagery less abstract and more accessible to the client for insights and integration. The use of creative arts modalities such as drawing, journaling, movement and musical improvisation are also used to assist in the return from an altered state of consciousness. Some therapists describe the creative processing as an additional part to the GIM session (the return), making the session five parts rather than four.

Therapists trained in The Bonny Method have made adaptations and modifications to the original method to make it more accessible to clinical populations. Modifications have included different genres of music, shorter programs, the addition of other creative arts modalities, and topic-focused sessions in dyads or group formats (Grocke, 2010; Muller 2010). There is overlap in the structure of how components are modified, but many differences still remain. Grocke & Moe (2015) have presented a large number of these modifications and adaptations in their book *Guided Imagery and Music (GIM) and Music Imagery Methods for Individual and Group Therapy*. The introduction provides a table that demonstrates the range of techniques, under the headings of: Music and Imagery (individual therapy), Group Music and Imagery, Group GIM, Short GIM (individual therapy) and The Bonny Method of GIM (individual therapy). Some chapter authors have given specific names for the modification used, others have named it Music and Imagery or modified GIM. As modifications are developed and researched, there emerges defining elements that can help name the technique being used, however currently in the field the term GIM and Music and Imagery (MI) encompass a plethora of ways of working. The terms "The Bonny Method" and "GIM" as used in this proposal are from Bruscia's (2002) definition in one of the first published textbooks on GIM. The Bonny Method refers to specific forms developed by Bonny, whereas GIM refers to "all forms of music-imaging in an expanded state of consciousness" p. 38. GIM is an umbrella term and includes all forms- Bonny's original method as well as variations and modifications developed by therapists trained in her method. [1]

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[1] For detailed definitions see Bruscia & Grocke (2002). *Guided imagery and music: The Bonny method and beyond.*

1.4.2. MUSIC AND IMAGERY

Music and imagery (MI) developed out of GIM, but is considered outside the basic definition of GIM due to the amount of modification (Summer, 2009). Music and Imagery is often an option when a client is contraindicated for GIM, but MI can be used with GIM clients as well, providing a focused intervention as a precursor or intermediately with GIM sessions. Common features of MI that differ from GIM are:

- Music selection- shorter musical selections, repeated music, music from different genres, client chosen music.
- Induction- a very focused induction in order to stay with and enhance one image.
- Role of the therapist- the therapist may talk over the music in order to support the client in exploring the identified topic, but there is generally no interactive dialogue.
- Structure of processing material that emerges during the music- clients are often listening with their eyes open and engaging in another creative medium such as drawing, moving, or writing during the music, or directly following the music. Processing of the experience may include active music therapy methods such as improvisation or songwriting.

Similar to GIM, there are many versions of MI for dyads and groups with a lack of agreement as to what constitutes a MI session. Grocke & Moe (2015) state that MI approaches are used "when the intention of therapy is to enhance a relaxed state" (p. 19). Though MI is sometimes used in connection with relaxation, there are instances where MI is used with the intent to address and/or transform issues (Meadows, 2015; Summer, 2009; Summer, 2015). Music and Imagery is often distinguished from GIM when there is no interactive dialogue during the music listening (Grocke & Moe, 2015). This seems to mainly be consistent in the literature, but there are examples of individual MI where interactive dialogue is used (Gimeno, 2010), and in clinical practice, the delineations may not be so discrete. The MI methods used in this study are ones defined by Summer and Goldberg (Summer, 2015) and further developed in the Continuum Model, which uses MI and GIM methods. See Chapter Six for a full presentation of the Continuum Model in the context of this study.

1.5. NEED FOR RESEARCH

The VA has increased attention to MST through implementation of MST treatment programs at VA Centers, but there is an inconsistency in treatment approaches and research related to women. (Kelly et al., 2011). Identified barriers to conducting research include small numbers of women in the VA system, identifying women

veterans who do not use the VA system, and negative attitudes about women veteran's research. In 2004 The VA office of Research and Development assessed the state of research with female veterans and set PTSD and MST as a high clinical research priority (Yano, et al., 2006). Yano et al. (2011) summarized research published from the time of the 2004 VA Agenda to 2010. Findings indicated an increase in studies related to women veterans but identified continued gaps, including a lack of research that examines treatment integration for women with complex mental health presentations. Other authors have summarized that most research has been descriptive and observational, focused on identifying the magnitude of abuse and psychological and physical outcomes of MST (Allard et al., 2011), but studies that examine the effectiveness of certain treatment modalities are slowly emerging. An evidence map, created at the request of the VA Women's Health Research Network, examined studies between 2008-2015 and found that observational studies continued to be the most prominent, with only 2% of 440 published articles being randomized trials (Danan, et al., 2017). An evidence map is useful for describing patterns, strengths and gaps across a research population, though it does not evaluate the strength of the studies or synthesize outcomes. Women in the studies were seen as subjects as opposed to stakeholders or partners in the research, highlighting the need for further integration of women veterans' collaboration in study design to strengthen study credibility.

The VA has endorsed individual manualized trauma-focused therapy, such as Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT), over pharmacologic medications or non-trauma-focused psychotherapy as first line treatments for PTSD (US Department of Veterans Affairs & US Department of Defense, 2017). The endorsed therapies are also being used to treat MST related PTSD despite unique symptoms and effects of MST. Trauma-focused therapies take clients directly into memories of the experienced trauma, and there is some concern regarding the distress caused during the process. The few RCTs addressing MST specific PTSD, showed improvement on all clinical measures for individual CPT and individual present centered therapy but identified higher attrition rates for the CPT treatment group (Surίs, Link-Malcolm, Chard, Ahn, &North, 2013). Related studies with adult sexual trauma report better PTSD outcomes for cognitive behavioral interventions or prolonged exposure therapies compared to supportive counseling or person centered therapy but also had a high rate of treatment drop out (Frost, Laska & Wampold, 2014; Gerger et al., 2014; Vickerman & Margolin, 2009). The high attrition rate may be connected to the distress from directly engaging with trauma memories or the demands of written homework.

Although there are no RCT trials with music therapy and this particular population, there is precedence for using music therapy with clients exposed to trauma. Identified client themes and benefits from the music therapy literature are: increased sense of hope, community, and social support, (Bensimon, Amir, Wolf, 2012; Blake & Bishop, 1994; Carr, et al., 2011). Specific quantitative measures have shown a significant

decrease in PTSD symptoms (Carr et al., 2011). In related clinical populations, an increased sense of coherence has also been found (Körlin, Nybäck, & Goldberg, 2000; Moe, 2011). Inpatient and outpatient mental health clients, with similar needs to those of trauma clients, have demonstrated favorable outcomes with modified Guided Imagery and Music sessions (Blake & Bishop, 1994; Goldberg, 1994; Justice, 1994; Körlin et al., 2000; Moe, Roesen, & Raben, 2000; Murphy, 2009; Short, 1992; Summer, 1988).

Further research has been prioritized for women veterans in general and there is a clear need for research related to effective interventions to support the needs of this growing population. There has been some support in the VA guidelines (US Department of Veterans Affairs & US Department of Defense, 2017) for complimentary and integrative health interventions, also called complementary and alternative medicine (CAM) for PTSD. The VA terms practices such as meditation, yoga and music therapy, CAM interventions. The VA recognizes that there is interest in CAM interventions, but further high quality studies are needed that have adequate power, active control conditions and longer follow-up periods. The interventions used in this present research, MI and GIM, would most likely be termed CAM interventions by the VA, though they are also forms of individualized psychotherapy.

1.6. BACKGROUND: RESEARCHER

My interest in this topic began in 2012 when I conducted weekly music therapy sessions at the VA Hospital as a university faculty member with undergraduate students. At the time, reports about MST were surfacing in the media throughout the US. These reports brought attention to the challenges for women in the military; challenges whose roots are in its hierarchical culture.

Through a process of personal reflection, I discovered that I had accumulated strong negative feelings regarding the military culture due to similarities I felt between it and the religious community in which I had been raised. Many religious fundamentalist communities value strict gender roles. This rigid hierarchical structure values masculine attributes and devalues feminine attributes, which is the kind of environment that some theorists claim breeds abuse (Turchik & Wilson, 2010) and a misuse of power (Parco, 2013).

Through my reflections, I understood that my upbringing as a woman in a fundamentalist system and my subsequent questioning and rejection of some of those values influenced the way I experienced my initial clinical work with veterans, as well as how I heard and interpreted the news reports. This background created within me multilayered feeling responses, including a strong feeling of compassion for those who are subjected to a rigid hierarchical structure. I understood that these layered responses would affect the study, especially in regard to how I would interact with

this population as a clinician and how I would interpret data as a researcher. My intention was to be cognizant of those responses and transparent in regards to how they affected the research. Prior to beginning interactions with participants, I went through a self-hermeneutic inquiry through a series of three music and imagery experiences to examine my pre-understanding and beliefs in regards to this population. A video I created as part of the PhD application and journal entries prior to starting sessions with participants were also used as material for examining my pre-understanding.

1.7. BACKGROUND: SOCIAL AND POLITICAL CONTEXT

Beyond the personal background of the researcher, there is the social and political context in which the research is occurring. All research is set in a certain time and place that will influence the researcher and the research process. In response to increased attention to MST and concerns being raised, a number of initiatives and bills were being introduced in the US government to improve the handling and judicial review of MST cases (Torreon, 2013). Barack Obama, then US President, requested a report from the DoD detailing improvements and updates in the prevention and response to MST. The report, released in 2014, showed an increase in number of MST cases and continued low rates of reporting (US Department of Defense, 2014). Though media continued to report the issue, attention was diminishing in the general public.

In 2016 Donald Trump, while campaigning to be President, responded to multiple allegations and charges of sexual harassment and abuse. Despite those claims, he was elected President. This contributed to an outcry from women and men that was organized into marches and rallies attended by an estimated two-five million people across the world.

Responses to the issue of sexual harassment continued with the #me too campaign that was named by a survivor of sexual abuse, Tarana Burke, in 1997, but attracted the attention of thousands through a Twitter post by actress Alyssa Milano in 2017 (Garcia, 2017). This was followed by an increase in reported sexual harassment and abuse cases in the US and other countries that have included the Hollywood movie industry, journalists, government officials and the Olympics.

1.7.1. PERSONAL REFLECTION

I resonated with the response of many women when Trump was elected President. I felt disappointed with my country, betrayed as a woman, and aware that I was experiencing a similar parallel process to the women in my study who had felt betrayed by the military and the country they were serving. I sensed I was in an interesting precipice as a woman researching sexual trauma. I felt at times both empowered and disheartened, understanding that I carried with me a body and life of

experiences of being a woman. I was filled with the challenges, emotions and stories of my own as well as those shared by my women friends. I wondered if a male researcher would be more objective or better at bracketing out preconceptions. I felt I could not exclude my experiences as a woman in this culture and society, but I attempted to approach the research from a place of honesty and transparency.

1.8. PARADIGM AND METHODOLOGICAL STANCE

The basic belief systems of the researcher will influence the research paradigm and chosen research methods.   From the start, this research was approached as a mixed methods inquiry for pragmatic reasons. This research was to explore a new clinical population and a new intervention. A complex understanding of the phenomena was viewed as pivotal in order to move forward and communicate with various stakeholders in the research in an informed manner. The researcher background, social and political context outlined some of my beliefs as a researcher- or my axiological stance. The belief that military sexual trauma is a social and political issue and a desire to increase awareness of the issue also led to a transformative lens in the research paradigm.   The dialectic approach of using both a pragmatic and transformative paradigm is outlined further in the methods section (Chapter Four), but it is important at this point to articulate further about the underlying beliefs.

In transformative research (Mertens, 2007), the axiological belief is the primary influence of the epistemological, ontological and methodological stances. From an ontological perspective a transformative paradigm aligns closely with social constructivism and an acknowledgement of multiple realities, but differs in that it maintains there is one reality with multiple opinions about that reality. From an ontological standpoint, transformative researchers need to contextualize their own privilege, social, cultural, economic and gender values that influence that opinion of reality.   In terms of epistemology, that means there is an interaction between researcher and participants, an awareness of cultural differences and an acknowledgment of power differentials in the process.   The underlying belief regarding methodology is that multiple methods may be used, and there is an attempt to include the participants in the research process. To further support the rationale for using multiple methods, a framework of Integral Methodological Pluralism (IMP) (Wilber, 2006) is adopted in this PhD research.   The integration and further explanation of IMP is discussed in Chapter Nine.

CHAPTER 2. THEORETICAL FOUNDATIONS

Informed by the published literature relevant to each topic, this chapter guides the reader further into the foundations of trauma, dynamics of sexual abuse and the theoretical foundations of Guided Imagery and Music related to the present study.

2.1. TRAUMA

> Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. (Herman, 2015, p. 33).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), traumatic events where one encounters a threat of death, sexual assault or major injury may trigger PTSD (American Psychiatric Association, 2013). Exposure can be in the form of direct involvement, hearing about a close family member or close friend's involvement, witnessing an event, or repeated hearings of descriptions. The addition of sexual assault is a new inclusion for DSM-5, as is the disorder's classification under trauma and stress or related disorders, rather than anxiety disorders. A subtype of PTSD with dissociative symptoms was added, and may be relevant to female veterans with MST, who in addition have high incidence of previous trauma and have been found to present with symptoms connected to Complex PTSD, such as dissociation (Luterek, Bittinger, & Simpson, 2011). Symptoms that accompany PTSD are divided into four clusters: re-experiencing, avoidance, negative cognitions and moods, and arousal.

Multiple theories for PTSD stem from various branches of science and psychological paradigms. A general summary will be provided of current PTSD theory followed by the presentation of an integrated framework related to this study.

2.1.1. NEUROBIOLOGICAL PERSPECTIVE

The neurobiological perspective of trauma seeks to explain the physiological effects on the brain. The experience of perceived overwhelming danger and accompanied feelings cause a dysregulation of the biological mechanisms that help the body to process stress (hypothalamic – pituitary adrenal axis and the sympathetic nervous system) (Sakellariou & Stefanatou, 2017). After the trauma, reminders of the experience activate regions associated with fear (the amygdala) and deactivate regions connected to emotional regulation (the anterior singular cortex) and thinking (prefrontal cortex). This bimodal response to trauma presents as hyperarousal and

shutting down. Traumatized individuals shut down in response to the hyperarousal due to the inability to neutralize stimuli in their environment. Shut down can occur through avoidance of situations and through emotional numbing, leading to decreased engagement in everyday life (Van der Kolk, 2003). Neurological theorists recognize the importance of working directly with the body and physiological responses in order to address trauma, prior to processing the narrative. Van der Kolk (2014) points out the limitations of language when describing trauma in that the imprint of trauma effects parts of the brain related to cognition, making it difficult to produce a coherent narrative. Being able to regulate physiological symptoms is of primary importance before building a narrative. So while acknowledging the importance of talking about the trauma, Van der Kolk also advocates for integrating mind-body approaches to healing.

2.1.2. COGNITIVE-BEHAVIORAL THEORIES

Cognitive-behavioral theories stem from two lines of development, learning theory and schema theory. Learning theory explains avoidance through behavioral conditioning where, in the context of PTSD, the traumatic event includes neutral stimulus- for example an apple tree the victim was walking towards, and aversive stimulus- for example the perpetrator of the trauma. After the traumatic event, the neutral stimulus (in addition to the aversive stimulus) continues to elicit a fear response due to its' previous association with the aversive stimulus. The traumatized individual avoids the neutral stimuli out of a belief that it will lead to the aversive stimuli (Jaycox & Foa, 1998). In the above example, seeing, reading or thinking about any apple tree- might create a fear response because of its' previous association with the perpetrator. The individual avoids any association with apple trees in order to avoid the feelings of fear. As a result of that avoidance, there is no reality testing. The belief that the apple tree and the perpetrator are always connected cannot be refuted as long as the individual avoids apple trees.

Schema theories focus on trauma's impact on an individual's existing mental structures. Cognitive appraisal, or an individual's perceived threat of the event, causes overwhelming emotional, behavioral and biological responses that lead to dysregulation. Existing mental structures influence the degree of an ongoing sense of threat that the trauma will re-occur or that the individual will not be able to navigate coping with the emotions. According to Dual Representation Theory (Brewin, Dalgleish & Joseph, 1996), memories of the event seem to be coded in two different ways, sensory related and conceptually related. There is a belief that conceptualized representations are impaired in their coding, which is why an individual might remember certain sensory details- like the color of the walls, but not the narrative component of the event (Nijdam & Wittmann, 2015).

Emotional Processing Theory (Foa, Huppert, & Cahill, 2006), the theory connected to exposure therapies, integrates learning and schema perspectives. The theory holds

that there are two negative cognitions in relation to the fear structures that lead to development of PTSD. The individual believes that the world is dangerous and that they are incompetent to handle adversity. Emotional Processing Theory maintains that in order to modify cognitions and thus the fear structure, fear must be activated. Exposure therapies activate the fear in a controlled environment in order to work with cognitions. Theorists see flashbacks as an opportunity to repair the information that is fragmented in conceptualized representations and strengthen connections with the sensory representations. This is accomplished by decreasing the anxiety around re-experiencing the trauma (through exposure) and confronting old beliefs in order to replace them with more adaptive cognitions. Prolonged exposure therapy activates the fear structure by having the client relay the trauma experience to the therapist repeatedly in order to habituate. As the client habituates to the trauma, the fear structure changes and the emotional and physiological responses are modified. Cognitive Processing Therapy accomplishes the habituation through writing the trauma narrative. In both forms of exposure therapy cognitive structures are examined and previous thought patterns are challenged.

In summary, cognitive-behavioral perspectives focus on fear conditioning and cognitive schemas as the foundation for development and maintenance of PTSD. Treatments of PTSD according to these models involve confronting the fear structures and modifying underlying cognitions that lead to behaviors.

2.1.3. PSYCHODYNAMIC THEORIES

In contrast to cognitive-behavioral theory and a focus on individual's cognitive schemas, psychodynamic theories focus on relationship. Early psychoanalysis theory focused on dissociation and re-emergence of trauma memories and unresolved childhood experiences (Nijdam & Wittmann, 2015). Over the years, early theories have been updated and now reflect a psychodynamic approach. In relation to PTSD, Nijdam & Wittmann (2015) identified three central tenants of trauma from a psychodynamic perspective. The first is that trauma is a subjective experience, which means that it is less the event and more the individual's life experiences that will determine the trajectory following exposure. Two people will not react in exactly the same way to the same trauma event. The second tenant is that an individual's personality that was shaped by (primarily early) interpersonal relationships, determines the ability to process traumatic experiences. A client may say when asked, that they are avoiding a memory because it is painful to talk about, but a psycho-dynamic perspective would maintain that there is a deeper interpersonal reason for the avoidance, such as an earlier memory of being undermined when sharing a painful experience. When processing previous experiences, psychodynamic therapists use a here-and-now approach to examine how past relationships are impacting current relationships, including the therapy relationship. Uncovering the previous patterns in relationships that shaped the personality allow the individual to look at present relationships and work to form new emotional patterns. The third tenant is that trauma

has a social dimension, meaning that trauma is not a discrete experience but an open one that continues to be shaped by social reactions and social constructs of the event. In other words, the relationships continue to influence how the trauma is perceived and processed. Greater awareness of the social dimension has led to development of social perspective theories.

2.1.4. SOCIAL PERSPECTIVE THEORIES

Social perspective theories suggest that societal values and reactions to trauma can be moderators in the development and recovery of PTSD. Multiple meta-analyses have maintained that social support is one of the primary predictors of PTSD (Brewin, Andrews & Valentine, 2000; Chaumba & Bride, 2010; Ozer, Best, Lipsey & Weiss, 2003), but references to the influence of social factors are hidden in most models of PTSD. Maercker and Horn (2013) maintain in their socio-interpersonal model that awareness of the social contexts of individuals can enhance treatment outcomes. At an individual level, social context includes the intrapersonal issues related to how the individual thinks about themselves in society, including the interpersonal element of social cognitions and related feelings of shame and guilt. The second level of social context is close relationships such as romantic partners, friends and family members and how those relationships interact with the trauma. Processes involved at this level are disclosure of trauma and level of social support offered from people close to the individual. The third level is termed the distant social level and comprises cultural and societal influences in how the individual processes trauma. Considerations at this level are whether the individual identifies with a certain religion or health system that would influence how trauma is viewed based on shared cultural values. One's culture of origin also greatly influences how trauma is perceived. Some theorists maintain that trauma is indicative of a societal illness and reflects the attitudes of the community and health models (Jakovljević, et al., 2012). Societal beliefs can be especially impactful in traumas that involve a perpetrator, such as sexual or physical abuse. These traumas are more often experienced by women than men, are referred to as high impact traumas, and likely involve a person of attachment as the perpetrator (López-Castro, Saraiya & Hien, 2017). In terms of responses from the community, women are more likely to experience negative interactions and are more likely to be impacted by the disruptions in social support (Andrews & Brewin, 2003). Gilfus (1999) suggests reframing trauma pathology into strengths and resistance strategies for rape victims, arguing that trauma is socially constructed to be a pathology that restricts victims to solutions at an individual level rather than collective.

> A trauma diagnosis erases any reference to the real source of the problem-the individual and collective perpetrators of violence…The medicalized trauma model looks only at the psychological aftermath (sequelae) for the victim, not at the offender, the source of the injury, or the social and

cultural context of the victimization-the conditions that give rise to such violence (p. 1242)

In summary, social perspective theories on trauma take into account the context of the individual in their societal group and the society's reaction and response to trauma. Social theorists seek to change the perspective on trauma away from an individualized approach and towards a community approach to prevention, response and recovery.

2.1.5. INTEGRATED PERSPECTIVE

An integrated theory of trauma works from multiple perspectives in order to build a more complete explanation of how trauma impacts the mind, body and interpersonal dimensions. Some integrated perspectives on trauma maintain two perspectives and others are more complex. Jakovljević et al., (2012) for instance, offer a theory that is a "transdisciplinary multiperspective integrative model of PTSD" and combines at least seven perspectives. This PhD research is grounded in Herman's three stage trauma model, but also draws strongly from Van der Kolk's views on trauma. Though Herman (2015) does not claim a specific theoretical orientation, there is a clearly implied connection to psychodynamic, feminist and social perspectives in her writings. Van der Kolk (2014) is grounded in neuroscience, psychopathology and interpersonal neurobiology. Both psychiatrists share an integrated view of trauma and recovery. A description of some key points from each will be presented followed by an integrated model that aligns the two perspectives.

Herman (2015) identified a three-stage therapeutic process that enables trauma survivors to stop unhealthy coping behaviors such as eating disorders, impulsive risk-taking and substance abuse and to move forward in life with a new perspective on the trauma. The first stage, regaining a sense of safety, is accomplished through establishing a trusting therapeutic relationship in which the therapist supports the client to learn self-care. From a neurobiology perspective, this is where the client is learning valuable coping skills that will help with regulating symptoms associated with PTSD. This is of primary importance since it is a pre-requisite for the second phase: active trauma work. The second stage, remembrance and mourning, explores the trauma through building a narrative. Verbalizing the memory of the trauma brings it into the present and allows the client to grieve. An increase of PTSD symptoms is common during this phase. When this occurs, the therapy process is slowed down to a tolerable level by returning to the earlier phase of establishing safety and practicing learned coping skills. The third stage is reconnection and includes engaging this new perspective of self with community, groups and society.

Herman views the therapeutic relationship as a collaborative one with a focus on empowering the client to have autonomy in the process (Herman, 2015). There is a beautiful paradox here as she acknowledges that healing cannot happen in isolation *but* the client must be the author of her own recovery. Other people can offer support

and care, but not the cure. Herman also calls on political action from society, stating that abuse will not go away as long as we are a patriarchal society. Her views were built strongly from her mother's political involvement and from Herman's own participation in the women's movement. Herman's work has primarily been with victims of violence and sexual abuse. Though all trauma is overwhelming, trauma that is experienced from a perpetrator who often is known to the individual, rather than trauma from an accident or combat, is unique due to issues of trust and imbalances of power that must be addressed. Essentially Herman's model addresses those issues through a focus on relationships, on bearing witness and on society's role, which is of great importance in this context (Herman, 2015).

Van der Kolk's primary contribution to trauma theory has been a focus on the connection between mind and body (2014). He acknowledges the imprint of trauma on the body and the importance of addressing physiological responses, such as increased arousal and decreased emotion before moving into verbal interventions. Verbal therapy necessitates an emphasis on language and insight, but one of the consequences of trauma is that individuals are disconnected from recognizing their feelings. With a disconnection from feelings there is a numbing of awareness and a barrier to the implicit knowing that comes from our inner world and contributes to intuition. Van der Kolk maintains that connecting the individual to an awareness of the feelings in their body is the first step to trauma recovery. "Neuroscience research shows that the only way we can change the way we feel is by becoming aware of our *inner* experience and learning to befriend what is going on inside ourselves" (2014, p. 206). In *The Body Keeps the Score* (2014), Van der Kolk provides guidelines for fostering the connection between the body and mind.

- Befriend the Emotional Brain through:
    - Mind body practices such as yoga to help cope with physiological symptoms.
    - Learning and practicing mindfulness to increase body awareness and recognition of feelings.
    - Building relationships in order to have a visceral experience of safety, love and trust.
    - Getting support from a professional therapist who can help the individual to stabilize, process trauma and re-connect.
    - Connecting and engaging with the community
    - Body work such as massage or craniosacral therapy to increase sense of touch and body awareness.
    - Activating the body to take action through body-based therapy or self-defense course.
- Once the "brain structures" are addressed through attention to mind and body awareness, processing the trauma in a narrative manner can begin.

The challenge is to "reestablish ownership of your body and your mind- of your self" (Van der Kolk, 2014, p. 203). Like Herman, he acknowledges the importance of relationship, connection to community *and* the importance of empowerment through gaining ownership of the self. But attention to the body is the primary focus and means for accomplishing ownership. Another alignment is that Herman's Stage One addresses trust and coping skills, much of which could be accomplished through mind-body techniques and the visceral experience of trust and care in a therapeutic relationship. And Van der Kolk's suggestions of working with a professional therapist to stabilize symptoms, process trauma and re-connect with community mirrors Herman's three stages of therapy.

Zaleski, Johnson and Klein (2016) draw on this alignment when they suggest grounding Herman's theory within interpersonal neuroscience. From a foundation of neuroscience, they offer an integrated model that highlights safety, relationship, trauma processing and reconnection. In Herman's first stage of safety, the focus is on learning to control the autonomic nervous system's response to trauma in order to restore disrupted biological systems that regulate processes such as sleep, hunger and concentration. From a neuroscience perspective, the second stage of remembrance and mourning is necessary in order to integrate the various neural pathways of the trauma memory into a coherent whole.

> This organized and verbal account allows the survivor to use the left hemisphere of her brain toward logical and linear recall of events, as well as the right side to acknowledge the embodied experience. Additionally, this process permits the lower parts of the brain, including the limbic areas, to move wordless memory toward the frontal executive portion of the brain to make meaning of the event (Zaleski et al., p.386).

Herman's third stage is seen from a neuroscience perspective as the "final phase of neural integration" as the individual reconnects with the community from a new perspective of trauma. From an interpersonal neurobiology perspective, neural integration is also seen as essential for reclaiming a sense of self. This is mirrored in Van der Kolk's point of "ownership of self" (2014, p. 203) and Herman's "arbiter" (2015, p.133) of recovery.

Some points highlighted in the integrated model are:

- Trauma that occurs in relationship must heal in relationship.

  - The consultation room is where safety is gained incrementally and the therapist's task is to attend to safety first and throughout treatment.

- Trauma processing can only occur once basic safety and self-regulatory capacities have been attained.

- o Neurological structures in the brain are impacted by the trauma (i.e., the amygdala is activated for a fight, flight, or freeze response). Processing too soon can flood the client, dysregulating the autonomic nervous system further, and perhaps exacerbate (or reenact) trauma symptomology.

- As the mind and body reregulate, the therapist acts as a bridge, helping the client regain safety in the world, testing each new social situation, with the anchor of safety in the consultation room.

- The final step for trauma treatment is often the reengaging with the outer world that the trauma has incapacitated. This can be in the form of vocational reentry, psychotherapy group treatment, or similar modalities.

(Zaleski et al., pp. 391-392)

Summary

The above theories present trauma from various perspectives as well as an integrated view. For this research study trauma theory was primarily informed by Herman's and Van der Kolk's perspective, which maintain an integrative view on trauma. There is a semblance between an integrated manner of addressing trauma healing and the GIM process. Van der Kolk (2014) makes a powerful statement in reflection of his early experiences and telling clients to feel or not feel a certain way. When confronted by a client that his verbal interventions were not helpful, he states that he realized that "my responsibility goes much deeper: I have to help them reconstruct their inner map of the world" (p. 128). A GIM therapist guides their client to connect with their inner world and through the method- through music, imagery and narrative- provides tools for re-connecting with the body and the mind, processing the trauma through direct memories or in metaphors, and exploring (re)connection of a new empowered self in the world. The theoretical foundations of GIM related to this study are presented in section 2.3 and are further explored in description of the Continuum Model in Chapter Six.

2.2. MILITARY SEXUAL TRAUMA

In order to understand the reason MST occurs, researchers have drawn on theories of sexual violence and war (Zaleski, 2015). Sexual violence as warfare is not the same as sexual trauma *within* the military, but MST has only garnered attention in the last few decades and the literature has been focused on the impact and support of victims rather than theory. Concepts from sexual violence and war provide a starting point for understanding sexual assault within the culture of the military. Much of the

understanding comes from feminist literature, which maintains that violence and abuse against women is an attempt for dominance and control through the subordination of women in order to uphold patriarchal institutions; however, MST is complex as its victims include men and women. To begin to understand MST, factors connected to gender, cultural and social constructs inherent in the military must be examined (Majewski, 2105). Skjelsbaek (2001) reviewed 140 scholarly texts that addressed the issue of sexual violence and war classifying them into three conceptualizations of understanding: essentialism, structuralism and social constructionism. Each conceptualization will be presented below, embedded with further support from recent MST literature.

2.2.1. ESSENTIALISM

Essentialism's argument is most similar to original feminist thought that men are focused on asserting masculinity and upholding patriarchy through the subordination of women. In essentialism the target is *all* women because all women are seen as inferior to men. In essence, feminist scholars argue that men are acting out a natural role that aggressively seeks to exploit and dominate what they possess, in this case, women (Skjelsbaek, 2001).

In Archer's (2013) examination of gendered stereotypes in the military, a US Marine Corp Captain alludes to that natural impulse in his statement.

> To be again perfectly blunt, in my mind to understand males, and which helps me understand even myself, is we operate on a cycle: hungry, horny, and sleepy. You know, when I'm tired don't mess with me and when I'm hungry the same thing. And when I'm fed and I've slept, there's only one thing on my mind. Now, that's an oversimplification, but you'll find when you use it you really understand both males in general and my Marines. (p. 368)

Archer found from her interviews that the men's most common descriptions of a female Marine was "easy, emotional and sexually coercive" (p.373). She maintains that a view of inferiority places female Marines at a disadvantage, making it unlikely that community building and successful work relationships will occur.

Military culture highlights gender differences and places higher value on masculinity (Drake, 2006). Cultures that promote masculine attributes in extremity are sometimes called hyper-masculine. Recruits into the military are indoctrinated to this masculine culture that is reinforced through daily structure and socialization. Burkhart & Hogan (2015) interviewed 20 women veterans from various branches of the US military, who identified a period of culture shock upon enlisting as they experienced "being yelled at" and harassed (p.115). Most of the women also described incidences where they were treated as inferior or demeaned for being female, residing in a culture of "harassment, verbal abuse, and sexual innuendoes" (p. 117). Hyper-masculine

cultures share certain attitudes towards masculinity, sexuality and women that have been found to have a higher incidence of rape (Drake, 2006). During times of war in particular and in the military culture in general, gender roles and gender relations are heightened, therefore the essentialist argument is that if men are likely to use rape to assert their power, they will be more likely to do so in a culture that places high values on power and views women as inferior (Skjelsbaek, 2001). Again, a key point of this argument is that *all* women are targeted for being women, rather than an attack on certain individuals. Essentialism is focused on the perpetrator, unvarying aggressive males, suggesting that at a basic level "It is what men do to women when they can or must" (Leatherman, 2011, pp 13-14).

2.2.2. STRUCTURALISM

Structuralists maintain that the flaw in essentialism is its claim that all women are victims and all men are perpetrators by nature. Structuralism asserts that although all women are subject to being victimized, there is a greater threat to women representative of certain economic, political, religious or ethnic groups that men perceive threatening. This places sexual violence and war into a cultural context theory in addition to a feminist one (Skjelsbaek, 2001). In this conceptualization, certain women would be targeted as being different while others would most likely be protected by men. Examples of this targeting are seen in incidences of ethnic cleansing and genocide (Leatherman, 2011).

Though structuralism seems plausible as an explanation for the war zone and targeting of women from enemy countries as the embodiment of that culture, it does not seem to hold true for sexual trauma within the military. There is presumably much more homogeneity in the political, ethnic and religious backgrounds of the US military for instance, than in two opposing countries. Though demographic data on political and religious background is difficult to find, many studies obtain information on ethnic background, employment and education level and have found no significant differences in victim profiles (Maguen et al., 2012; Surʹıs et al., 2013). Though the literature shows little difference- aside from gender in individuals being targeted, it is plausible that there are other factors connected to identity or personality not captured in the data. Military studies would need to analyze gender and socio-cultural mediating variables to determine if some groups of women are targeted more than others. Structuralism maintains an emphasis on the perspective and identity of the women rather than the perpetrator, but it fails to acknowledge that men are also victims of sexual violence.

2.2.3. SOCIAL CONSTRUCTIONISM

Military sexual trauma happens to men and women and therefor needs a broader context that encompasses systems, beliefs and norms and their intersection with the situational expressions of gender. Social constructionism recognizes that both men

and women can be victims, that the violence is contextualized by the social identities given to the victim and perpetrator, namely that the masculine/ power role of the perpetrator is highlighted as is the feminine/ passive role of the victim (Skjelsbaek, 2001). Rather than biological deterministic rules of patriarchy, the given social identities are based on beliefs and expectations of normal social behavior by each gender (Leatherman, 2011). Because social constructionism rejects a static view of gender it would not be considered feminist theory in a purist sense, but the common ground is a focus on power dynamics and hierarchies.

Social constructionism recognizes the truth in essentialism and structuralism but maintains that the key is the feminizing of the victim and the masculinizing of the perpetrator regardless of the gender of each individual. The hyper-masculinity of many military cultures requires adherence to rigid masculine qualities of independence, power and control. In these rigid identities, masculinity is equated with male, white and heterosexual. Anything outside that preconceived idea of masculinity, such as women in the military, homosexuals, other ethnic backgrounds or men perceived with feminine qualities, would be seen as threatening to that construction of masculinity. According to Leatherman (2011), "allied masculinities are empowered, while subordinate and marginalized masculinities are ostracized or exploited along with womanhood and femininity" (p.18).

Social change is possible as social constructions of gender change. It is likely that women will remain a part of the military force in many countries, so the solution lies in constructing a military culture that is more socio-culturally balanced (Archer, 2013; Leatherman, 2011). More than essentialism or structuralism, social constructionism provides some sense of hope that the dynamic that leads to MST can change.

2.3. GIM: THEORETICAL FOUNDATIONS

The theoretical foundation for this study is grounded in previous theory work from: Körlin's (2002) neuropsychological theory on music, imagery and trauma, Summer's (2009) music-centered GIM and Bonde's (2004, 2005b) GIM narrative and metaphor. These theoretical foundations pertain to particular components of the GIM session.

2.3.1. IMAGERY

In GIM, images are expressions of the inner world of the client. Images hold memories of conflict and trauma, but more importantly, positive inner resources or what Körlin terms "resource imagery" (Körlin et al., 2000). A resource image connects a client to her ability to be resilient in the face of conflict, or to overcome some adversity. The images that hold these resources come in various forms such as visual, kinesthetic and emotional feelings[2]. Examples of such resources would be

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[2] See Grocke & Wigram (2007), Table 5.2 for types of imagery experiences.

subjective to the inner schema and life experience of the client, but she might experience a visual image of a nurturing figure or the feeling of the music being holding in a nurturing way, images that represent inner strength, colors that represent her strength or sense of peace. Strong connections with positive inner resources become important in terms of a client's cognitive appraisal and coping with the effects of trauma. Learning to use these positive images, along with the music, can be a coping resource for decreasing arousal and emotional regulation (Story & Beck, 2017). This connection with resource imagery also allows the client to symbolically confront traumatic material, come to a resolution and prepare for the next challenge. Numerous GIM therapists have written about these positive inner resources (Beck et al., 2017; Blake and Bishop, 1994; Goldberg, 1994; Story & Beck, 2017; Summer, 2010). Körlin (2007) describes the process as "resource mobilization" and further states that these experiences have the potential to take a client beyond the psychodynamic dimension and into addressing archetypal and transpersonal issues.

Clients also manage difficult or traumatic material through the use of defensive maneuvers. "Defensive maneuvers" is a concept Goldberg named to describe the process of the client transforming a potentially overwhelming image into something less threatening. Defensive maneuvers are seen as a healthy coping mechanism used to avoid fragmentation (Goldberg, 2002).

There are similarities between defensive maneuvers and resource mobilization, but defensive maneuvers are a way to manage trauma through not engaging with material in that moment, whereas resource mobilization is connected to accessing positive inner resources to move forward and confront difficult material. An example of a defensive maneuver might be a client feeling afraid in the midst of a forest and suddenly finding themselves by a relaxing stream, whereas an example of resource mobilization might be a client feeling afraid in the midst of the forest and accessing some form of helper who walks with them to confront their fears. Neither mechanism should be viewed as having a discrete mechanism as one can also find defensive maneuvers described as a method for empowerment (Moe, 2002), and resource mobilization as a way to establish safety (Körlin et al., 2000). Though GIM therapists are generally non-directive in their guiding, a therapist may provide possibilities to support defensive maneuvers and resource mobilization to manage difficult material.

2.3.2. MUSIC

Images symbolically provide something more concrete to bring back from the experience, through drawing, writing, or discussion of the images. Those images result from the experience with the music as music is at the core of the GIM process. Summer (2009) presents a music-centered framework for GIM where clients are supported to recognize and deepen their relationship to music. This is encouraged through techniques such as repeating a piece of music numerous times and guiding in a manner that directs the attention to the music.

For a client with PTSD and MST this music-centered focus along with resource-oriented music and imagery, can be a supportive entry to GIM work fostering a connection to her music and her positive inner resources, which in turn may improve resilience. This would be encouraged through supporting the client to choose a piece of music from her own collection that aids in identification of a positive resource and holding the client in that space. Building safety and trust as in Herman's first stage of recovery, the emphasis is on activating inner resources and highlighting her ability to re-connect to her core strengths through *her music* or more accessible music chosen by the therapist. Once those strengths and resources are mobilized, she could begin modified GIM work and symbolically confront the trauma, moving into narrative re-construction. This would lead into work with more complex classical music. Principles of this process are further explained in Chapter Six.

Bonny specifically chose Western Classical music because of the aesthetic experience that affords a structured, non-threatening space for self-exploration (Bonny, 1999). Classical music is complex enough to provide the right amount of support or freedom needed to elicit material from the conscious and unconscious mind. Summer describes a "not-me" experience that may be connected to the levels of tension in the music. Choosing the music for a session is based on the holding and stimulation needs of a client. The client's experience of music as it develops further away from the client's home-base, allows images and thoughts from the unconscious to emerge and then be re-integrated. The "not-me" aspect results from the stimulation of the music as it develops. This stimulation occurs in the actual elements and structure of the music written by the composer, as opposed to listener generated thoughts. The musical theme and development is an analogy to the client's core self and development throughout the GIM session (Summer 1992).

Guided Imagery and Music therapists have examined the music in an attempt to understand what elements or properties support or correspond with emotional responses and imagery formation in the client. Bonny (2002a) identified five musical elements that have a strong influence on GIM, they are: pitch, rhythm and tempo, vocal or instrumental mode, melody and harmony, and timbre. Music programs were developed based on those qualities and what they brought to the music. This development was based on previous experience with GIM, not on empirical evidence. Bonny stated that she chose the programs intuitively and then later analyzed them for the musical elements. Having seen what was effective, Bonny started with the final product and worked backwards, breaking the music into its parts.

Grocke (1999) analyzed four selections from Bonny Method programs and found fifteen elements of music that supported pivotal moments in a GIM session. In her analysis, distressing imagery matched the music's strength and feeling. This aligns with Bruscia's (2002) view that the depth of the music will match the depth of the experience. The following features were found to be common to all four selections Grocke analyzed: formal structure, importance of rhythmic motifs, slow tempos,

diatonic and predictable harmonic progressions, a legato line, and dialogue between the instruments. Rather than lining up exact sections of the music, Grocke compared the overall flow and development supporting the imagery development.

Also considering overall music profile, Bonde (2005a) used phenomenological and heuristic methods of analyzing music and imagery from GIM sessions with six participants. Analysis of two movements from the Bonny Method programs was compared to the client's imagery. Commonalities in the music were not compared, rather the focus was on the overall form and style of the music. From the analysis, a grounded theory model was developed that explained how musical forms and styles might influence the development of imagery. The model is based on three different types of music used in the GIM session (supportive, mixed, and challenging) and works under the premise that if the music meets the client at their level, changes in intensity and tension will be reflected in the imagery.

Examining musical qualities through Stern's (2010) forms of vitality is another way to approach the music in GIM. *Forms of Vitality* (Stern, 2010), highlighted the connection of vitality affects, or vitality forms to music and other time-based arts: "the time-based arts, namely music, dance, theater, and cinema, move us by the expressions of vitality that resonate in us" (p4). Vitality affects are seen in forms of early communication that we learn as infants through interactions with our primary caregivers. In particular, interactions in the mother infant dyad were studied to identify vitality affects that pre-verbal children access as they learn to relate to others and form a core sense of self (Stern, 1985). Stern (2004) identifies vitality affects as central to our implicit knowing, which is a precursor to explicit knowledge. However, once explicit knowledge becomes available it does not render the implicit knowledge obsolete, rather they remain two independent systems that are active throughout our lives. Stern further argues that implicit knowing be identified as the primary one on which to focus during therapy sessions. The vitality forms connected to implicit knowing, and also found in music, are described, but not limited to: surging, fading away, crescendos, and decrescendos. Music and other art forms have found ways to code these dynamic forms in order to make them translatable to other performers. In music, markings such as *piano, mezzo- piano, forte* relay the intensity or force that is used to play a series of notes, while *changes* in intensity are noted by *crescendos* and *decrescendos.* There are many others, such as accent markings, phrasing, and tempo or rhythm changes (Stern, 2010).

Not connected to specific content, vitality forms are about *how* we experience something. Stern (2010) summarizes the importance of vitality forms and their connection to dynamic experience.

> Dynamic experiences are essential aspects of what art, and life, are all about. It is interesting that the arts have been the pioneers for so long in exploring the dynamic dimension in the human experience. However, this

is not strange given that the vitality forms are not readily describable in words or mathematics. Moreover, when they are so described, and they can be, they lose most of their ability to evoke. (p. 98).

Stern's connection to dynamic experiences being essential aspects of life resonates closely to Winnicott's (1971) attention to importance of play in life. Both focus on the dynamic dimension of relationship, whether termed "play" or "vitality forms," being the space where therapeutic processes unfold. Moe (2002) also draws a connection to Winnicott's play in relation to the manner in which clients play with their inner forces through the imagery that emerges in GIM sessions. One possibility is that clients are engaging or responding to the vitality forms that emerge in the music and are reflected in the imagery.

Vitality forms occurring in music are a collection of dynamic musical properties working in combination to achieve a stimulation of emotional processes through arousal of the autonomic nervous system. These affects have an important role in connecting the traveler to imagery also expressive of those same dynamic forms of vitality. Stern (2010) identified the following implications or roles of vitality forms in psychotherapy:

- Vitality forms lead to an exploration of previously non-conscious material
- Vitality forms lead to "(re)-constructed" phenomenal experience
- Vitality forms lead to "imagined movement" that stimulate neural activity, leading to a re-shaping of mental models and neural networks
- Attention to vitality forms leads to increased awareness of behaviors at a local level, or micro-level
- Vitality forms are a core component of affect attunement and intersubjectivity
- Vitality forms aid in identification and understanding in relationships
- Vitality forms communicate authenticity

All of the above mentioned implications are important therapeutic processes in psychotherapy and in GIM. In relation to trauma and the before mentioned integrated theories, these factors can be interpreted as important for learning to "befriend the emotional brain" (Van der Kolk, 2014).

With the view of music *as* therapy in GIM, practice is from a music-centered perspective where the relationship with music holds the therapeutic potential where transformation occurs. Garred (2006), referring to Stern's concept of implicit relational knowing, explains it in this way:

Following the rationale for music as therapy, it is the intensity of experience that may hold therapeutic potential here, because it implies a

possible change in the implicit relational knowing, through a moment of meeting with music. It is to the degree that this kind of meeting happens that it may be said to be therapeutic, in that such an experience may bring with it a new sense of self. With an experiential approach, it is the intensity of the experience, rather than the "content" of it, which becomes central. (pp 296-297)

Experiences in music that hold intensity are difficult to communicate, and by communicating we produce this "content" Garred refers to as secondary to the "experience". This also relates to trauma theory in that the individual must re-experience this implicit way of knowing through re-connection with the body in a safe way in order to trust their gut feeling or their intuition. The content however, assists in our integration of implicit knowing into explicit understanding. Integration of implicit and explicit knowledge is one of the final goals in trauma work from the perspective of neural integration. Metaphors help to bridge that implicit/ explicit process.

2.3.3. NARRATIVE PROCESSING

There is a power in the narratives that emerge from this process, narratives that may be a metaphorical product of the relationship to music. One of the ways that implicit knowledge becomes explicit is through processing the images and metaphors that emerge in a GIM session through the client's relationship to music. Grounded in Ricoeur's theories of narrative, Bonde (2004) has written about metaphor and narrative in relation to GIM work, identifying three levels within the therapeutic narrative:

1. The core metaphor, where previously hidden meaning emerges in imagery
2. The discovery of personal voice through metaphors of ego and Self
3. The narrative from joining the imagery with the individual's life story

Images from the sessions function as metaphors that with more explicit processing may serve to re-construct personal narrative and a stronger sense of self. These concepts also connect to self-psychology, which maintains that individuals are driven towards interpersonal experiences that develop a sense of coherent self; and script theory, which analyzes underlying principles or rules of a particular experience- or in this case imagery- in order to make meaning or order from the experience (Ruud, 2003).

Many of the images that emerge in GIM work are metaphors that are difficult to put into words. Through processing creatively and re-telling the metaphors, a client may come to new understandings and integration of her life story. But the narrative that emerges is also contextual. A story, or interpretation of an image, that a client shares is constructed for the listener (her therapist or other group members), as well as

contextually influenced by the family, social, or in this case military system, of which she is a member. The context of the therapy and choices that are made within each session also influence what emerges, especially in connection to the music choices. But the beauty of GIM is that though the metaphors and music may change, there is a connection to the unconscious and implicit knowledge through the music. With a deep connection to the music, what needs to emerge will repeatedly emerge in various forms providing the client numerous opportunities to process material and gain insight.

In summary, certain therapeutic factors that interplay in the moment to facilitate change and healing come from:

1. The imagery: Identification of positive inner resources and a new experience of "self" in the music
2. The music: Supporting an awareness and deepening of the client's relationship to the music
3. The processing: The use of metaphors and reconstruction of personal narrative to form a more cohesive neural integration.

CHAPTER 3. EXTENDED LITERATURE REVIEW

During the four-year course of this study, the number of research studies related to military women and MST increased significantly as awareness and response to the issue intensified. What follows is a systematic literature review conducted prior to the formulation of research questions for the study. It is unaltered from the time is was conducted in order to allow the reader to follow how the published literature at the time informed the research questions and study trajectory. More recent literature is reflected in the background (Chapter One), the feasibility study (Chapter Five) and the discussion (Chapter Nine) of the thesis.

At the time of this review there were no published studies that addressed GIM or music therapy with female veterans and MST or PTSD, therefore a literature review was completed that addressed music therapy or GIM with related clinical populations: male veterans and PTSD, women and PTSD, women and sexual abuse. The intent of the review was to identify emergent common themes in music therapy sessions, prevalence of particular research designs, and theoretical mechanisms. After establishing a lack of music therapy studies, literature was examined related to female veterans, military sexual trauma, and post-traumatic stress disorder. The aims of the literature review were to determine the needs of the population, learn about current practices and endorsed methods of treatment, and examine related populations who received GIM in order to build a rationale for how GIM can potentially address the identified needs of women veterans with MST and PTSD.

3.1. FEMALE VETERANS

The following section includes a plethora of information related to female veterans. In the midst of all the studies and facts, one may lose site of the weight of the issue and the impact on the women who have encountered military sexual trauma. The following quote, in reference to MST, is to ground the reader in the perspective of a female veteran through her words.

> One of the problems over in Iraq for female soldiers is that there is a lot of sexual harassment and rape is huge. And it does not matter if you're 18 or 58. It does not matter. Women serving over there don't have to be worried about enemy fire. They have to be worried about the guy that's next to them, you know, that's supposed to be protecting and taking care of them and a lot of times he becomes like public enemy number one for them. (Mattocks et al., 2012, p. 540)

A growing body of literature on female veterans outlines unique challenges of being a minority in the military system as women differ from men in relation reactions and effects of trauma, coping skills, sense of identity, treatment trajectory, and re-integration to civilian life. Many studies that have sought to gather this information, mainly through descriptive data from women who have sought care from the VA hospitals in the US, but due to multiple reasons outlined below, most female veterans do not seek care from the VA (Koo & Maguen, 2013). As a result, the descriptive experiences from most of these studies represent a small percentage of women who served in the military, predominantly the US military, and have sought care through a VA hospital

Following guidelines summarized by Hanson-Abromeit & Moore (2014), a systematic literature review was undertaken to explore the following questions in regards to female veterans with military sexual trauma and PTSD:

- What are the predominant issues for women exposed to military sexual trauma?

- What are the standard care recommendations for veterans with PTSD?

- What are the mechanisms of action in therapy, possible mediators and outcomes?

The articles are organized in sections beginning with those that address predominant issues followed by clinical trials. Relevant articles are presented in a table followed by a summary of those found to be most salient. Finally, findings are summarized (section 3.1.4) related to the questions for this review of literature.

During July 2014, the following databases were searched: Academic Search Complete, CINAHL, HealthSource, Medline, PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection. In order to answer the questions related to the review, two separate inquiries were performed. The first question related to female veterans and MST used the terms: "female veterans," "military sexual trauma," and PTSD. Both quantitative and qualitative studies were included. Inclusion criteria were that the articles be peer reviewed, published in English, and address the experiences of female veterans or military sexual trauma and PTSD as the primary focus. Editorials, studies focused on medical outcomes or studies with only men were excluded. The initial return of peer-reviewed articles was 63, after duplicates were removed the total was 28. After reviewing abstracts and detailed information, 26 articles were found to be relevant.

3.1.1. PREDOMINANT ISSUES: PREVIOUSLY PUBLISHED REVIEWS.

When there is a topic that has been identified as high priority, such as MST, literature quickly emerges in order to identify salient features of the issue. There are several published literature reviews related to female veterans, some as systematic reviews with a very specific focus and others more general, which led to much overlap from the reviews in the articles retrieved and the summarized findings. Any articles examined in a published literature review were not re-examined for this review. Of the 26 articles retrieved eight were previous literature reviews, encompassing all relevant articles found up to 2012. Table 3-1 lists the eight literature reviews published between 2006-2014, followed by a summary of three of those reviews.

Table 3-1 Previous literature reviews: Female veterans

Study	Focus	Description	Outcome
Allard et al., (2011)	Identify gaps and propose a research agenda	<2009 74 articles	Prevalence/ health correlates are most researched
Bean-Mayberry et al. (2011)	Accomplishments since previous review (Goldzweig et al., below)	2004-2008, 195 articles	Increased research, but small number of RCTs with research mainly descriptive
Chaumba & Bride (2010)	Examine experiences, programs, services	2005-2007, 23 articles	Social support is a protective factor
Conard & Sauls (2014)	Is there a correlation between deployments and PTSD in female veterans?	10 articles	MST is a traumatic stressor from deployment Females had a higher risk of depression and males of substance abuse
Crompvoets (2011)	Explored health and well-being issues that emerged from a systematic review	35 articles reviewed from 3 countries	Components of well-being: Ability to cope and symptoms of PTSD Sense of identity influences outcome and access to services Debrief and comfort from peers is important
Goldsweig et al. (2006)	Reviewed state of research in relation to female veterans	1980-2004 182 articles	Most research is descriptive Experimental and quality of care studies were rare
Middleton & Craig (2012)	What are the themes and gaps in literature?	1990-2010 28 articles	Themes explored: trauma types, previous hx trauma, combat exposure, health correlates, gender, and effective treatments Gaps: role conflicts, social support and gender; attention to comorbid diagnoses, combat exposure

Study	Focus	Description	Outcome
O'Brien & Sher (2013)	What are the social, epidemiological, and clinical characteristics of MST?	1990-2012 # of articles reviewed not disclosed	MST related to PTSD, substance abuse, depression, anxiety, eating disorders, suicidal behavior, more medical illness, difficulty in involving intimacy Higher prevalence of trauma before, during, and after their military involvement

Allard et al. (2011) published a literature review in order to propose a research agenda for MST. The review identified gaps in the current literature. The articles focused mainly on prevalence and health correlates from MST and of the 74, only 3 addressed treatment outcomes specifically for female veterans. Prevalence of MST was the largest researched topic and rates covered a wide range from 22% to 45%, perhaps due to question format and whether a definition of MST was provided to the questioned veteran.

Identified findings from the synthesis are that distress from MST has been associated with PTSD, anxiety, depression, and overall poor mental health functioning. Other presented correlates were complications in sexual functioning, a greater number of physical health complaints, and increased number of chronic health problems. Civilian sexual assault research is often applied to this population, however Allard and colleagues stress that the literature reveals unique components of MST due to individual, trauma-related, and contextual factors.

- Individual factors: Multiple traumatic events are a predictor of greater distress. Military personnel report previous sexual trauma at a higher rate than civilians.

- Trauma-related factors: Interpersonal trauma leads to more severe presentation of symptoms due to closeness of relationship. MST is most often perpetrated by other service members in the military.

- Contextual factors unique to MST that lead to greater distress are continued exposure to the perpetrator, the hierarchy and power issues in the military rank system, an emphasis on unit cohesion, and limited social resources.

Based on the Allard review, there is some support for Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE), the two mainline treatments endorsed by the VA. Some of the studies that used methods other than CPT or PE were listed as promising but with limited value due to small sample sizes, lack of a control group, or insufficient description of treatment. Treatment attrition was another identified area of need. Based on studies reviewed that examined attrition, there was a high

dropout rate among participants enrolled in PTSD studies (ranging up to 54%) and a suspected higher dropout rate in the actual clinical population not enrolled in studies (ranging up to 80%).

Chaumba and Bride (2010) sought to identify trauma experiences, services and programs for women in the military. After excluding articles that addressed severe PTSD, only included male samples, or were evaluative treatment approaches, 23 of the 105 retrieved articles met criteria for review. An important finding from this synthesis was that "Social support has been shown to act as a protective factor in the development of PTSD, especially among female veterans" (p.299). Women who had a greater number of friends and family with whom to process experiences during deployment had a lower incidence of PTSD. There is no mention of whether social support had an effect on recovery from PTSD, but reaching out for support is difficult for individuals with PTSD, who isolate and withdraw as a means of coping with their symptoms (Steward, 2013).

In one of the few articles that addressed female veterans from countries in addition to the US, Crompvoets (2011) reviewed 35 studies from the mid 1990's from America, Australia, and the UK. The narrative synthesis was driven from questions related to experience and well-being of female veterans.

Several components connected to identity factored into a female veteran's experience of well-being. Depending on her particular circumstances, a woman in the military may be balancing many identities such as, professional, military, being female, being a spouse or partner and being a parent. These various identities can be at odds and create tensions that can also be a barrier to seeking care. Components that led to or took away from a veteran's sense of well-being were primarily her ability to cope, satisfaction with parenting, effects of sexual harassment, and PTSD symptoms. Female veterans found that talking about their experiences with other veterans was an effective means of coping. Crompvoets also draws attention to the power of narrative, explaining that the act of telling the story of one's trauma transforms it into a more tolerable form in order to achieve a more integrated understanding and sense of self.

3.1.2. RELEVANT DESCRIPTIVE STUDIES SINCE 2010.

Included studies published since 2010 were limited to those that led to further descriptive demographics of MST or clinical trial research with MST and PTSD. Other published articles, not included, were written with a focus on educating specific health care providers that may come into contact with MST, such as lawyers (Koo & Maguen, 2011) or vocational counselors; as these types of articles are also a synthesis of what was found in previously published literature reviews, they are not included in this section. Listed in Table 3-2 are the relevant articles published after 2010 that met inclusion criteria, followed by brief summaries of the most relevant.

Table 3-2 Descriptive studies 2011-2014

Study	Research focus	Description	Outcome
Curry et al. (2014)	Comorbidity correlates in current female veterans	Diagnostic interviews registered from previous research studies, n = 1700	Major depressive disorder was frequent Anxiety/ eating disorders common in women
Gibbons et al. (2012)	Gender differences in response to deployment	Secondary data analysis n = 455	Greater impact on social relationships among females than males
Katz et al. (2012)	Prevalence/ gender differences	Completed questionnaires, n = 470	MST strongly related to intimacy problems No gender differences in symptoms
Kelly et al. (2011)	Relationship of lifetime trauma and PTSD	Review of data from medical records, n = 135	95.4% reported at least one trauma in addition to MST
Luterek et al. (2011)	Explore relationship between MST and PTSD and other symptoms associated with Complex PTSD	214 (50% female) veterans completed questionnaires and participated in one interview	Female veterans with MST reported a higher incidence of other traumas and symptoms similar to Complex PTSD
Maguen et al. (2012)	Correlates of PTSD, including MST	Retrospective data records (2002-2008), n = 213, 803	Veterans with MST had more comorbidity Gender differences in type
Mattocks et al. (2012)	How do veteran women cope with combat and MST?	Semi-structured interviews, 19 participants	Stressors: post-deployment integration and stressful military experiences including combat, MST, separation from family Engagement in healthy and unhealthy coping measures
Mott et al. (2012)	Describe treatment of female veteran with MST, and resulting comorbid PTSD and eating disorder	Case study with 28 year old woman	Participation in treatment that included group CPT and 1:1 exposure therapy Client decreased PTSD symptoms and began improvements in eating disordered behaviors

Studies continue to focus on correlates and comorbidity in order to determine best treatment trajectory for this unique subset of PTSD. Examining MST among veterans who had been deployed to Iraq and Afghanistan, Katz et al. (2012) used questionnaires to explore prevalence, readjustment, and gender differences. Of the 470 returned, 42% of the women reported MST. Conclusions continue to support findings that MST is related to PTSD and readjustment issues. There was a strong correlation to issues of intimacy. Women reported MST at a higher incident than men, however men reported a higher incidence of MST in combination with multiple war-related stressors.

There are other gender differences connected to comorbidity. Maguen et al. (2012) examined medical records for correlates of PTSD including MST. Among the 31% of women who screened positive for MST, there was high incidence of a comorbid diagnosis of depression, anxiety, or eating disorder compared to men who were more likely to have a comorbid diagnosis of substance use disorder.

Comorbidity from additional diagnoses such as depression, anxiety, and substance abuse make treatment more complex, however another confounding variable is past history of sexual abuse. Kelly et al. (2011) reviewed cross sectional data of women referred for MST treatment. Over 95% reported at least one trauma in addition to MST. The most common additional trauma was sexual abuse as a child or adult civilian. There were clinically significant rates of PTSD, depression, and sleep difficulties.

Multiple traumas among female veterans may be an important consideration in treatment, though Walter, Buckley, Simpson, and Chard (2013) found that a history of sexual abuse did not affect the outcomes of treatment of MST related PTSD. Luterek, Bittinger, and Simpson (2011) argue for treating a subset of female veterans reporting MST with an intervention targeted for Complex PTSD. Similar to data from other studies, Luterek et al. concluded that female veterans have a higher incidence of multiple traumas and report a higher incidence of symptoms similar to Complex PTSD, including difficulties with interpersonal relationships, emotion regulation, dissociation, somatization, and self-perception. This is significant to the intervention in this proposed study as there is some support that GIM improves outcomes connected to Complex PTSD (Maack, 2012; Moffitt 2003; Ventre, 1994).

In order to understand more about women's experiences in the military through rich qualitative data, Mattocks et al. (2012) conducted semi-structured interviews with 19 women who had been involved in conflicts in Afghanistan or Iraq. Major stressors identified were post-deployment integration and stressful military experiences including combat, MST and separation from family. Of the 19 interviewed, 32% had a clinical diagnosis of PTSD. The findings from this study provide further support of identity issues synthesized in the Crompvoets (2011) review, particularly in connection to separation from family. Mattocks highlights an alarming department of

defense statistic: more than 30,000 single mothers have been deployed to Iraq and Afghanistan.

Preferring to isolate rather than address emotional content, most women chose not to share their difficult memories with friends and family. Other common coping strategies identified by the interviewees were avoidance behaviors- overeating and purging, over-spending, over-exercising, and prescription drug abuse. Some women did engage in positive coping strategies such as planning regular routines or engaging counseling and peer-support. However, they expressed difficulty finding support groups for women veterans and expressed a need for more. They expressed discomfort seeking help from the VA and felt their experiences as women were not recognized or understood in the US when they returned. With a feeling of not being able to talk to friends and family, not being able to seek help from the VA, and not feeling supported by their country as a whole, unhealthy coping skills often followed (Mattocks et al., 2012).

Mott et al. (2012) published a case study from therapy with a 28-year-old who had experienced MST through rape. A fellow male soldier forced her to have oral sex after she had revealed in an earlier conversation among peers that in her country of origin oral sex is considered "filthy" and "unclean." In addition to PTSD, she developed an eating disorder that she felt was a result of the attack. It is difficult for many to hear details of trauma, but in exposure therapy, one of the endorsed treatments for PTSD, the client is required to close their eyes and re-tell in first person the details. The client does this repeatedly in one session and then listens to the recording of the story daily between sessions. In this particular case study, exposure was part of her weekly individual therapy, as was 90-minute group CPT sessions, and 60-minute bi-weekly dialectical behavior therapy. The client did not attend the exposure therapy her first week, in order to build up coping skills first. At the end of the first week, the client reported feeling overwhelmed, was encouraged and agreed to stay in the program, and was enrolled in exposure therapy the following week. Conclusions when her full treatment ended were that she improved on self-reported PTSD symptoms, began to develop healthy eating habits, and through exposure therapy habituated to her trauma-related fear and anxiety. Unfortunately, there was no long-term follow-up to ascertain whether improvements continued.

According to the majority of published evidence, therapies with an exposure component are effective for this population. It would be helpful to read some published experiences of clients who have been through exposure therapy, but they are not found in the literature. We do know that interventions with an exposure component have a high attrition rate, which perhaps would lead one to conclude that they are not a pleasant experience. Based on general PTSD effect studies the VA has endorsed trauma based cognitive therapies as first line treatment for any veteran with PTSD. The next review of studies for this proposal was to explore the specifics of that evidence-based recommendation and effect-studies carried out since that

endorsement. Included studies were with related populations and PTSD as there was only one RCT to date with female veterans and MST.

3.1.3. PTSD AND VETERANS: RELEVANT CLINICAL TRIALS AND META-ANALYSES.

The *VA/DoD Clinical Practice Guideline for Management of Post-traumatic Stress* (2010) is an update to the 2004 published guidelines and is based on a review of clinical trials and systematic reviews published between 2002-2009, as well as guidelines published in 2009 by The International Society for Traumatic Stress Studies. The guidelines concluded that trauma based cognitive therapies such as CPT, or exposure therapies such as PE delivered in an individual format provide the strongest evidence for effectiveness in treating PTSD. Based on 21 clinical trials on cognitive therapy and PTSD with civilian men and women exposed to combat and non- combat trauma, "There is good evidence that individual CT is effective in reducing PTSD symptoms, and limited evidence that treatment gains persist for up to 2 years. Additional research is needed to demonstrate the efficacy of CT delivered in a group format" (p 122). Exposure therapies were also found to be effective based on 32 clinical trials that included most often PE, but also Oral Narrative therapy and Brief Eclectic Psychotherapy - a treatment that includes imaginal exposure combined with relaxation, writing assignments, use of mementos from the traumatic experience, exploration of meaning, a farewell ritual, and psychoeducation. Stress Inoculation Training (SIT), which focuses on managing anxiety and coping skills, and Eye Movement Desensitization and Reprocessing (EMDR) also were rated as demonstrating good evidence, though not as strong as the above mentioned trauma based or cognitive therapies.

Though the document provides a strong rationale for VA funded services that treat PTSD, the absence of strong evidence does not mean that other treatments such as group therapy, psychodynamic therapy, or Guided Imagery and Music are not effective, only that there is insufficient evidence of their effectiveness. In the five years (2010-2014) following publication of guidelines, several studies were published that address other treatments for PTSD, in particular ones that previously provided weak or poor evidence; endorsed treatments with unique presentations of PTSD, such as MST; and different delivery formats of the endorsed therapies, such as group delivery or Internet delivery.

The second question that drove the systematic review was related to standard care recommendations for veterans. The VA/DOD Clinical Practice Guidelines was the main source used to examine that question, but an additional search was performed to retrieve additional studies and meta-analysis. Because those recommendations were based on clinical trials, the search was limited to the terms: "clinical trials," "systematic review or meta-analysis," PTSD, and veterans. Databases searched were the same as the first query: Academic Search Complete, CINAHL, HealthSource,

Medline, PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection. Inclusion criteria was that the articles be peer-reviewed and published in English between 2010-2014. Exclusion criteria were drug-related trials or trials examining a medical outcome. The query generated 9 results. Only one clinical trial specifically addressed MST. Table 3-3 lists brief specifics from relevant studies, followed by summaries of five meta-analyses and three other clinical trials.

Table 3-3 Clinical trials and meta-analyses 2010-2014

Study	Research/ focus	Description	Measurement	Outcome
Barrera et al. (2013)	Evidence for group CBT Differences between groups w/ trauma exposure?	12 RCTs n = 651	Comparison of mean effect sizes	Effective with no sig difference between groups Higher attrition w/ trauma-based groups
Bisson et al. (2013)	What are effective psychological treatments for adults with PTSD?	Cochrane review update, 70 studies 1950-2013, n = 4761	Comparison of effect sizes	Strongest effects from CPT, PE, EMDR Higher attrition in active treatment Studies poorly designed
Castillo et al. (2014)	Effectiveness of group CT for women veterans with PTSD	51 groups (8,10,or 12-week dosage), n = 271	PCL	Medium to large effect sizes with 10-week dosage strongest.
Frost et al. (2014)	Is PCT an effective and acceptable treatment for PTSD?	5 RCT's using PCT as active control	Comparison of targeted/ secondary measures, and dropout	Large effect sizes, but not as large as trauma based tx Attrition rate lower in PCT
Gerger et al. (2014)	Effectiveness of psychological treatments for PTSD	Systematic review/analysis of 66 trials n = 4,190	Effect sizes on treatments and between groups	Most robust evidence was for individual CBT/ exposure tx
Katz et al. (2014)	Outcome study for sexual trauma among female veterans	N = 119, no control group	BSI, PCL, Rosenberg's self-esteem scale, PTCI	Improvement across all measures with large to moderate effect sizes
Sloan et al. (2012)	Evidence of group treatment for PTSD	Meta-analysis of 17 RCTs n = 1,856	Between group effect sizes	Group tx effective Effect sizes smaller than individual tx
Surís et al. (2013)	Evaluate CPT for PTSD related to MST	RCT individual CPT or PCT n = 86	CAPS, PCL, QIDS	Improvements in both groups Higher attrition in CPT group

Study	Research/ focus	Description	Measurement	Outcome
Walter et al. (2013)	Does childhood abuse influence outcome of PTSD treatment for female veterans with MST?	Data analysis compared outcomes between groups. n = 110	CAPS, PCL, BDI	Improvement on all measures with no difference between women with or without childhood sexual abuse

Note: BDI = Beck Depression Inventory; BSI= Brief Symptom Inventory; CAPS = Clinician Administered PTSD Scale; PCL = PTSD Symptom Checklist; PCT = Present Centered Therapy; PTCI = Posttraumatic Cognitions Inventory; QIDS = Quick Inventory of Depression Symptomatology

Bisson, Roberts, Andrew, Cooper, and Lewis (2013) published an update to earlier Cochrane reviews from 2005 and 2007 that examined psychological therapies for PTSD in adults. Conclusions support other reviews that the strongest treatment effects were from individual trauma focused CBT, such as CPT or PE and EMDR. Other supportive and group therapies were stronger than waitlist groups, however effect sizes were not as strong as the trauma focused individual treatments. Results are to be interpreted with caution due to overall poorly designed and underpowered studies.

Gerger et al. (2014) used network meta-analysis, a statistical approach that enables direct comparisons from existing studies. Analyzing data from 66 trials totaling 4,190 clients demonstrated no statistically significant differences between specific treatments for PTSD. Moderate to large effect sizes were found in all psychological treatments, with the strongest and most robust evidence being for cognitive and trauma-based therapies (d=1.10 − 1.37). Conclusions echo findings from the VA/ DoD guidelines, and the Bisson et al Cochrane Review.

The lack of compelling evidence for group therapy is an issue because in practice, therapy is frequently conducted in groups especially in residential facilities and community day treatment programs. Sloan et al. (2012) conducted a meta-analysis of group treatment for PTSD. Seventeen heterogeneous RCTs were included in the analysis, which based on between group effect sizes concluded that group treatment is an effective approach (d=0.24-0.54), but not as effective as individual treatment (typically greater than 1.0), further validating the findings from the VA/ DoD guidelines. Seven of the 17 studies used a waitlist comparison, which does not provide any information regarding the mechanism of action in therapy (i.e. what components of the therapy are working aside from just being together in a group) and historically produces a larger effect size than when active treatments are compared. Eleven of the 17 RCTs used an intention- to-treat analysis and an analysis based on the last-endpoint-carried-forward can result in substantial bias. Research on group treatment continues to emerge more slowly than individual studies for several reasons: sample size needed is higher, mechanisms of group therapy are more complex, and group trials can be more expensive to conduct. Sloan and colleagues recommended that

future research should measure outcomes in addition to PTSD, such as social functioning, treatment adherence, and engagement- all suspected benefits of a group therapy format, but thus far not tested.

One of the criticisms of trauma focused cognitive therapies in a group format is whether disclosure of trauma has negative effect on other group members. Barrera et al. (2013) performed a meta-analysis on 12 RCTs totaling 651 participants in order to determine empirical support for group cognitive therapy for adults with PTSD and to examine if there is a difference between groups with a trauma component and groups without a trauma component. Conclusions of the authors were that group cognitive therapy is effective and there is no significant difference between groups that have a trauma component and groups that do not. Therefore, the trauma component does not affect the outcome. These conclusions should be accepted with caution, given the limitations of this study. Analyzed studies covered a variety of populations- male veterans, sexual abuse survivors, vehicle accident survivors and sample sizes ranged from 24-180. Treatment interventions varied: acupuncture or present centered group treatment for instance in the non-trauma examples, and Multiple Channel Exposure Therapy or Group CBT in the trauma component examples. There was no mention of how therapeutic mechanisms differed for various types of groups. The included studies were determined to be poor in quality due to lack of information regarding blinding and randomization, and four studies failed to include an intention-to-treat analysis. Dropout rate in the exposure-based therapies was higher, but consistent with attrition rates in individual CT as well as medication trials. The authors conclude that the concerns about disclosure of trauma in group therapy are not supported and clinicians have a range of viable treatment options to offer clients. No difference in effect sizes between groups with a trauma component and groups without would lead one to wonder whether the trauma component is necessary.

Present-Centered Therapy (PCT) is a supportive cognitive therapy that includes psycho-education but no trauma element. Frost et al. (2014) examined five RCTs that used PCT as an active treatment comparison to another evidence-based treatment in order to examine its effectiveness and acceptability. In three out of five studies, PCT was as good as the evidence-based treatment. Note that these were not designed as non-inferiority studies, but interpreted in that manner. Between treatment differences were calculated for targeted measures, secondary measures, and dropout rates. The effect sizes between groups were small on targeted and secondary measures, and the dropout rate for PCT was significantly lower. The authors' conclusion was that PCT has strong evidence of effectiveness and should be included as one of the evidence-based treatments recommended for PTSD treatment.

Another recently tested treatment that does not contain a trauma component is an integrative treatment called Renew. Kratz et al. (2014) looked at the impact of Renew on sexual abuse (including MST) among female veterans. Renew is conducted in a group format and also incorporates creative art modalities. Described as integrative,

Renew is a cognitive therapy with no trauma-focused component, but a psychodynamic element that examines relationships. In summary, "the goals of Renew are to (1) help participants improve coping skills, (2) identify interpersonal patterns, (3) reappraise the meaning of trauma, (4) release negative affect and regain positive affect and (5) build a more positive self-perception and optimistic vision for the future" (p. 3). Data was taken from 119 women in twelve cohorts over four years. Preliminary data on all measures showed positive results with moderate to large effect sizes. The PCL scale had an effect size of .59. The largest effect sizes were on measures related to posttraumatic cognitions. Main limitations to the study were absence of control group and issues related to having multiple cohorts.

Multiple traumas may complicate presentation and treatment of MST. Previous history of sexual abuse in particular is often mentioned in studies as a confounding variable that may influence treatment success. Walter et al. (2013) analyzed data from 110 female veterans with MST being treated for PTSD in a residential program, separating the data into two groups: those with a history of childhood sexual trauma, and those without a history. Improvement occurred in both groups across all posttraumatic and depression symptom measures, with no significant difference in scores between the two groups. This study challenges the assumption that individuals with a previous history of childhood abuse would be more symptomatic or less responsive to PTSD treatment. The authors further state that this study provides support for the effectiveness of CPT for PTSD in women with complex trauma history but it should be noted that improvements may have been related to other aspect of the residential program. Along with CPT, women were receiving other treatment interventions including psycho-education and other related psychotherapy on an individual and group basis.

In the only published RCT that specifically addressed MST to date, Surís et al. (2013) randomized 86 veterans, 73 females and 13 males, to CPT or present-centered therapy (PCT) for 12 individual therapy sessions. Measurements were taken at baseline, posttreatment, and two, four, and six months posttreatment. Measurements included the Clinician Administered PTSD Scale (CAPS), the PTSD self-reported checklist (PCL), and the Quick Inventory of Depressive Symptomatology (QIDS). CPT and PCT were both effective at reducing posttraumatic and depressive symptoms. Effect sizes tended to be larger in the CPT treatment, but there was no statistically significant difference between the two treatments. There was a higher dropout rate for the CPT treatment (35% compared to 18%). The authors note that the attrition occurred between sessions 3-6, the time during which participants wrote their trauma narratives. This supports voiced concerns in the literature regarding the trauma component in CPT for this population. A final limitation to note from this trial is that there was a treatment fidelity issue with one of the therapists, and the data from those sessions were not included in the analysis, which highlights the importance of using trained professionals in the intervention of choice and making sure that there are monitors in place for treatment fidelity.

3.1.4. SUMMARY OF FEMALE VETERANS RESEARCH.

Returning to the questions stated under section 3.1 that were driving this literature review:

1. What are the predominant issues for women in the military exposed to military sexual trauma?

Commonly identified issues connected specifically to MST for women in the military are the development of PTSD, anxiety, depression, relationship difficulties, and other medical issues. Comorbid diagnoses are common in addition to PTSD specifically for women there are high rates of depression and eating disorders. Women with MST have a higher incidence of previous and subsequent trauma compared to civilians, leading to presentations that share symptoms common to Complex PTSD.

2. What is the existing evidence that the VA is using for standard care recommendations for PTSD?

Most research with this particular population remains descriptive in nature, so the standard care recommendations that are adopted are based on reviews of clinical trials with all adults with PTSD. All previously published meta-analyses and individual studies conclude that individual and group therapy interventions are effective for adults with PTSD. The most robust evidence is for individual therapies with a trauma component- such as CPT or PE, but all published studies on treatments showed superiority to no treatment with moderate to large effect sizes. The most commonly used measurements were CAPS and PCL, both measurements of PTSD symptoms, and various depression inventories. Interventions showed a decrease in PTSD symptoms posttreatment, however results are mixed when measures are taken 1-2 years posttreatment. Attrition rate in treatments with a trauma component is higher than in other non-trauma therapies.

3. What are the mechanisms of action in therapy, possible mediators and outcomes?

In general, studies are not looking at specific mechanisms of action in different interventions, a repeatedly identified gap in the included studies. Social support is found to be a protective factor from developing PTSD and is also a veteran-identified component of well-being. The perceived benefits of a group modality of treatment is generally around peer support and community, something that female veterans have stated as important in their healing, but very few studies have included social measures as an examined outcome. Qualitative data also suggest that sense of identity can influence outcome and access to services.

3.2. MUSIC THERAPY AND RELATED CLINICAL POPULATIONS

A brief search of the literature at the beginning of my interest in this topic revealed that there were no published studies on female veterans and MST. Once grounded in the issues and evidence related to female veterans with MST, a more detailed review of the music therapy literature was undertaken. The review was completed to determine existing studies that addressed music therapy or GIM with related clinical populations: male veterans and PTSD, women and PTSD, women and sexual abuse. The questions driving this systematic review were:

- What are common themes or issues addressed in music therapy sessions with related populations?
- Is there a prevalence of particular research designs?
- Are there specific theoretical mechanisms mentioned in the literature?

As with the literature search for female veterans, the following databases were searched: Academic Search Complete, Child Development and Adolescent Studies, CINAHL, HealthSource, Medline, PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection. The Music Index Database was added to the search in order to include some music journals that are not listed elsewhere. Search terms used were: "women or female, military or veterans, PTSD, sexual abuse" in various combinations with "guided imagery and music, and/ or music therapy". Inclusion criteria were that the articles be peer reviewed, published in English, and address the use of music and sexual trauma and/ or PTSD as the primary focus. Editorials, studies focused on medical procedures, traumatic brain injury or dementia were excluded. Ten relevant articles were retrieved. Six other articles and book chapters that had not been retrieved in the search were recommended and added as well as two dissertations with relevant content. A summary of the report on music therapy and military populations released in 2014 by the American Music Therapy Association is mentioned following the table.

Table 3-4 Music therapy and related populations

Study	Research Question or focus	Description	Outcome
Amir (2004)	To explore role of MT improvisation for sexually abused	Case study 32 yo woman	Client showed improvements in ability to take risks and self-expression
Beck (2012)	To explore GIM as a treatment for adults on leave for work-related stress	Mixed methods through an RCT and hermeneutic inquiry with 20 participants.	Improved: mood, sleep, anxiety; reduced cortisol Themes: coping, enhanced creativity and self-esteem, connection to body, hope

Study	Research Question or focus	Description	Outcome
Bensimon et al. (2008; 2012)	To explore themes of MT group for Israeli soldiers with PTSD	Qualitative inquiry 6 male participants Group MT sessions	Social themes related to connection; reported decrease of symptoms
Bishop (1994)	GIM as treatment for adults with childhood sexual abuse	Individual GIM with female patients in an acute psychiatric setting	Self-empowerment images integrated with traumatic material
Blake (1994)	To explore GIM and DIM with male veterans	Exploratory study-8 male veterans with PTSD	Increased: ability to concentrate, relaxation, self-understanding
Blake & Bishop (1994)	Descriptive use of modified GIM in inpatient setting	Descriptive, based on authors' clinical work	Themes: empowerment, hope and inner-resources
Borling (1992)	GIM with 36 yo female with childhood sexual abuse	Case Study: 17 GIM Sessions	Themes: connection to inner wisdom, and ability to mobilize energy to begin to confront issues
Bunt (2011)	Individual GIM with woman with Hx abuse	Case study, 17 sessions with woman in mid 50's	Client accessed memories of abuse; healing through expressing grief.
Carr at al., (2011)	Group MT for clients unresponsive to CBT	Exploratory RCT and analysis of qualitative themes	Improvement of PTSD for music group; themes: engagement, trust, expression
Gao (2013b)	Determine long term effects of MER with PTSD	Survey of 26 clients who had participated in individual MER sessions	73% of clients reported no relapse, and 19.2% reported some degree of relapse but greatly improved overall
Hahna & Borling (2004)	To determine use of GIM in field of intimate partner violence	Paper survey of GIM therapists, 62 responses	Identified importance of establishing safety, using modifications & resource of creative processing
Körlin et al. (2000)	Development and evaluation of a creative arts program for pts with psychiatric disorder	58 clients participated in 4 weeks of structured creative arts program	Significant improvements on all instruments and most subscales
Körlin (2007-2008)	Music breathing (MB) and GIM with PTSD	Description of method and examples from 9 case studies with PTSD	A combination of MB and GIM and in some cases EMDR or CBT led to improvements of PTSD symptoms and less anxiety

Study	Research Question or focus	Description	Outcome
Maack (2012)	GIM as a method for treating Complex PTSD	Mixed methods comparative design (GIM vs PITT) 136 participants, naturalistic setting.	Improvement for both treatment groups with stronger effect sizes in GIM
Moffitt (2003)	GIM with a woman with childhood sexual trauma	Case Study	Worked from framework of Herman's stages of recovery in Complex PTSD
Pickett (1995)	GIM with 28 yo male with PTSD	Case study from 12 individual sessions	Client accepted his anger, engaged in cognitive restructuring and saw improvements in external life
T & Caughman (1999)	GIM with male with hx of sexual abuse	Series of journal entries by client detailing GIM work	Accessed memories of sexual abuse, expressed feelings, and obtained a connection to spirituality and appreciation for life
Ventre (1994)	GIM with a woman with childhood sexual trauma	Case Study	Herman's Complex-PTSD framework Explored memories, expressed feelings, connected with self

3.2.1. CLINICAL RESEARCH: MUSIC THERAPY AND PTSD.

In 2014 The American Music Therapy Association (AMTA) published a status report of music therapy with military populations. Because there are so few clinical studies with veterans or active military and MT, much of the literature cited was drawn from populations having related issues, such as traumatic brain injury (TBI), PTSD and pain management. Salient points from the document are the identified need for more rigorous clinical studies with high priority conditions such as TBI, PTSD, and polytrauma, as well as the need for collaborative research that factors in music therapy interventions and patient outcomes. None of the articles addressing veterans and PTSD included women, but these articles were the closest clinical population due to the shared military culture.

Bensimon et al. (2008; 2012) produced two articles from one study that was an intervention of group drumming music therapy sessions with post-traumatic soldiers. Participants were six soldiers diagnosed with combat or terror related PTSD. Data collected was through filmed sessions, participant interviews, and a self-report of the therapist. The group music therapy included improvisation and listening to relaxing music. From session transcripts, Bensimon and colleagues (2012) identified four

phases that demonstrated a balance of engaging directly with trauma or with healing. The phases were described as the trauma vortex and the healing vortex, referring to Levine's (1994) concept of pendulum movement as the autonomic nervous system's healthy balancing function. The soldiers reported an overall improvement in their well-being and an enhanced feeling of belonging and less feelings of isolation. Common themes that emerged from the session were an increased sense of openness, togetherness, belonging, sharing, closeness, connectedness and intimacy (Bensimon et al., 2008). There was also a reported decrease of PTSD symptoms. The participants preferred different instruments for trauma-engagement versus relaxation, and there was a definite split in how the participants described their lives before trauma and after trauma. Though the study is limited by a small sample and a lack of quantitative data to measure clinical outcomes, there is strong qualitative data to support emergent themes found in other veteran literature and in support of the theory that activating positive internal resources is an important balance to engaging directly with trauma memories.

Carr et al. (2011) conducted an exploratory RCT with participants with PTSD who had been unresponsive to CBT. The treatment group received ten group music therapy sessions, which resulted in a significant decrease of PTSD symptoms compared to the wait list control group. There was also a marginally significant decrease in depression. The mixed gendered groups were not all veterans, though some of the trauma indexed was related to war. The music therapy sessions included active and receptive interventions, but were primarily free improvisation. Qualitative findings were similar to Bensimon's study with themes of engagement, establishing trust, and expression of emotions. Participants also identified musical instruments that were more effective for expressing anger versus relaxation. Results should be cautiously interpreted as the sample size was small, and there was no blinding to randomization. The authors identified a significant effect size, though it is not published in the article perhaps due to small sample size. Also significant to note are some of the negative responses to the sessions such as 33% of participants in the treatment group reported too much noise due to certain instruments. Several of the participants felt that the intervention would have been improved with more verbal discussion about their trauma. Finally, the most frequently identified helpful aspect of the sessions was meeting people, which highlights the social connection but not the role of music.

There are more studies relevant to this present research, especially case studies, with women who have a history of childhood sexual abuse. Mainly included are examples that used GIM (see next section) and the following study that involved active music making. In a case study with a 32-year-old woman with childhood sexual abuse, Amir (2004) explored the use of improvisation for trauma work. The client, who initially played classical piano pieces in an unexpressive way, gradually began to express emotions and improvise pieces over the course of two years of therapy. The client uncovered memories of sexual abuse by her father and was able to work through control issues in her life that had led to relationship problems and an inability to take

risks. Before therapy was terminated, the client was playing with a full range of emotion, playfully improvising with the therapist, and had begun a new intimate relationship with a caring partner. Though Amir does not specifically identify themes in a qualitative manner, she writes of the client's increase in self-expression, self-confidence, and feelings of safety that allowed her to take risks inside the therapy sessions and in her external life.

3.2.2. CLINICAL RESEARCH: GIM AND PTSD.

Guided Imagery and Music that is focused on connecting clients to the music and their positive inner resources might be a more supportive method of processing trauma. Blake and Bishop (1994) described their work in an inpatient setting and highlighted the use of GIM to help patients with PTSD identify with empowerment and hope. Some of the findings from Bishop's project were that self-empowerment images, along with an exploration of trauma, led to improved patient functioning and positive healing experiences. Below are summaries of several other studies mentioned in the table above, summarized in greater detail because of their support for the current thesis research.

The Blake (1994) study from a music imagery project with male veterans is the one published study at the time of this review that involved GIM with veterans with PTSD. Blake conducted a music and imagery project with eight male Vietnam veterans in order to explore how GIM affects veterans diagnosed with post-traumatic stress disorder. In this qualitative study, veterans participated in GIM sessions or Directed Imagery and Music (DIM) sessions followed by interviews of the veterans' experiences with the particular method. Study findings were that veterans were able to use GIM and DIM to access images and emotions in a safe and contained way. Commonly veteran-identified valuable outcomes of GIM were an increased ability to concentrate, increased relaxation and increased self-understanding. Veterans especially connected to the positive images they were able to access during sessions. Directed Imagery and Music takes the client into exploration of a specific trauma, mirroring one component of the VA endorsed therapies that address trauma directly. Blake (1994) writes of the Veterans' experiences with DIM:

> DIM sessions were particularly difficult because they required emotional and sensory confrontation of traumatic memories, which veterans tend to want to avoid. According to the veterans' reports and observations by the therapist, the music in conjunction with the guide provided a redirecting function for the memory, for uncovering greater detail, and for providing a support for associated emotions. All of the veterans were able to maintain a sense of control with necessary defenses during the sessions. Some veterans found DIM relieving while others found it disturbing. (p. 7)

Not all veterans are ready to directly address the trauma, which makes a more open GIM process more accessible than DIM or endorsed trauma therapies for some clients.

The study is limited by the small number of participants as well as number of sessions with each method, but provides important initial findings on veterans' experiences with this method.

Modified GIM was one component of a structured creative arts program examined as alternative programming for psychiatric patients. Körlin, Nybäck, & Goldberg (2000) reported that 88% of the 55 patients with various diagnoses completed the program and showed improvements on all primary measures. The study further examined results by clinical subsets finding that clients with trauma compared to clients without trauma made greater improvements. Outpatient therapists reported that in regards to social functioning, seven of the clients began work or studies and 18 increased their capacity to handle relationships. Because there was no control group, it is not possible to say if improvements were due to participation in the creative art therapies program.

In three separate case studies with female clients who were recovering from childhood sexual abuse, Moffitt (2003), Ventre (1994), and Bunt (2011) worked from a framework of Herman's three stages of recovery from PTSD. Each of the women was able to access memories of abuse, express feelings around the trauma and make steps to move forward in her life. Moffitt (2003) draws attention to the use of music with fragile populations and the importance of not having the music be another source of trauma. In the beginning sessions, musical choices needed to be flexible- as opposed to using a set Bonny program. Moffitt worked through attuning to the client's needs to choose the best musical container for her inner tension and trauma. By the end of her sessions, the client was able to work with more complex programs- an indication that there was an internal shift in regards to her trauma. Ventre's (1994) client discovered inner strength, beauty, grace, patience, humor, wisdom, and the ability to nurture herself through music and the imagery produced. That positive identification was supported through the personal relationship to the music, and provided a safe structure through music. The case studies by Moffit and Ventre highlight the importance of establishing trust and the ways in which each woman connected to positive aspects of herself and her positive inner resources.

Bunt (2011) also used individual GIM with a woman in her 50's with a history of sexual abuse, but the initial reason for therapy was grieving the loss of her partner. The trauma memories connected to sexual abuse unfolded after several sessions during which trust and safety were established. Over the course of 17 GIM sessions, the client saw improvements in her life demonstrated by increased self-confidence and improved sleep.

Maack (2012) conducted mixed methods research to examine GIM as an intervention for women with Complex PTSD. Conducted in a naturalistic environment, the women chose their preference of therapy- either individual GIM or individual Psychodynamic Imaginative Trauma Therapy (PITT)- as well as their therapists. In addition to the two therapy interventions, there was a wait list group and a follow-up group for a total

of 136 women equally divided among the four groups. The quantitative portion of Maack's study was a comparative outcome study that collected self-reported measures on five scales that examined symptoms of Complex PTSD, dissociation, interpersonal problems, and sense of coherence. Both treatment groups showed improvements on each measure with the GIM participants showing greater improvement. The effect sizes for the dissociation scales (d=1.52 on the Somatoform Dissociation Questionnaire and d=2.55 on the Dissociative Experiences Scale) and Sense of Coherence (d=2.85 Sense of Coherence Scale) were very large for the GIM group. Participants received a minimum of 50 hours of therapy, but the therapists decided on the frequency and duration of sessions. The follow up group showed fewer Complex PTSD symptoms, which suggests that improvement continues post treatment and/ or with a greater number of sessions. Interviews with five PITT participants and four GIM participants were conducted after 50 hours of treatment with a purpose of gathering clients' experiences and descriptions of the roles of music and imagery. Maack also included reflections of her own experience. Qualitative themes were that music can be a teacher, holder of knowledge or abilities, model different kinds of relationship, be a space for different experiences, represent dissociated parts, bring or evoke imagery, be a connection with beauty and non-violent parts of the world, and perceived as a helping being. Based on the experiences of participants in GIM and PITT, imagery was described as something that can be used for learning, as a connector, and as a resource.

In Beck's (2012) mixed methods study of GIM as treatment for adults on long-term stress-related work leave, PTSD was exclusion criteria for participation in the study, but the study is described here as relevant due to the emphasis on coping and the connection to trauma. The study produced strong effect sizes and similar qualitative themes to previous studies. Twenty participants, the majority female, were randomized to six individual modified GIM sessions or a wait-list control group receiving standard care followed by GIM sessions. Measurements were taken at follow-up. Participants in the first cohort receiving GIM improved on measurements of mood, sleep quality, anxiety, well-being and decreased cortisol levels. The control group received six GIM sessions after waiting and improved on measurements of perceived stress, mood, depression and anxiety, however it was determined that the effect was stronger on the early intervention group. The qualitative portion of Beck's study was grounded in hermeneutics and sought to explore the music therapeutic process of embodiment and coping. Themes from the clients' experiences were "new coping strategies, new ways of being, increased contact with their bodies, reduced pain and enhanced creativity and hope through the music journey" (p.5). Clients found the music to be "a supportive space for self-regulative body processes, emotional expression, reconnection to self-esteem and competence, processes of existential life issues and contact with creativity" (p. 5). Beck concluded that with GIM, clients were able to begin to recover from traumatic work experiences, enhance their coping skills, and access newfound hope for their work life. Relevant to this

proposed research with female veterans, coping skills is one of the potential mediators for outcomes of PTSD.

Beck used Körlin's (2007-2008) music breathing, developed to support clients in processing trauma. Music Breathing (MB) involves using meditative breathing to connect to the breath and imagine a space that is then filled with music. The function of the music is to modify the size of the breathing space. The focus is on grounding and allowing images, often trauma memories, to emerge and be processed in a safe manner. The method of MB depends on the stage the client is occupying: grounding, dissociation, or integration. Once the breathing space is established in silence, the grounding stage begins and music is introduced. Music during this stage is grounding and supportive, which allows safety to be established and resource imagery to be mobilized. Once that has been established, the client moves into the next stage. Like some other modified forms of GIM, guiding takes place after the music, generally through processing material in the mandala drawn by the client. Once a client has moved through the various stages of MB, they may be ready to move into full Bonny Method sessions. There is a homework component to MB that involves self-directed sessions at home. This practice time allows the client to learn to self-regulate reactions through the breathing and use of music. This home practice also places some of the control onto the client, allowing her to take a more active part in the therapy process and her healing. In addition, the strong body component through using her breath, connects the client to her body, which is an issue in clients with sexual trauma history.

Though Körlin's (2007-2008) case study examples include clients with trauma profiles other than sexual abuse, there are improvements in PTSD symptoms and overall ability to manage anxiety. In some cases, the MB method was effective on its own, while other cases also utilized Eye Movement Desensitization and Reprocessing (EMDR) or CBT therapies. The MB method highlights the importance of using a modified GIM in order to provide a manner of building up inner resources as a precursor to trauma work, which is often addressed within a small time-frame of tolerance for clients with PTSD.

Gao (2013a, 2013b) developed Music Entrainment and Reprocessing (MER), another modified GIM approach for working with PTSD. The modification uses elements of GIM and EMDR in a structure that follows Herman's trauma work: establishing safety, engaging with trauma memories and moving forward. Using a music-centered approach, MER uses a music and verbal intervention that includes an imagery component. The therapist chooses supportive music to help establish safety and build inner resources, before using more complex music to support engagement with a trauma memory. During the stage of trauma memory work, the music is chosen to entrain to the identified emotions related to the memory. As the client verbalizes imagery, the therapist chooses music to support and help guide the client through grief and eventually to calmness. From 2005-2010, Gao used MER with 56 clients with PTSD. Clients completed 1-5 sessions during which time they had reached a sufficient

score on the Subjective Units of Disturbance scale. In 2010, he followed up with phone interviews with 26 clients, finding that 73% self-reported no relapse in symptoms and 19% reported some relapse, but continued satisfaction with the MER therapy. Gao reported that only two of the 56 cases were unsuccessful with the MER treatment. The client's trauma experiences ranged from extramarital affairs to physical abuse and rape, without any reporting of the different experiences with therapy connected to trauma type, which makes it difficult to determine how effective this method would be with MST.

Gao makes two strong statements relevant to music and imagery work: "A higher self-esteem comes from the individual's increased ability not only to control the exterior world but also to source more positive experiences in his or her inner world" (p. 102), and that "music in trauma healing has a strong capacity to help clients rewrite their experiences through imagined visual pictures" (p. 108). More research would be needed with MER to determine its effectiveness with PTSD, but this study provides further support for using music to build inner resources, and support a client's emotions connected to trauma.

3.2.3. SUMMARY

Returning to the questions that drove this literature review, the findings will be summarized below under each question.

1. What are common themes or issues addressed in GIM or music therapy sessions with related populations?

The themes and issues varied depending on the individual client(s), however most of the clients in these studies were working through trauma to some degree and themes of coping skills, empowerment and inner resources were prevalent.

2. Is there a prevalence of particular research designs?

The most commonly identified design was case study. Descriptive studies and studies that involved a qualitative analysis were fairly common. Rarer were studies that involved a quantitative analysis, which has been historically seen as difficult to carry out with process-oriented methods such as GIM. But mixed methods studies are emerging in the field and there are several examples summarized from both GIM and music therapy sessions.

3. Are there specific theoretical mechanisms mentioned in the literature?

Theoretical mechanisms were rarely mentioned directly in studies. But many authors identified components, such as importance of connecting with inner resources, or relationship to music that were central to the therapy process.

In summary, in the above studies, music provided a supportive container to allow access to trauma memories, express emotions and connect clients to their positive internal resources, leading to improved functioning in their external life. The improvement of social relationships was accomplished in several studies involving individual sessions, demonstrating that although improved social skills is often a goal in group therapy, individual therapy has also demonstrated improvements in this area.

Statistically significant improvements were shown on the majority of measures in studies that employed statistical analyses. The body of literature remains small, and poorly designed in terms of clinical trials due to small sample sizes and lack of control for external and internal validity, but the represented studies demonstrate positive findings and suggest further research.

3.3. CONCLUSIONS FROM COMBINED LITERATURE REVIEWS

Military experiences have a greater impact on social relationships among females than among males with females reporting more conflicts in their relationships after returning from deployment (Gibbons, 2012). Social support is a mediator to developing PTSD (Chaumba & Bride, 2010) and female veterans found that talking about their experiences with other veterans was an effective means of coping with experiences during deployment (Crompvoets, 2011). This draws attention to the relational aspect of women and builds support for group therapy, but overwhelming evidence from published guidelines, reviews, and meta-analysis studies suggest that individual therapy is more effective for PTSD. There are no studies that directly compare group therapy to individual therapy for PTSD, so analysis of effectiveness is based on comparison of published group studies to published individual studies. Studies of group therapy with PTSD have thus far not proven as effective as individual therapy with small to moderate effect sizes for groups compared to large effect sizes for individual treatment (Sloan et al., 2012). The studies of group therapy have not shown results unique to any specific components of types of group therapy, other than general benefits connected to the group factor. There are only a few group studies that have examined social functioning and they obtained mixed outcomes. The two studies that reported improvements specifically included social skills training as part of the treatment (Sloan et al., 2012). As stated before, comorbidity is high among veterans with PTSD, which presents challenges in a group format as there may be various secondary diagnoses present in the group.

Studies of individual GIM interventions have demonstrated large effect sizes (Beck, 2012; Maack, 2012), providing support for an individual method. Group and individual treatments in music therapy and PTSD have drawn attention to the importance of building positive inner resources in order to engage with the trauma memories and navigate symptoms of PTSD. While recognizing commonalities among group members is a strong therapeutic factor, choosing music and identifying positive inner resources is more tailored in individual sessions allowing the maximum

resource benefits. It is important to understand how these mechanisms work on an individual basis before applying them to the group format in order to identify specific mechanisms of action as opposed to the general benefits of group therapy that are making the impact. It is also more possible to move in and out of different levels of work along a continuum with an individual, whereas a group may need a more constant focus at the supportive level only. The endorsed exposure therapies and CPT work at an intensive level, and utilizing solely supportive group music and imagery would not mirror that level of work.

The attention to the power of narrative (Crompvoets, 2011) with female veterans provides support for using a GIM method. GIM also connects an individual to her narrative through a connection to the music and the images that emerge as part of her story, providing the opportunity to reconstruct her story and its meaning in a new way (Bonde, 2004; Gao, 2013). Working through a resource-oriented music and imagery method maintains the focus on positive inner resources and building resilience, which may mediate PTSD symptoms; and the imagery work, through use of metaphor and narrative reconstruction can work towards increased sense of self. Resilience and identity are connected to better outcomes in social functioning, addressing one of the primary areas of concern for female veterans.

Military sexual trauma and PTSD are disruptive to an individual's life and music therapy and GIM in particular have been used to address trauma and resulted in positive outcomes. From a synthesis of the systematic reviews, the conceptual framework for the research was mapped (figure 3-1). A conceptual framework for research is a manner of illustrating the problem or stressor- including confounding variables, the independent variables, potential mediators and outcomes of interest. The mapping of a research conceptual framework is mainly seen in outcome studies. In the conceptual framework illustrated in figure 3-1, MST is the stressor with possible covariates of previous trauma and history of mental illness. The targeted interventions are GIM or CPT, which presumably mobilize resources, reconstruct narrative and address coping skills. The primary or proximal outcome of interest is whether PTSD symptoms change as a result of the intervention and social functioning is a distal outcome, meaning that it is believed there would also be a long-term effect on social functioning. Acceptability and feasibility issues are also an outcome of interest and are placed below the interventions as they are not directly related to the research trajectory. This conceptual framework, along with overall findings from the literature review informed the research questions and initial study design, which are presented in Chapter Four.
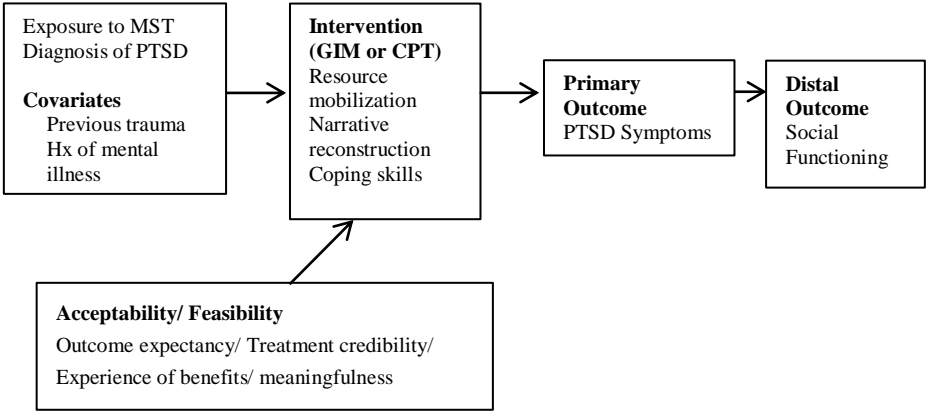
Figure 3-1 Conceptual framework

CHAPTER 4. METHODOLOGY AND DESIGN

This chapter outlines the research questions, planned study design and rationale for different aspects of the study, including mixed methods design, transformative research and the non-inferiority trial. The specific method and design for the feasibility study are mentioned in Chapter Five and described in the published article. The RCT protocol outlined below was formulated following the literature review and adjusted after the feasibility study but was not carried out as part of this PhD research. The decision to delay the RCT is explained in Chapter Seven. Additional research question, aims and methodology related to a second project are presented in Chapter Eight.

4.1. RESEARCH QUESTIONS AND AIMS

The following research questions were formalized following the systematic literature review. These questions helped to inform the overall design outlined in figure 4-1.

Aim 1: Discover how female veterans are experiencing MI/GIM.

1.1 How do female veterans experience components of the MI/GIM sessions (music, imagery, creative processing)?

1.2 What are female veterans' perceptions about the meaningfulness and helpfulness of the MI/GIM intervention?

1.3 What is the change in self-reported PTSD symptoms following MI/GIM sessions?

Aim 2: Determine the feasibility and acceptability of MI/GIM as a treatment modality for female veterans with MST related PTSD.

2.1 How many female veterans consent to participate in the study after being introduced to the study details?

2.2 What percentage of MI/GIM study sessions do participants complete?

2.3 What percentage of study measures do participants complete?

Aim 3: Obtain effect sizes and preliminary data on the efficacy of MI/GIM for female veterans with MST related PTSD as an alternative to evidence-based CPT.

Hypothesis 3.1: MI/GIM participants will score no worse than CPT participants, on reduction of PTSD symptoms at end of individual therapy sessions and 8 weeks follow up.

Hypothesis 3.2 MI/GIM participants will score no worse than CPT participants on social support measures at end of individual therapy sessions and 8 weeks follow up.

Hypothesis 3.3: MI/GIM participants will score no worse than CPT participants, on stress coping skills at end of individual therapy sessions and 8 weeks follow up.

In order to examine the research questions and meet study aims, the study was proposed to be a transformative sequential mixed methods design that would occur in three phases:

- Phase I: explore treatment intervention through a feasibility study with a small number of female veterans.

- Phase II: refine treatment protocol for the RCT and create a flexible manual for the MI/GIM intervention.

- Phase III: implement a randomized controlled trial that compares GIM to CPT in order to build evidence of non-inferiority.

Overall Aim: evaluate GIM as a treatment modality for female veterans with MST related PTSD		
Phase I: Feasibility Study Aim 1 and Aim 2 (RQ: 1.1, 1.2, 2.1, 2.2, 2.3) and preliminary data on pre/ post PTSD symptoms primarily qualitative approaches, flexible design	Phase II: Create intervention manual and refine RCT protocol	Phase III: Randomized Controlled Trial Aim 3 questions/ hypothesis testing non-inferiority trial fixed design additional interviews related to benefits of interventions (RQ 1.2)

Results from quantitative data and qualitative interview data will be triangulated to form a complete picture.

Figure 4-1 Proposed Research Phases

4.2. RATIONALE

4.2.1. MIXED METHODS RATIONALE

Though RCTs are at the top of the hierarchy of best evidence, RCTs provide incomplete evidence that is only a picture of the external outcome. Bradt, Burns and Creswell (2013) recommend a mixed methods approach:

> Accordingly, music therapists need research that *integrates* multiple ways of knowing and forms of evidence. Mixed methods research holds great promise for facilitating such integration. Combining qualitative and quantitative methods overcomes the limitations of each method alone by generating data that provides context or meaning for quantitative results, arguments from multiple perspectives, and more evidence to assist in the application of findings to clinical settings (p. 124).

Mixed methods research requires an integration of multiple ways of knowing blending different ontological and epistemological perspectives. A dialectic stance where there may be multiple perspectives that seem in conflict with each other, but out of which a fuller truth emerges may be one way to integrate the differing perspectives.

Pragmatism is a research paradigm that is often used in mixed methods. Feilzer (2010) argues that pragmatism steps away from the quantitative vs qualitative debate, focusing instead on the problem or research question and whether the research methods accomplish answering the question. Pragmatism rejects, or perhaps more accurately, does not care about the ontological dualities present in mixed methods data, often relying on a convergence of the data. From a pragmatic perspective, multiple methods are needed with this study because this is a new area of research. It is a new clinical population and a new intervention- a specific modification and continuum of GIM that has not been researched. The research questions proposed require information regarding process *and* outcomes suggesting a mixed methods inquiry. Producing data that speaks to different stakeholders in the study also requires a pragmatic approach. The overall driving goal of the research is to increase services for female veterans with MST and PTSD. Quantitative data in the form of outcomes is the language of the Veteran's Administration, who provides most of the current resources for veterans. Qualitative methods support validation of the female veterans and their experiences with this treatment modality and can be converged with the quantitative data. In addition, from the perspective of building a rationale for funding a larger clinical trial the National Institute of Health (NIH) recommends that research be carried out in phases that may include multiple types of data.

4.2.2. TRANSFORMATIVE RATIONAL

While the study is pragmatic in its approach, it also employs a transformative lens. One way to approach the two research paradigms may be to say that pragmatism is driving the overall design while transformative is informing the ethical considerations, such as how the participants are approached and their relationship to the researcher and research. Transformative research seeks to understand the culture in which the researcher is engaged and to connect findings to the greater community for the purpose of increased awareness and action (Mertens, 2007). In transformative research, subjects are viewed as co-participants alongside the researcher, and a main tenet of such research is to address the power issues at each stage of the process. The voice of the participant is given a prime role, and is part of the transformative power of the research. Given the hierarchical nature of military institutions and the power differentials inherent in sexual abuse, transformative research is a necessary approach because it acknowledges and brings into better balance the hierarchical relationships that are in many models of research. It also gives voice to the minority in the military culture, which is often not heard.

Because a qualitative exploration into the culture of female veterans is important to place at the beginning of the study, the structure is sequential in design. Though research questions have been proposed for all phases of the study, it is recommended that in a sequential mixed methods design with a transformative lens, the research questions emerge as the study evolves (Tashakkori & Creswell, 2007). For this reason, the methodology and research questions for the RCT remained flexible until the feasibility study was complete.

Examples of transformative mixed method designs that have a RCT component are few, but emerging in the literature (Puschel & Thompson, 2011; Schwantes, 2011). Integration of different methods into one study requires a shifting of perspectives on the researcher's part between different methodologies depending on the phase. Hess-Biber (2013) refers to this as weaving and shifting, and proposes it as a way to re-vision the RCT study design through a transformative lens. In this PhD study, Phase One used primarily qualitative methods and Phase Three proposed quantitative methods. Where the transformative paradigm influences the methodological assumptions in the RCT is in the process of refining the RCT, based on input from participants in the feasibility study and their responses to qualitatively driven questions. Following the standard protocol of an RCT, care is taken to minimize biases and threat to internal validity during the experimental portion through using a therapy intervention manual, random assignment of participants to the treatment interventions and blinding to measurement results until end of RCT study phase.

In conclusion, a transformative lens to the research places emphasis on giving participants a voice in the research and minimizing the hierarchical relationships. The qualitative portions of this mixed methods design were guided by inquiries that

acknowledged relationships and the voice of participants. In addition, feedback from participants in the feasibility study was integrated into the design of the RCT.

4.2.3. INTERVENTION MANUAL RATIONALE

In researching the standard treatment approaches endorsed by the VA, it became clear that most approaches were manualized. Many music and expressive arts therapists who utilize creative processes want flexibility in how they make decisions and move forward during a therapy session but producing a therapy manual reduces threat to validity by enhancing therapy fidelity, adding more credibility to the study. Rolvsjord, Gold, & Stige (2005) explored the rationale for a therapy manual for use in RCTs, and advocate for a flexible manual.

> In a contextual model, the specific ingredients (techniques and procedures) are not seen as the main source of change in the therapeutic process, but are necessary to construct a coherent treatment that the therapist have faith in and that provides a rationale for the client to believe in. (p. 19)

A flexible model would not prescribe a rigid set of techniques and when to apply them, but would identify guidelines related to process and procedures.

In the case of this study and a continuum of MI/GIM sessions, the techniques may occur at different timelines for different clients. Some clients may require 2-3 music and imagery sessions during which safety and positive inner resources are highlighted before moving into more traditional GIM work, while others may never move into GIM sessions in a traditional sense. Some may move back and forth between supportive and issue-focused interventions. A manual that were to include rigid guidelines for moving into different types of work would not support this population, however it is possible to develop guideposts for when to move to a more complex intervention.

Using previous descriptions of music and imagery and modified GIM sessions in addition to material from the feasibility study, a flexible therapy manual was created (Appendix A) that utilizes the MI/GIM Continuum model (Chapter Six) for trauma.

4.2.4. NON-INFERIORITY TRIAL: DEFINITION AND RATIONALE

When comparing two groups, the most common approach to treatment outcome studies is to apply superiority significance testing to determine if one group's outcomes are statistically different and in what direction. The intention is to establish that one treatment is more effective than the other. Comparative effectiveness designs, such as non-inferiority designs, are structured to examine whether an intervention is as effective- or rather is not less effective than a previously endorsed treatment (figure 4-2). A study is designed to compare the intervention of interest to an established active treatment control, rather than a placebo or waitlist group (Greene, Morland,

Durkalski & Frueh, 2008). The null hypothesis is stated that there *is* a difference, of greater than a pre-determined margin, between the two groups; or to approach it from the alternative hypothesis, the new intervention is equal or only inferior by less than the pre-determined amount. Drug companies make use of this design when attempting to show that a generic drug works as well as the high cost version, making it a more viable alternative for some individuals. Because both treatment groups are active treatment options, no client is assigned to a placebo or asked to wait to receive services, therefor non-inferiority trials are sometimes viewed as more ethical. Though more infrequently used in mental health trials, there is evidence of non-inferiority designs in the literature (Garland, Carlson, Antel, Samuels & Campbell, 2011; Morland et al., 2009). To date, there is no evidence of a completed non-inferiority trial in the music therapy literature, though there has been one published protocol (Beck et al., 2018).
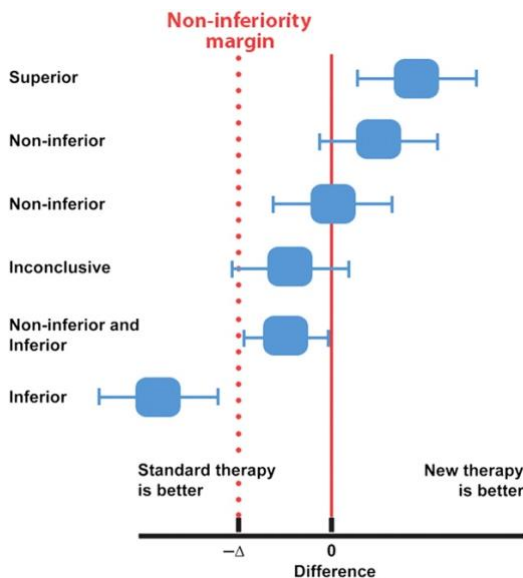
Figure 4-2 Possible outcomes in a non-inferiority trial (Head, Kaul, Bogers & Kappetein, 2012).

Once a therapy is endorsed as an effective intervention, a successful non-inferiority trial allows a clinician to recommend the novel treatment with confidence that there is no loss of clinical benefit. It is a way to demonstrate to the institution that has endorsed the standard treatment that there is another effective option, which may have less side effects, more compliance and/or be more cost-effective. But non-inferiority trials are not easy to design for several reasons: one must find an appropriate active control, a margin of non-inferiority must be determined and statistical analyses are more complex (Greene et al., 2008). In addition, if the study is not also using a placebo

as a third arm, the study must be designed as similarly as possible to past studies that used a placebo with the active control that demonstrated effectiveness of the active control. Each of the challenges in relation to this study are addressed below.

Active control. Numerous meta-analyses were reviewed and individual CPT or individual ET were found to have the strongest effect sizes in clinical trials with PTSD. The VA has endorsed those two therapies as the first line treatment choices for PTSD with veterans, making either treatment an appropriate active control for a non-inferiority trial. Both treatments include a trauma component, however CPT spends a limited time on the trauma and has a strong focus on cognitive restructuring making it more similar to GIM than ET would be. Therefore, in this trial CPT will be used as the active control.

Non-inferiority margin. There is no standard guideline for determining a non-inferiority margin, but a common recommendation is that through statistical reasoning the margin be one half or less of the active control intervention effect based on the average effect size from published studies (Greene et al., 2008). Because the main outcome of this proposed study is a reduction of PTSD symptoms, published effect sizes of reduction of symptoms as demonstrated by a change on the Clinically Administered PTSD Scale (CAPS) were examined. The average effect when comparing between group effects in trials using placebo as a control group was 1.0, a high effect size (Individual treatment effect sizes ranged from 0.97- 1.12 based on ITT analysis of results from CAPS scale). Using ½ of the control intervention effect would result in a non-inferiority margin of 0.5. If GIM Individual treatment effect sizes based on ITT analysis of results from CAPS scale produces a moderate effect size, it is considered still effective/ not inferior. If the 95% confidence interval of the difference does not cross the margin (0.5), then GIM is not inferior.

Another method of determining the margin is by clinical judgment. In the case of clinical judgment, the margin is set based on the least mean score reduction that would be clinically meaningful on the outcome being measured, i.e. the GIM group will have a mean reduction on the CAPS score of no more than 10 points lower than the active control score. Morland et al (2009) provide an example of using clinical judgment to determine a non-inferiority margin in which the CAPS was also the primary measure in the study. Based on consultation with experts, the researchers determined that 10 points was the lowest possible reduction on the CAPS to have clinical meaning. For their population of combat veterans, the average standard deviation was 20. Using this method of clinical judgment for this proposed study also results in a 0.5 margin.

Assay treatment. It is not feasible to include a placebo group as a third arm for this proposed study, so precautions were taken to design the study similar to other studies that established CPT as an evidence-based practice. This included maintaining a similar dosage (10-12, 90 minute sessions, delivered weekly) and using tools to increase therapy fidelity across sites.

4.3. RCT PROTOCOL

Below are details for a multi-site RCT that examines whether a MI/GIM Continuum of sessions is inferior to CPT for PTSD related to MST. The protocol was designed early in the PhD research, following the systematic review. Results from the feasibility study were used to refine the protocol. The detailed study protocol is organized according to the Consort 2010 checklist for randomized trials.

4.3.1. HYPOTHESES

Hypothesis 3.1: Guided Imagery and Music (GIM) participants will score no worse than Cognitive Processing Therapy (CPT) participants, on reduction of PTSD symptoms at end of individual therapy sessions and 8 weeks follow up.

Hypothesis 3.2 GIM participants will score no worse than CPT participants on social measures at end of individual therapy sessions and 8 weeks follow up.

Hypothesis 3.3: MI/GIM participants will score no worse than CPT participants, on stress coping skills at end of individual therapy sessions and 8 weeks follow up.

4.3.2. DETAILED PROTOCOL

Trial design
This is a parallel two arm randomized non-inferiority clinical trial with a one to one allocation ratio. This is an efficacy study under controlled conditions with single blinding (outcomes assessor).

Participants
Age and gender eligible for Study: female, >18 years

Inclusion Criteria:

- Female veteran from any era with current diagnosis of PTSD due to MST
- Three or more months since experienced MST prior to entering the trial
- Consent to be randomized into treatment
- Not beginning other psychotherapy during active treatment
- If being treated with psychoactive medication, a stable regimen (no change in drugs or dose) for at least 6 weeks before enrollment
- English literate

Exclusion Criteria:

- Current unstable or uncontrolled psychotic symptoms, mania or bipolar disorder
- Current suicidal or homicidal ideation
- Moderate or greater cognitive impairment

Notes on inclusion/ exclusion criteria:

- It is established in the literature that PTSD has a high rate of comorbidity such as depression and anxiety. Veterans with MST also have a high rate of previous sexual trauma. Participants will not be excluded based on comorbidity or previous trauma, but these will be addressed as covariates in data analyses.
- Participants with significant cognitive impairments are excluded due to the necessity of abstract thinking in imagery work.
- Medication changes are allowed if clinically justified and documented in the data analyses.

Settings and locations: Multiple settings that serve veterans in the USA

Interventions

Experimental Arm 1: Each participant will be scheduled to receive individual therapy through 10 weekly 90 minute MI/GIM Continuum sessions.

MI/ GIM Continuum sessions are structured to provide clients tools to identify and connect to their positive inner resources, to provide a safe structure to identify and express emotions connected to the trauma, and help to reconstruct a narrative post-trauma. For further description see section 1.4 and Chapter Five of this thesis.

Therapists who are Fellows of the Association for Music and Imagery and have been trained in GIM modifications will facilitate the MI/GIM Continuum sessions. The therapy manual created in Phase Two of this study will be used to provide guidelines to the GIM therapists facilitating the sessions.

Active Comparator Arm 2: Each participant will be scheduled to receive individual therapy though 10 weekly 90-minute Cognitive Processing Therapy (CPT) sessions.

CPT is a manualized cognitive behavioral therapy that is focused on helping a client to access traumatic memories, identify and experience connected emotions, and challenge beliefs connected to self and world as a result of the trauma. Interventions include education, writing trauma narratives, and cognitive restructuring (Surˊıs et al., 2013).

Therapists with training in CPT will facilitate the CPT sessions, following guidelines in the published manual for CPT.

Therapy fidelity

Therapists for the MI/GIM participant group will be trained in specific study protocol and the therapy manual. Sessions for both groups will be recorded and reviewed by an external reviewer.

Outcomes

Clinically Administered PTSD Scale for DSM-5

The primary outcome measure is PTSD scores objectively administered through the Clinically Administered PTSD Scale for DSM-5 (CAPS-5). This 30-item structured interview is the standard for assessing the severity of PTSD using a face-to-face interview with the patient and a professionally trained administrator. Internal consistency: Cronbach's alpha 0.85; Good convergent validity (Weathers, Keane, & Davidson, 2001). The CAPS was chosen as the primary outcome measure for the non-inferiority trial because it is the most common outcome measure used in previous trials with PTSD and cognitive processing therapy. Timeline: baseline, end of week 10 (post-treatment) and week 18 (2 months follow up)

Informed by the literature review, secondary outcome measures of resilience and social support were chosen based on the potential mediating effect on PTSD.

Connor-Davidson Resilience Scale (CD-RISC)

The CD-RISC is a 25-item scale developed specifically in order to provide a strong measurement for stress coping ability (resilience) in PTSD clinical work. The scale has demonstrated good internal consistency (alpha 0.89), and good convergent validity in studies with PTSD (Connor & Davidson, 2003). Timeline: baseline, end of week 10 (post-treatment) and week 18 (2 months follow up)

The Social Provisions Scale (SPS) (Cutrona & Russell, 1987)

The SPS is a 24-item scale that measures the degree to which an individual's social relationships provide various dimensions of social support. The scale has been tested on a variety of populations and has good internal consistency (0.89) (Lopez & Cooper, 2011). Timeline: baseline, end of week 10 (post-treatment) and week 18 (2 months follow up)

Sample size

In a non-inferiority trial, Type I and Type II error are reversed from what they are in a superiority trial. Type I error would be a conclusion that a treatment is not inferior when the evidence was not sufficient to make that conclusion.

Using a 95% confidence interval, in order to determine that GIM is not inferior to CPT by a specified margin, in this case 10 units on the Clinically Administered PTSD Scale (or ½ of the average effect size of CPT, 1.0), 55 participants in each group (allowing for attrition of 5 in each group) would allow 80% power to reject the null hypothesis that GIM is inferior.

Two-sample t test power calculation:

$$n = 49.64188$$
$$delta = 0.5$$
$$sd = 1$$
$$sig.level = 0.2$$
$$power = 0.95$$
$$alternative = one.sided$$

Recruitment

Recruitment will happen through VA hospitals, veteran centers and community clinics who serve female veterans. The principal researcher will work to coordinate with MST coordinators at the local VA hospitals. Recruitment flyers will also be posted on closed social media groups that serve veterans.

Randomization

One hundred and ten participants will be randomized using a computer-generated randomization to the experimental condition or the active control condition at a one to one allocation ratio. An individual who otherwise does not have contact with the participants will conduct randomization.

Blinding

This is a single blind design. The professionals administering baseline and post-treatment assessments will be blinded to intervention assignment. Care will be taken to ascertain whether administrators determined the assigned intervention.

Statistical analyses

In a non-inferiority trial, an intention-to-treat analysis favors the alternative hypothesis (the opposite of a superiority trial, which would favor the null hypothesis), so data will be analyzed on an intention-to-treat and completers basis. Means and standard deviations will be calculated for change from baseline to posttreatment and two-month follow-up. Confidence intervals will be used to demonstrate non-inferiority between the two treatments. The confidence interval for the difference between GIM and CPT needs to be to the right of the non-inferiority margin in order to conclude that GIM is not inferior. Hypothesis testing is another approach to interpreting the findings, so *p* values will be provided as well. Secondary regression analyses will be employed to examine relationship of covariates, such as comorbidity, previous sexual trauma, and time passed since primary trauma.

CHAPTER 5. SUMMARY OF PUBLISHED ARTICLE

Story, K. M., & Beck, B. D. (2017). Guided Imagery and Music with female military veterans: An intervention development study. *The Arts in Psychotherapy*, *55*, 93-102.
Link to published paper: https://doi.org/10.1016/j.aip.2017.05.003

The first phase of the research entailed a feasibility study with a small number of veteran women. The aims were to assess the feasibility of working in a continuum of MI and GIM sessions to support trauma recovery and to further develop the intervention for a later RCT. The published study is summarized below, followed by a discussion that was beyond the scope of the published article.

5.1. BACKGROUND

In order to develop treatment modalities that better support women veterans who have encountered MST and have experienced PTSD, a pilot study related to intervention development and feasibility was conducted that explored the following research questions about the participants' experience of MI/GIM sessions:

- How do female veterans experience components of the MI/GIM sessions (music, imagery, creative processing)?

- What are female veterans' perceptions about the meaningfulness and helpfulness of MI/GIM?

- What are the changes in PTSD symptoms as demonstrated by pre and post test scores on the PTSD self-reported check list (PCL-5)?

Additional research questions were related to feasibility and acceptability of the study:

- How many female veterans consent to participate in the study after being introduced to the study details?

- What percentage of MI/GIM study sessions do participants complete?

- What percentage of study measures do participants complete?

In addition, there was an overall aim of using the findings from the feasibility study to inform the development of an intervention manual for the intervening therapists in the follow-up RCT and to refine the protocol for the RCT.

5.2. METHOD

Five women participated in a series of MI/GIM continuum sessions. Four of the women had experienced MST and one of the women had encountered MST as a military police officer. The choice of these five women was a result of accepting the first five who responded to recruitment flyers, met inclusion criteria and expressed interest to continue with the study. Participants encompassed unique profiles in terms of age, ethnicity, branch of military service and time since experienced trauma, allowing the opportunity to explore the intervention with participants of varied backgrounds.

All individual sessions and a post focus group session were audio recorded and analyzed using a process of meaning condensation in order to identify themes related to the women's experience with components of the GIM sessions. Pre and post PTSD symptoms were measured using the self-reported PCL-5 questionnaire. The PCL-5 is a 20 item self-reported scale used to monitor PTSD symptom change before and after treatment (Weathers et al., 2013).

5.3. RESULTS

Participants shared their experiences with music, imagery, guiding and creative processing, generating the following themes related to each category:

Music: Participants experienced music as a tool to regulate emotions, decrease arousal, express feelings and connect with others.

Imagery: Participants experienced imagery as a resource for grounding, a reminder of goals and a mediator to insights.

Guiding: Participants experienced being guided through the music as a supportive, structuring and empowering element.

Creative Processing: Participants experienced the creative processing experiences as a way to continue processing between therapy sessions.

Participants shared what they felt was meaningful and helpful from the MI/GIM sessions. The common themes were increased coping skills, increased self-awareness and feeling empowered.

The National Center for PTSD (US Department of Veterans Affairs, 2017b) states a change of 5–10 points on the PCL-5 scale as reliable and 10–20 as clinically significant. Results on the pre to post PCL-5 scores showed a clinically significant reduction of symptoms in 3 out of 4 participants and a reliable reduction for one participant (Table 5-1). One participant did not complete post session measures.

Table 5-1 PCL-5 scores before and after 10 weeks of GIM

PCL-5 pre score	PCL-5 post score	Change Score	# Sessions completed
45	34	-11	9
70	Missing	Missing	5
29	17	-12	10
14	8	-6	10
27	4	-23	10

Note. PCL-5 is a PTSD checklist related to the DSM-5
Data related to the feasibility and acceptability of the study resulted as follows:

Consent to participate: Five out of six women who inquired about the study consented to participate after presentation of study details. One participant declined due to commitment of time that would be required.

Number of sessions completed: Three out of five participants completed all ten sessions. One participant completed nine sessions due to cancelled sessions related to car issues and family illness. One participant completed five sessions, cancelling approximately every other session for multiple personal reasons.

Study measurements were fully completed by four out of five participants. One participant completed the PCL-5 pre-test measure did not attend or contribute to the final focus group and did not respond to follow up to obtain post PCL-5 measurements.

The results reported above were specific to the research questions addressed for the study. There were also results related to the overall aims, to develop an intervention manual and inform RCT protocol, as well. Many of those results are addressed in the discussion section of the article with further reflections below.

5.4. DISCUSSION

5.4.1. PARTICIPANTS INCLUSION CRITERIA

Four out of five participants were able to complete the pre and post measures and attended at least 90% of the sessions. The fifth participant cancelled every other session and did not attend the focus group or complete the post measures. It was discussed whether to count this participant as an attrition, but we chose not to because she continued to attend every other week. She reported benefit from the supportive sessions she received and there was no indication that the sessions were leading to any regression or decompensation (see case vignette, section 6.6.4). During the course of the study, it was discovered that she had been non-compliant with therapy in the past. It did lead to a reflection of the inclusion/ exclusion criteria and whether there should be a required commitment to therapy through attending a minimum number of sessions. This commitment, however felt antithetical to the model of working in a client-centered way, acknowledging that perhaps this client knew herself and understood that therapy every other week was the best situation for her. This becomes an ethical consideration perhaps and an example of where research protocol and real life clinical situations may be at odds.

5.4.2. INTERVENTION DEVELOPMENT

Prior to implementing the study sessions, the decision had been made to begin with resource oriented music and imagery and then work along a continuum of supportive and re-educative/ issue-oriented work as appropriate for each participant (see Chapter Six where the Continuum Model is presented). The structure of aligning with the Herman trauma recovery model was present from the beginning but the full model for working in a continuum was not detailed until after results were examined. All session series started with supportive sessions and continued in a client-centered manner through re-educative and reconstructive work, as appropriate. In the published article, beginning with resource-oriented MI sessions and then moving into GIM sessions is described but there is little mention or description of the other levels along the continuum as those were articulated in the context of trauma work later following analysis of the sessions. The articulation of utilizing different experiences along the continuum in alignment with the Herman stages was developed in the manual based on the progression in the feasibility study sessions.

During the course of study implementation and publication of the article, a study (Beck et al., 2017) and a presentation outlined in a conference summary (Scott-Moncrieff, Beck & Montgomery, 2015) were published that described the alignment of Herman stages with GIM work. As seen in the literature review, GIM and trauma recovery informed by Herman's framework is not new, but these additional studies provided further support for the structure of the manual.

5.4.3. USE OF CLIENT CHOSEN MUSIC

One finding from this study was the impact of focusing on the client's existing relationship to music through the use of music from her own collection. Literature and research from health musicing have begun to distill the benefits individuals experience from engaging in music experiences outside of the professional use of music therapy (Batt-Rawden & DeNora, 2005; Bonde, 2011; Bonde, Ruud, Skånland, & Trondalen, 2013; DeNora, 1999). The feasibility study began with the use of client-chosen music from their music collection, the music they often used in their everyday lives (see section 6.4 & 6.4.1). Acknowledging that existing music relationship and inviting it into the therapy process provided a foundation on which to build. Upon reflection, using the client's music in the feasibility study helped to accomplish several things:

1. Use of client-chosen music provided a tool to foster the client-therapist relationship and develop trust.

Each client, in her first therapy session, was asked to share music from her personal collection. All participants were able to do this with little direction or instruction. And yet, it felt very personal, as if they were giving a special piece of themselves through this musical selection. Through a process of accepting it without judgement or critique of their choices and meeting them in *their* music, they began to share their narrative and to develop trust in the music and the therapeutic process.

2. Use of client-chosen music established a strong connection between identity and music.

Recognizing parts of themselves in their own music and then in other music was a way to remind themselves of who they were and what they valued, as well as what they wanted to enhance and who they wanted to become. De Nora (1999) calls the music material "active ingredients in identity work" and reflects that people "find themselves" in music (p. 51). The music, or certain elements of the music can hold what they value about themselves and even be used as a representation. By initially using familiar client-chosen music, the women in the feasibility study easily recognized parts of themselves in their music. They knew their music, and often knew which parts of themselves the familiar music activated. They then took this concept of "finding themselves" in music in order to find selections that held components of themselves (inner resources) they wanted to enhance.

3. Use of client-chosen music increased their awareness of how they already used music in their lives and provided a coping tool for using music at home between sessions.

Beginning with the client's music, attention was drawn to how *their* music can be used to enhance a particular feeling and also how their feelings in the moment can impact their music choices. Through the process of reinforcement in sessions, they were able to use music to safely access and/or regulate their feelings and emotions outside of sessions.

We know from the health musicing literature that individuals know how to use music on their own to regulate, to activate emotions and to motivate themselves in their daily lives (Batt-Rawden & DeNora, 2005; Bonde, Ruud, Skånland, & Trondalen, 2013). "Music is a device for self-management and self-regulation and people often 'know what they need', musically speaking" (Batt-Rawden & DeNora, 2005, p.290). In the feasibility study, participants often knew what music they needed to connect to a certain feeling. But clients dealing with trauma can have difficulty bringing feelings into awareness. Initially, the therapist's role was more prominent in helping them to focus and identify feelings/ images and then teach them how to find the best music to match from a number of selections they easily identified. Over time, the participants were able to use elements of that process on their own between sessions.

4. Use of client-chosen music recognized the knowledge they brought to the therapy process, which helped to transfer some of the power inherent in the relationship.

The women in the feasibility study had come from an institution where they were taught not to trust themselves but to depend on a hierarchical chain of command. When clients come to a music therapist, they may consider them an expert on music and what they need/ how they might use the music. Acknowledging and using *their* knowledge of music, gives them some sense of agency in the therapy process. Beginning with client-chosen music and progressing to therapist-chosen music allows the locus of power to be in the client's hands.

The client's existing relationship to music and implications for clinical practice is explored further in Chapter Nine.

CHAPTER 6. CONTINUUM MODEL OF MI AND GIM

This chapter presents the Continuum Model of MI and GIM, the model that informed the approach to sessions implemented in the feasibility study summarized in Chapter Five. The intervention manual that was created as a guide for intervention therapists for the proposed RCT, utilized this model and is included in Appendix A.

Developed from Summer's clinical experience and establishment of the Institute for Music and Consciousness, The Continuum Model employs modifications of MI and GIM so that therapy may occur in smaller manageable pieces (Summer, 2009). The term "continuum" is taken from the practice of working within the three levels of psychotherapy practice: supportive, re-educative and reconstructive. Many GIM therapists are familiar with the Wolberg (1977) levels of practice adapted to music therapy by Wheeler (1983) and further adapted for GIM and introduced into The Bonny Foundation training in 1999. There is less familiarity with the levels of practice in relation to MI work as it is described in this chapter. The term "model" is taken from Bruscia's (1998) definition of a model which is more encompassing than a "method" wherein "a method is a particular type of music experience the client engages in for therapeutic purposes" and "a model is a systematic and unique approach to method, procedure and technique based on certain principles" (p. 115). The Continuum Model uses both MI and GIM methods along the psychotherapy continuum creating a model of six experiences.

The history and development of the continuum model will be described, followed by an overview of the six experiences that make up the continuum. Key differences between MI and GIM will be highlighted in addition to how the Supportive, Re-educative and Reconstructive levels of working are applied to each method. This is not meant to serve as a manual for how to apply the practice of working in a Continuum Model, which requires specific training.

6.1. HISTORY AND DEVELOPMENT

When Bonny originated her GIM method in 1970, there was no thought of adapting it for clinical populations. Based on humanistic principles, The Bonny Method training initially involved learning to facilitate GIM sessions for adults in search of personal growth and transformation. In 1989 The Bonny Foundation re-oriented the training to psychotherapy and began to teach GIM adaptations developed by Summer and Goldberg for clinical populations who were contraindicated for GIM in its' original form (Summer, 2015).

While working in psychiatric settings, Summer and Goldberg modified components of GIM so that clients could focus on a single image. Both practiced using a spectrum of GIM experiences but in terms of modifications, Goldberg's focus was on enhancing inner strengths and working at the supportive level (Goldberg, 1994); Summer's focus was on gaining new perspective about symptoms, working at the re-educative level (Summer, 2015). They defined MI as, "Whereas the Bonny Method is an exploratory method that utilizes a deeply altered state of consciousness and sequenced, evocative music programs to stimulate many images, music and imagery is a directed method that utilized brief relaxation and simple, repeated music to stimulate a single image" (Summer, 2015, p. 341).

6.2. MODIFYING THE METHOD: FROM GIM TO MI

When the method is modified, GIM is modified to become MI in order to provide a more structured contained field in which to work. When the level is modified the MI or GIM method is changed to become supportive, re-educative or reconstructive aligning the focus and intent to the client's emotional needs. The Continuum Model is comprised of six different approaches that are tailored through modification of the method and modification of the level, focusing the work to occur in smaller manageable pieces.

Music & Imagery techniques are often presented with an intention of relaxation (Grocke & Moe, 2015), but in The Continuum Model, MI is used in *supportive, re-educative and reconstructive* levels of working. In order to better understand why a therapist would choose supportive, re-educative or reconstructive MI rather than GIM, one must first understand the differences between the methods. In GIM literature, we conceptualize music as a container, and consider that the complexity of the music yields different size containers (Grocke & Moe, 2015). The term is in reference to Bonny's explanation of the music providing containment. If we think of the container in terms of sizes, the more complex music provides a larger container and simpler music provide a smaller container in which to explore.

But there are other elements of GIM and MI that are contributing to the container size. For instance, the induction can be very focused or very open. If using a client identified image of a tree as a representation of an inner resource of strength, an induction for an MI session would encourage them to really notice that tree, examining it from all sides and using all of their senses; or for a GIM session, the therapist might ask a client to start by bringing the tree to mind and then suggest that the music join them there and take them where they need to go. The MI induction encourages them to stay with the tree. The GIM induction does not contain the client within the territory of the tree. In fact, the tree is simply a starting point to encourage the client's free exploration. Another analogy would be a picture as opposed to a film. Music & Imagery focuses on one picture, whereas GIM is the entire film (Summer, 2015). Essentially, MI provides a smaller working container than GIM and it does this

through changing certain components of a Bonny Method session. Below is a list of the components and how they are modified for MI (also table 6.1).

Prelude: During the prelude the therapist is helping the client to identify one image or feeling on which to focus the music listening time.

Induction: There is a shorter relaxation time with the intent of turning the focus inward as opposed to entering a deeper altered state of consciousness. The verbal induction that is bridging to the music is very focused, encouraging a connection with one image (this is different at the Reconstructive level).

Music Listening: The music chosen is one piece, shorter in length and often repeated. During the music time, clients will often be drawing, journaling, or moving to the music. This requires a different cognitive presence than listening with eyes closed, so the altered state is not as deep.

Table 6-1 Modification of GIM to MI

Guided Imagery and Music	Music and Imagery
Extended relaxation	Brief time of relaxation
Several selections of music, during which the feeling/ image/ emotional state may change	Commonly one piece of music, often repeated to hold client in a certain feeling/ image/ emotional state
Therapist and client dialogue as client explores imagery freely during the music	Therapist talks during the induction, sometimes including talking over the music to enhance the focus
Creative processing may be used following the music listening during postlude and integration for material	Other creative processing (such as art, movement, journaling) occurs during the music or directly following brief music

As described above in the history and development, Summer and Goldberg developed MI techniques to use with populations who were contraindicated for GIM. Music & Imagery can provide a more manageable method of working within each level when GIM is contraindicated. For instance, a client may have a healthy sense of inner resources and be ready to focus on an issue or symptom but because of the significant level of symptoms, still need a focused way of interacting with them. Similarly, a client who has experienced trauma may be ready to engage with an issue, but still need the safety of exploring it through a more cognitively aware process (sitting up, eyes open and drawing). Beyond using MI when GIM is contraindicated, it is a useful method for GIM clients as well. For instance, a GIM client who has had material emerge briefly in an open GIM session and would benefit from returning to the image

in order to encourage closer examination of that material. In summary, MI can be thought of as a smaller working container than GIM, making it appropriate for someone who is contraindicated for GIM, but also a useful tool for a more focused examination of material. Through modification of the psychotherapy level, each method can be tailored to a client's needs in the moment.

6.3. MODIFYING THE LEVEL OF PSYCHOTHERAPY

Summer (2002) provided a clear definition of the three levels of working in an article about Group MI, describing the goals of each level of working. At the time, the common modification of The Bonny Method for groups was group GIM, and in her words, "I was, in essence, conducting sequential individual GIM sessions with each member of my therapy group, which was antithetical to the desideratum of stimulating therapeutic group process" (p.298).

It was clear that there needed to be a different approach to the modification that could utilize therapeutic group factors. That approach became the three-level model of group music and imagery, adapted from Wolberg's (1977) psychotherapy levels wherein the goals were to:

- Establish trust and engagement in therapy
- Increase self-awareness of maladaptive life/interpersonal patterns and self-understanding
- Address underlying existential and spiritual issues

The three-level model of working was also developed and applied to individual MI out of a need to develop new MI techniques to address clients' emotional limitations (Summer, 2009). In the Korean Language publication, *Case Studies in Music Imagery Techniques* (Summer & Chong, 2006)*,* three case studies were presented to demonstrate how different components of MI could be tailored to the intention and focus at each level according to the client's needs. In 2004 when Summer formed the Institute for Music and Consciousness, Wolberg's (1977) three levels were used as the foundational structure of the training that included a MI/GIM continuum of practice, shown in table 6-2 (Summer, 2015). Recently, examples of the Continuum Model in clinical practice and research have begun to appear in the literature (Scott-Moncrieff, Beck & Montgomery, 2015; Story & Beck, 2017).

Table 6-2 Continuum of Practice with Corresponding Training Level

Supportive MI	Level I
Re-educative MI	Level II
Reconstructive MI	Level III
Supportive GIM	Level III
Re-educative GIM	Level III
Reconstructive GIM	Level III

With a basic understanding of the differences between the two methods, each of the six approaches will be presented below, grouped by level. These will be framed in the context of trauma work, supporting the use of the model with this population.

6.3.1. TERMINOLOGY

In regards to the levels of working within the continuum, the terms Resource-Oriented, Issue-Oriented and Transformation-Oriented are used. These are terms that Summer has used interchangeably with Supportive, Re-educative and Reconstructive (Montgomery, 2012). Supportive, Re-educative and Reconstructive are descriptive of the process involved at the level of working; whereas, Resource-Oriented, Issue-Oriented and Transformation-Oriented are descriptive of the focus of each level. This may be clearer to the reader when both terms are used in the hypothetical clinical example under "summary."

In regards to the music terminology, Summer has used supportive, re-educative and reconstructive to describe the music chosen to help structure the corresponding level of working. This present study employs the terminology used by Wärja and Bonde (2014), "supportive", "mixed", and "challenging." The three terms are taken from Bonde's (2005a) grounded theory model that categorized music types and their influence on imagery. The terminology used is more descriptive of the music rather than the levels of working; however, there were some differences in the approach to choosing music for the feasibility study. Those are elaborated on in section 6.4.

6.3.2. SUPPORTIVE/ RESOURCE-ORIENTED LEVEL

Resource Oriented Music and Imagery (RO-MI), the most contained level and method in the Continuum, is a supportive MI process that uses a client's relationship to music to connect and enhance inner resources, build trust and provide a music resource for self-care.

The goal of Resource-oriented Music & Imagery is to discover and integrate inner resources through music. The components of the session – prelude, transition (resource and music selection), induction, music experience, and postlude – are strategically planned to provide the client with a simple, easily verbalized inner experience. In the prelude the client is initially guided towards a supportive resource as an entrance point for inner exploration. If conflicts or tensions emerge, the therapist addresses them with empathic listening and containment. A collaborative listening process between the client and therapist empowers the client to select a piece of music that is felt to match the resource. In a short induction, the client is instructed to center inward, to focus on the resource, and directed to draw it during the music experience. The drawing serves to contain the inner experience to one image and the single piece of music – which is simple, with little tension and little structural development – is repeated, approximately 20 minutes, to immerse the client in a deepened emotional, bodily, sensory experience of the image. After the session, the client's personal music is activated as a health resource, and it is used in conjunction with the image as daily self-care. (Summer, email conversation 2016)

The music in RO-MI is often chosen from the client's music collection, which allows her to begin with what she knows, establishing it as a known external resource that can be used to activate inner resources. It is important to note that inner resources help to activate safety, but they are not limited to this purpose. Inner resources also promote empowerment. A client may find an inner resource through an image that is nurturing such as relaxing by a stream or having a supportive loved one with them or she may find a resource in an image of strength or invincibility such as a growing fire at the center of her body or standing tall and grounded. I think of an inner resource as the heroine's superpower that allows her to move forward. This is of primary importance since being well-resourced and *able to connect* to those resources is a pre-requisite for moving into active trauma work.

In a RO-GIM session, the relaxation induction is extended, there is interactive guiding during the music rather than other creative modalities, and the music pieces would include supportive music. The music experience may be modified to be shorter than a full length GIM program and a musical piece may be repeated. Drawing sometimes occurs following the music experience. The RO-GIM allows for a larger container than RO-MI, while still maintaining a focus on inner resources.

6.3.3. RE-EDUCATIVE/ ISSUE-ORIENTED LEVEL

Explored from a place of enhanced inner resources, the goal of an IO-MI session is to address issues or symptoms and to gain new perspective regarding them. The issue or symptoms may be in the client's awareness but with IO work there is some component that is foreign, a not-me experience that will be discovered with a new

awareness. The aim is to hold the client in that tension so that she can gain new perspective on it, not necessarily to transform it. The components of the session – prelude, transition and induction, music experience, and postlude remain the same as RO-MI, but the goal changes from identifying resources to engaging with issues. During the prelude, the client and therapist identify an issue, symptom or image as a starting point before the music. An example of an issue from a client with PTSD might be anxiety around daily transitions or fear of being in a crowded room. A single piece of music is chosen that matches and holds the tension of the issue. As in RO-MI, the music may be repeated and drawing or other creative processing occurs during the music in order to help contain the experience. During the postlude, the issue is explored through further verbal and creative modalities maintaining a here-and-now focus, while still building a narrative that addresses the impact of trauma and helps to gain new perspective.

Verbalizing the memory of trauma brings it into the present and allows the client to grieve, but not all survivors find benefit in re-telling their trauma story. Building narrative without directly going into trauma memories can be accomplished through the use of metaphor and maintaining a here-and-now focus on the impact of trauma. Issue-Oriented Music & Imagery allows this building of narrative in small manageable pieces. Clients are not taken directly into a trauma memory, but trauma memories *may* emerge during the music listening through actual memories or metaphors. Verbal processing or creative modalities are then used to explore the memories and metaphors. It is also common however, for the client and therapist to identify an issue *connected* to the trauma such as anxiety around daily transitions or fear of being in a crowded room, rather than a direct memory, that will then be explored through a MI experience. If tolerated, this is also the stage where Issue Oriented GIM would be indicated.

In an IO-GIM session, the relaxation induction is extended, there is interactive guiding during the music rather than drawing, and the music pieces would include supportive and mixed level music. Drawing sometimes occurs following the music experience. These differences in the IO-GIM vs IO-MI, allow for a larger container, while still maintaining the intention of examining an issue through a focused induction and supportive, or mixed music.

6.3.4. RECONSTRUCTIVE/ TRANSFORMATION-ORIENTED

Transformation Oriented Music and Imagery (TO-MI) modifies the session from GIM to MI in a similar manner to the other levels. The aim of the reconstructive level is to address the root of the issue or symptoms and obtain transformation of emotional struggles (Summer, 2015). In a TO-MI session the prelude involves identifying an issue or exploratory focus. Challenging music would be chosen, which has more development and complexity than supportive music, encouraging exploration and transformation of the image (as opposed to holding). As in an RO-MI or IO-MI

session, the music may be repeated, however challenging music is longer in length and may not need repeating. In addition, one of the functions of repeating the music is to hold the client in a feeling or image and with TO level work the image needs room to change and transform. During the music listening time, the client may draw or engage in other creative modalities. At the TO-MI level, the creative modality needs to be structured in a way that allows the transformation of an image. For instance, when drawing, a client may need multiple pages for new images. Transformation-Oriented level of work has the largest container of all of the MI levels. Indicators that a client would be ready to work at this level would be that they are able to connect with their inner resources and have a clear sense of their issues/ symptoms.

In a TO-GIM session the relaxation would be extended, music would be chosen from supportive, mixed, and challenging pieces and interactive guiding would be used. A TO-GIM session is synonymous with a Bonny Method session.

6.4. APPROACH TO CHOOSING MUSIC

The approach used to choose music for the feasibility study was a combination of drawing on previous training and using a strong client-centered process. Terminology from the taxonomy is used and music was chosen following the intention of Summer's supportive, re-educative and reconstructive levels of working. In addition, music from the client's collection of music or what is referred to as their "music pool" was prioritized at the resource-oriented level.

Wärja's and Bonde's (2014) taxonomy classifies music into three categories: supportive, mixed, and challenging. The taxonomy was developed from Bonde's grounded theory model and Wärja's method of choosing music for the modified GIM approach, KMR-Brief Music Journeys. Music is categorized based on the intensity profile and the mood of the music. In general, the supportive fields are shorter selections of music conveying a lighter mood with lower intensity and complexity whereas the challenging fields are longer complex pieces of music with high levels of intensity and are more dramatic in mood. The terminology used for the subcategories (three under each major category) reflect safety, opening and exploring under the supportive field; exploring, deepening and challenging under the mixed field; and rhaposodic, metamorphosis and transformation under the challenging field. The intention of the music in the supportive field is to provide safety and holding. The intention of the music in the mixed field is to explore and deepen, possibly experiencing emotions that may be challenging or new. The intention of the music in the challenging field is "to explore new, enigmatic-mystic and even frightening areas of consciousness" (p. 20). In the development of the taxonomy, Warja and Bonde (2014) also highlight the importance of attunement and attention to therapeutic needs when making music choices. The aim of the taxonomy was to provide a tool with clear steps for selecting music in therapeutic music and imagery work through categorization of music according to musical properties.

Summer described music as having a "home base" that is created by various musical elements such as tonality, tempo and rhythm (Summer, 1992). The closer the music stays to home-base, the more support and holding is provided. Music that has more development moves further away from that home base, creating more tension and stimulation, thus a sense of exploration. Music is dynamic and unfolds in a unique manner as per the composer's decisions in composition and development, regardless of type or genre of the musical piece. Clients who come to therapy are also dynamic, each with a unique home base and process of developing and experiencing music. Attuning the music to a client requires an awareness of the client's home-base as well as an awareness of how the music develops. In the Continuum Model, music is holding and deepening at the resource-oriented level, holding and deepening at the issue-oriented level, and exploring at the transformation-oriented level. Music at the resource-oriented level is chosen that matches the image or feeling connected to the chosen resource. Music at the issue-oriented level is chosen that matches the image or feeling connected to the chosen issue. In general, issue-oriented level music would hold more tension or complexity in order to match the issue, however the function of the music continues to be containing. "The music chosen for the re-educative level of practice serves the same aesthetic and containing functions as in the supportive level. It should be repetitious, with little musical development" (Summer, 2011, p. 80). At the reconstructive/ transformation-oriented level of working, the focus is on exploration. It could be intense or a playful exploration, or an exploration of self-care, but the focus is on exploration, using music that moves further from a client's homebase.

In summary, the taxonomy, informed by clinical experience and previous research in GIM, provides the therapist a structured and focused way to choose music for a client. It does so by classifying music into specific categories according to mood and the stable or changing qualities of the music, while relying on the therapist's ability to assess the client's readiness to engage at a particular level of working. The intention of the music in the taxonomy fields is holding, exploring and transformation. The Continuum Model approach used for the present study also involves choosing music with the intention of three different levels of working, but the intent of the music at each level differs, focusing on holding or holding and deepening in the first two levels and exploring in the third level. The level in the Continuum Model is descriptive of the intended amount of containment versus exploration, not the quality of the chosen issue/ image therefor music for the level is chosen based on its level of containment and may include lighter moods and/or darker moods.

6.4.1. REFLECTION AND APPROACH TO CHOOSING MUSIC FOR THIS STUDY

My training in the use of Supportive MI entailed using music that was of a quality that would be described as non-Classical in nature, often of New Age or World Music genre- music that was very holding and mostly calming.   If a Classical genre, it was

typically one or two instruments engaged in a repetitive consonant melody. When I was developing the protocol for the feasibility study, I met with Lisa Summer to discuss resource-oriented music and imagery. In her clinical practice, Summer had started to integrate music from a client's pool of music in Supportive MI work, first as homework to help connect clients to their own music and then as the music pool for use in MI sessions. She facilitated a session for me, using my music in order to demonstrate and have me experience the use of client's music in Supportive MI sessions. For me it was also a vehicle to examine my research process and connect with my inner resources as a research student.

As I was led through the process of identifying an image and music, I recall choosing pieces that resonated with my pre-learning of what Supportive music should be. As she encouraged me to think differently, and to try different genres, I began to choose pieces outside the box of what I considered "appropriate" MI music. Eventually, we settled on a piece that began *with* drums, *and* had lyrics, *and* would be considered of the rock genre. Based on my training, I never would have labeled it a "Supportive" piece of music to use with clients. But it deepened the connection to my image and my understanding of how to move forward as a student. It was a perspective-changing experience and so clear to me how much stronger my connection was to the piece because I already had a relationship with it. I felt strongly that this could be a powerful vehicle for connecting the women to their inner resources. There were several reasons why I thought that. I was already focused on the idea that inner resources and relaxing experiences do not always align. Though sometimes nurturing and relaxing, I also viewed inner resources as being empowering and energizing, helping to mobilize clients. It was difficult to pair those qualities with my pool of relaxing, calm music to the same effect. I also anticipated that I would be working with women from various cultural and socio-economic backgrounds, some of whom may have had no previous exposure to the music traditionally used in MI and GIM sessions.   I was questioning how to build that openness and trust of new and unfamiliar music.

Writing about music from a psycho-dynamic perspective Summer stated, "the 'me' state is best stimulated through a 'sympathetic music structure;' music that is either familiar to, or preferred by, the client" (2011, p.3). In reading this, I was struck then that using the client's existing relationship with music by using music from their music pool would provide the most "me" experience and the most feeling of support, particularly in a resource-oriented session.   Throughout the feasibility sessions however, I found that I involved the client in the music choice even when the intent was an issue-oriented session. In essence, I was surrendering some of my control over the music choice to the client. I re-visit this concept and the clinical implications in Chapter Nine.

The approach to choosing music for this study, was a highly client-centered approach. Each initial session of a series began with using music from a client's pool of existing music. The music did not need to fit into what would traditionally be considered a

supportive category of music. The primary criteria for choosing a piece were the connection the client had to it and how it connected with the chosen induction image. Subsequent sessions in the series either used music from the client's pool or the therapist's pool, including some selections from GIM programs. The manner in which potential music fit the intent of the session (the level of working) was considered as well as the client's experience of the music upon hearing it. The client was offered the option of hearing a portion of the music before it was chosen, even when it was a GIM program. Other than beginning with a resource-oriented session using music from a client's pool, this approach to choosing music was emergent as the feasibility study progressed. Although terminology from the taxonomy is used in reference to the chosen music, and music was considered that supported the intention of working in a certain level of the Continuum Model, the client's relationship and reaction to the music was prioritized in the final decision.

6.5. SUMMARY AND EXAMPLE

Modifying the two methods, (MI or GIM) and the level (RO, IO, TO) contribute to the amount of containment and focus for a session. Adjusting the individual parts of the session – prelude, transition (focus and music selection), induction, music experience, and postlude- changes the size of the container the therapist is providing for the client. While adjusting the features of each approach changes the working container, it is the *intention* of the session, often identified by the therapist and client during the prelude and articulated during the induction that help the therapist to hold that container. To further illustrate, what follows is a fictitious example of a client presenting two themes during the prelude and how a therapist might proceed depending on the intention of the therapist to structure the work at a particular level.

During the course of the prelude, Iris described how she was able to say "no" when a friend asked her to assist in planning an upcoming local event. She explained that her usual behavior was to say yes because she wanted to please her friend. But this week, she had a noticeable feeling of self-caring and felt an internal impulse to say no. She attributed this new emotional skill to the fact that, at that moment, she saw her drawn image of a beautiful well-tended flower garden from the previous MI session. After Iris described this interaction in an excited tone, her focus turned to her difficult feelings regarding an upcoming project deadline for her employer. The deadline felt unreasonable, and her words, affect and body language all reflected her feeling of being overwhelmed. She felt stuck, unable to move forward in order to meet the deadline, and worthless in the eyes of her employer.

The therapist facilitating this prelude can choose from the six methods on the continuum: the primary choice is in regard to the psychotherapy level (resource, issue or transformation); the secondary choice is the method (MI or GIM). In reality, the therapist has many subtler choices to make, but for clarity I will only describe the six selections. For simplicity in this example I will refer to drawing *during* the music listening time in a MI experience, though sometimes other creative modalities are used

and sometimes they happen following the music. When deciding on the method, the considerations are the same for each level of therapy. If the goal is to use a smaller container and hold Iris very close to the image, an MI method would be chosen. If Iris is not contraindicated for GIM and the therapist wanted to provide a larger container to explore the image, GIM would be chosen. The postlude is not described in detail as it would vary depending on content that emerged during the session.

Resource Oriented MI or GIM: If Iris were in a stage of therapy where she was not aware of inner resources, just beginning to be aware of her inner resources or did not demonstrate the ability to regularly access them, the therapist would choose to use a resource-oriented focus and work in a supportive manner. The therapist would acknowledge that Iris is feeling overwhelmed and stuck but suggest that they focus the session on the feelings around saying no to her friend. The session would continue in a RO manner of identifying an image and/ or feelings connected to that experience. For example, Iris might choose to focus on the self-care or the empowerment that came from saying no. The therapist's role would be to help Iris identify or recognize that feeling/ image and to enhance the new emotional skill as an accessible inner resource.

Leading up to this point in the session, the process is the same, regardless of the method. If proceeding with an MI method, music would be chosen through the process of listening and identifying together music from Iris's collection that enhances that feeling, focusing on music that Iris feels connected to or has an existing relationship with. A brief centering in order to focus inward would be used rather than an extended relaxation. An induction would be described that holds Iris close to the image, encouraging her to examine it from multiple perspectives before moving into the music listening time. The chosen music would be repeated as Iris is instructed to continue exploring the image through drawing. The postlude would focus on the inner resource.

If proceeding with a GIM method, supportive music, consisting of one or several pieces is chosen by the therapist. An extended relaxation would be used. The induction would be the same as described above in order to focus on the inner-resource, however during the music there would be interactive guiding. A music selection may be repeated in order to hold Iris close to an image. The postlude would focus on the inner resource.

Issue-Oriented MI or GIM: If Iris was well connected to her inner resources and demonstrated an ability to regularly access them, the therapist would choose an issue-oriented focus and work in a re-educative manner. The therapist would re-inforce that Iris was able to connect to insights from the previous week and her need for self-care, but suggest that they focus the session on the feelings of being overwhelmed and stuck. The therapist would explain that it is okay for Iris to feel overwhelmed and stuck and that allowing herself to really feel and examine that may lead to a new perspective on the issue. The session would continue in an IO manner of identifying an image connected to being overwhelmed/ stuck or using overwhelmed/ stuck as the

image. Postlude integration would focus on new insights or perspectives regarding the issue.

For an IO-MI method, the therapist would choose music, normally one piece repeated, that matches the level of tension around the issue. A brief centering in order to focus inward would be used rather than an extended relaxation. An induction would encourage Iris to examine and stay with that one image. The chosen music would be repeated as Iris is instructed to continue exploring the image through drawing. For an IO-GIM session, music chosen by the therapist may be a mixture of supportive *and* mixed level pieces. An extended relaxation would be used and the induction would remain the same. Interactive dialogue may occur during the music listening. Drawing may be used following the music experience. Postlude integration would focus on new insights or perspectives regarding the issue.

Transformation-Oriented MI or GM: In addition to being well-connected to her inner resources, if Iris also had a clear understanding of the issues, the therapist would choose a transformation-oriented focus and work in a reconstructive manner. In this level of working it is about the manner of working with the image/ feeling as much as which image/ feeling to bring into the induction. So the therapist might suggest working with the self-care *or* the overwhelmed/ stuck feelings, *or* the therapist might suggest that they both be there as part of the induction. But the key part of the induction at this level is that it is more open. Rather than holding Iris close to one of the images in order to enhance and deepen or gain a new perspective, the induction suggests exploration and being open to a transformation of the image(s). Using challenging music that is more episodic in nature or contrasting music from multiple levels allows Iris more room to explore, to move to more than one place.

For a TO-MI method, one challenging piece of music would be chosen, a brief centering in order to focus inward would be used rather than an extended relaxation. This is where the therapist would use a more traditional Bonny Method induction bridge to the music such as "allow the music to take you where you need to go." Drawing would still occur during the music listening time, however in order to allow more room for the image to change, Iris would have the option of completing several drawings. This can be structured by providing paper visually divided into several sections or providing and encouraging exploration on several pieces of paper. Postlude discussion would focus on transformation that occurred in the progression of the imagery, utilizing the drawings as an added visual representation of the changes.

For a TO-GIM music chosen would include supportive, mixed and challenging pieces. An extended relaxation would be used. The induction would be an open induction, as above. Interactive dialogue would occur during the music listening. Postlude discussion would focus on transformation that occurred in the progression of the imagery.

Table 6-3 Continuum Model of MI and GIM

Levels	Music and Imagery (smaller container; more focused)	GIM (larger container; more room to explore)
Resource-Oriented (Focused on empowerment)	Brief relaxation Resource-oriented induction Supportive music/drawing	Extended relaxation Resource-oriented induction Supportive music Interactive guiding
Issue-Oriented (Focused on holding and feeling the issue/ emotion)	Brief relaxation Issue-oriented induction Mixed music/ Drawing	Extended relaxation Issue-oriented induction Mixed music Interactive guiding
Transformation-Oriented (Focused on exploration)	Brief relaxation Transformation-oriented induction Challenging music/ Drawing	Extended relaxation Transformation-oriented imagery Supportive, mixed and challenging music Interactive guiding

Note: (adapted from Summer, 2015 and music level terminology from Warja & Bonde, 2014)

6.6. CASE VIGNETTES

With the aim of providing examples of session series that utilized the Continuum Model, five case vignettes from the feasibility study participants are presented below. Each case begins with a brief client profile, a description and chart summarizing the sessions, and thoughts regarding progression of sessions. The chapter ends with a chart detailing all participants progression through the sessions according to the continuum method/level and Herman Stage. The case vignettes are written from my perspective as the therapist in the study. For confidentiality, names have been changed and specific age and ethnic background have been omitted.

6.6.1. SUE

Brief profile
Sue was in the military from 1966-1968, during the Vietnam War. During her participation in the study, she also received individual CPT sessions and attended a MST support group. She occasionally took medication for anxiety, but otherwise was not receiving medication.

PCL-5 pre-score: 29, met criteria in 3 of 4 symptom clusters (c- persistent avoidance, d- negative cognition/ mood, e- alterations in arousal and reactivity); PCL-5 post-score: 17

Introduction

Sue presented with a moderately high PCL-5 score. A recently retired health care provider, she was exploring issues connected to identity and the impact of trauma. Having served during the Vietnam War, she had been out of the military for over 40 years, but was only recently processing the MST and subsequent departure from the military. Sue spoke highly of her time in the military. She enjoyed her work there but also spoke to how difficult it was with the magnitude and severity of injuries she witnessed. Unlike some of the women, she identified feeling protected overall by the men she was with while in the military. But she also noted their degrading comments about women, especially women from other countries.

Sue had taken piano lessons as a child and currently sang in choirs and was learning ukulele and guitar through a community music program. During the study, she attended CPT therapy and a MST support group and felt that the combination of that and the music therapy was a positive process for her. She often arrived to sessions with many images to work with and continued processing them through self-initiated homework. Sue was very descriptive in what she needed from the therapy process and naturally worked in metaphor, meaning she quickly saw the connection to the images and was insightful about her process.

Progression through the Continuum Model

Following the initial interview, session one employed an MI method at the RO level in order to connect Sue to her music and to activate an inner resource. I asked about the music she connected to before her military trauma, specifically something she enjoyed and felt like herself with. She identified a piece from the musical theater repertoire and shared memories of being in plays in college. Just before beginning the music, she shared that she was feeling emotional and chose to relay details about her attack. It is important to note that beyond establishing whether they have experienced MST, I did not ask participants about the trauma or take them into trauma memories. When Sue shared that her thoughts had turned to the trauma, I acknowledged it and her feelings, but turned the focus back to resources. I had not yet assessed whether she had a strong connection to her resources, a pre-requisite for working with the trauma. Focusing on the music she chose, she identified a time filled with hope and expectations. We listened to this very strong upbeat music and she drew with vivid colors and wrote words like "chance it" and "live out loud." One of the statements she made about the experience was: "So it represented energy to me, rather than the quiet meditative part. And I keep this part mostly hidden. People don't usually see that, because I'm not quite sure what to do with it. Where do I put it?"

This energy and vitality was a resource for her that she knew was there, but also knew was mostly hidden. We talked about ways that she could deepen that during the week through listening to the piece and noticing how it felt. She returned the following week energized and reporting that she did not go into her "dark space" as much that week and that if she did, she put on music and it helped. She was aware of the delicate

balance between her "light and dark moods" and how in her dark moods she would have a tendency to just freeze up. I acknowledged that presence of light and dark, but chose to focus on enhancing inner resources further. Listening together to music she had brought, she identified an image: "somebody who takes more risks than I have in my life." She was curious about the image and felt energized by it. During the music, she felt restricted by trying to draw, so we shifted to dancing. She felt connected to one movement where she had her hand pushing out in front of her in a motion of "stop." She associated it with saying stop to her attacker and also to the current negativity she was feeling in her life. We spent time exploring and enacting the movement and in this way, rather than drawing, worked to enhance the empowerment she was feeling. But when we verbally processed the experience further and connected it to the initial image of risk taking, she felt sad and wondered if "stop" was a reaction to taking risks. This led to an insight for her that taking risks also require strong boundaries and the possibility of saying stop when needed.

This session is a good example of a session that started with an intention of being RO, using supportive music and a supportive starting image. But she actually worked in more of an issue-oriented manner. She considered risk-taking to be empowering but this led to an area of boundaries and fear about being able to say stop when needed, it also led back to self-judgment about not being able to stop her attacker and about currently feeling responsible to stop her negative moods. She was able to reflect on that and gain insight regarding boundaries. This provided a window into her ability to work in an IO manner, while still being able to draw on her inner resources when needed. She easily connected to inner resources and was insightful regarding her process.

During the prelude of session three, Sue was exploring themes of self-care. She wanted to move away from using her medication to manage anxiety, but she had trouble identifying what she needed and ways to care for herself. A very brief RO-GIM session was chosen for the intention of the session. I chose to use a GIM method as a way of providing more space for Sue to examine this theme, but continued to use a RO level of connecting to resources, in this case, self-care. Noticing that although it was a positive theme, she was unsure how to care for herself. She was able to identify some images that were nurturing- a walk on the beach, a family cabin. We listened to music selections from my collection and she chose one that most connected to her nurturing images. In the music, she easily connected to a younger playful version of herself. We discussed the resources of playfulness and joy, two of the identified feelings connected to her images. She also identified a strength and ability of the younger girl to care for her adult self. This image of the little girl stayed with her in subsequent sessions as a strong inner resource and helper when she metaphorically confronted her abuser. The session allowed me to see her ability to utilize GIM in a very contained manner.

Session four also used a RO-GIM format but with a longer music experience. During this session, she was able to feel a strong depth of support from her ancestors. She was curious about the darkness that she was starting to sense in her images and seemed ready to engage with them more. In session five an IO-GIM process was used, but attention was drawn to inner resources during the prelude and at the beginning of the induction. She was enjoying the GIM method and continued to easily engage with her imagery. In session six she was aware of a tension between her ideas of a masculine kind of strength and a feminine kind of strength. I began with an IO-MI experience for her to examine that, during which she became aware of her sadness around not allowing the feminine strength. She had an insight that her identity development had been interrupted by her abuse. She was saddened by this and afraid that she would never get back the parts she had lost. I used an induction that started with that same music used in the IO-MI experience and the sadness and fear induction to lead into an IO-GIM experience. In sessions seven and eight she used the IO-GIM experience to confront her abuser and express anger and sadness regarding her trauma. During session nine she explored questions of identity in a more open way with the use of supportive and mixed music in a TO-GIM experience. Session 10 was focused on integration of the work, but her focus continued to be exploratory in regards to her future. Sue's sessions are summarized in table 6-4.

Table 6-4 Summary of sessions, Sue

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
1	RO-MI	Risk-taking, boldness	Client Chosen: F. Loesser, *Luck Be a Lady*	Re-connected with aspects of self from before the trauma
2	RO-MI	Taking risks, taking care of self	Client Chosen, The Trammps: *Disco Inferno*	Connected to importance of boundaries
3	RO-GIM	"What I need"	Selection from Peak Experience Program: Beethoven *Piano Concerto no. 5, adagio*	Connection to girl in pink dress
4	RO-GIM	Connection to older wise self	Selections from Nurturing and Caring Programs: V. Williams, *Rhosymedre*; Berlioz, *Shepherd's Farewell*; Puccini, *Humming Chorus*; Massenet, *Scenes Alsaciennes*; Haydn, *Cello Concerto in C, adagio*; Warlock, *Pieds-en-l'air*	Connection to support through her ancestors
5	IO-GIM	Feeling disappoint-ment and setting a boundary	Selections from Positive Affect: Elgar, *Enigma Variations 8,9* Mozart, *Laudate Dominum* Barber, *Adagio for Strings* and Schumann *Funf Stucke*	Engages with darker images and finds comfort in mother and grandmother

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
6	IO-MI; IO-GIM	1: Feminine/ masculine strength 2: Feminine strength	IO-MI: M. Lauridsen, *O Magnum Mysterium*; IO-GIM: M. Lauridsen, *O Magnum Mysterium*; *Les Chansons des Roses 4 & 5*	Meeting the ballerina. Insight about feminine strength
7	IO-GIM	"the ballerina"	From Imagery Program: Ravel, *Intro and allegro*; Copland, *Appalachian Spring* (excerpts)	Ballerina feels like a façade but doesn't know who else to be
8	IO-GIM	Patience-through image of holding grand-mother's hand	From Grieving Program: Marcello, *Oboe Concerto c minor adagio*; Rodrigo, *Concierto de Aranjuez, adagio*; Grieg, *Holberg Suite Air*; Dvorak, *Larghetto*; Bach, *Prelude eb minor* Other: Schumann, *Funf Stucke*	Uses images to express feelings and confront abuser. Little girl comforts ballerina. Emotional expression of cognitive therapy work
9	TO-GIM	Exploring the yellow dress and the ballerina	Yo Yo Ma, *Dolce de* Coco; Mostly Bach and Positive Affect Programs: Brahms, *Violin Concerto, adagio*; Elgar, *Enigma Variations 8, 9*; Gounod, *Sanctus*; Bach, *Come Sweet Death*	Ballerina expresses anger, comforted by little girl Exploring direction and identity, expressed desire to move forward
10	TO-MI	Synthesis and closure	*Lauridsen: Les Chansons des Roses no. 5* (repeated)	"I want to dance a new dance" Focus on integration and moving forward

Comments and future directions

Sue worked in all 3 Herman stages and in all levels of the continuum. At the end of the series, it felt appropriate to take a break. For her, 10 sessions were adequate in order to build up resources, engage with material from the trauma, and explore themes related to connection and community. She had a stronger sense of her relationship to music as evidenced by her continued use of it at home between sessions. Her age, time since trauma event, and her CPT sessions are factors that may have contributed to her ability to successfully engage in sessions. At the end of her study time, she was also experiencing closure with her CPT therapist, who was leaving the Center where she received sessions. Sue remained connected to the support group she was attending and was being assigned another therapist through the Center. She was also connected and actively participating in several community music groups. When I spoke with her 2 years later, she was continuing to make music with these groups.

6.6.2. MARY

Brief profile
Mary was in the military from 1991-1996, mainly stationed in European countries. During her participation in the study, she attended an anger management therapy group and was under the care of a psychologist. She received medication for depression and anxiety.

PCL-5 pre score: 45, met PTSD criteria for all symptom clusters (b- intrusion, c- avoidance, d- negative cognition/ mood, e- alterations in arousal and reactivity); PCL-5 post score: 34

Introduction
Mary had a high score on her her self-reported experience of her PTSD symptoms (PCL-5), but was actively engaged in treatment. She had volunteered in several other research studies, was completing an anger management course, had received cognitive therapy and started exposure therapy but dropped out when she found it triggering. She was a single parent of two teenage children. She had previous music experiences singing in choirs, but was not currently participating in a choir. Mary stated during her first session that her main goal was to have the PTSD symptoms be more manageable. She was also concerned about an inability to successfully have friendships with men due to issues of trust. She grieved her own lack of being parented adequately, as well as current loneliness and lack of support.

Progression through the Continuum Model
Sessions one and two were highly structured RO-MI sessions that used selections she chose from her music in order to connect and enhance inner resources. The first session connected her to an image of her grandmother as a positive resource from her childhood that she continued to use throughout the session series. The second session connected her to a feeling of community through making music together. She had experienced this in the past as fun and playful. We ended that session with some active musicing that she tentatively engaged in, but refused in subsequent sessions. She was successfully able to identify and connect to her inner resources through her imagery.

Mary arrived for session three appearing tired and focused on processing themes connected to family of origin. She relayed stories from her childhood but physically showed signs of being overwhelmed as she re-lived these incidences through her telling. In order to support her, I used a directive approach in choosing supportive music from my collection and re-enforced her identified inner resources during the induction and music listening time. We identified homework of using the MI process in some way on her own at home in order to cope with symptoms. I was more intentional in session four about limiting the prelude time and drawing attention to her

coping skills and inner resources prior to moving into a RO-MI experience where she was able to connect with her resource image of serenity.

In session five, Mary shared that she was working on forgiveness and being able to stop blaming others. She also shared that she was connecting with her new-found voice and a level of empowerment she has discovered when she sets boundaries. I suggested maintaining a focus on her voice and empowerment as a resource. Though she had connected to inner resources, her connection seemed tenuous as demonstrated through her anxiety during sessions. I used supportive music and an induction to support Mary's connection with her voice, through a shortened RO-GIM session. The image of her voice continued to be with her strongly in session six, though she felt it was more of a thought, than an integrated component of her. There was some tension around interacting with her voice, but she described it as "a happy little cloud" she could see in the distance. An IO-GIM session was initiated in order to gain perspective on that voice, but she showed signs of being overwhelmed and unable to engage with the material, particularly when the music became more complex. I shifted to more supportive music and she experienced calmness and support as she breathed with the music.

Session seven, she was in touch with her anger about her past, but she did not want to engage with the anger, feeling that would only make it worse. Given her need for support in the past, I agreed with her, but the anger was such a large presence, we needed a way to acknowledge it before shifting the focus. A brief mandala drawing allowed her to draw the anger on the page, around the circle. On the inside she drew an image to represent a sanctuary from the anger. Using her image for the sanctuary and supportive music, a RO-GIM session was initiated, which allowed her to re-connect with the support. In session eight she was able to work in an IO-MI session that used a highly structured focus for her to explore an issue of conflict. In the final session, a RO-MI process was used to reflect and synthesize on the work. Table 6-5 summarizes Mary's sessions.

Table 6-5 Summary of sessions, Mary

Sess-ion	Level/Method	Induction	Music	Themes and Notes
1	RO-MI	Happy energy	Client chosen: Los hombres G: *Tiene un Marca Pasos*	Strong connection to images of her grandmother
2	RO-MI	Playful-ness	Client chosen: Gotea, *Gang of Rhythm*	Connection to Grandmother's playfulness
3	RO MI	Grand-mother	Therapist chosen: Piazzolla, *Oblivion*	Grieving lack of parenting by mother
4	RO-MI	Serenity	Yo Yo Ma, D'Rivera, *Trad: Dolce De Coco*; Yo Yo Ma, O'Connor: *Appalachia Waltz*	Semi-directive guiding into supportive images

Sess-ion	Level/Method	Induction	Music	Themes and Notes
5	RO GIM	Grieving loss, loneliness	From Caring/Nurturing Programs: Bach, *Shepherd's Song;* Puccini *Humming Chorus* x3; V. Williams *Rhosymedre*	Connected to voice-acknowledgement of it Direct guiding to support
6	IO-GIM, but shifted to RO	Voice as cloud	From Nurturing Programs: Canteloube, *Songs of the Auvergne*; Puccini, *Humming Chorus*	Exploring voice, but unable to do so Longing for peace Encouraged to sit with voice
7	RO-GIM	Support from grand-mother	Copland, *Rodeo, Corral Nocturne*; Lauridsen: *Les Chansons des Roses no. 5*	Aware of anger and abandonment Connection to self/others
8	IO-MI x2	Connect-ion to her body; emerging flowers	D. Grant *"Chrissie's Song"* (Repeated)	Feeling disconnected from her body Used music to observe feelings; wants more beauty in her life
9	RO-MI	Integration	Lauridsen, *Les Chansons des Roses no. 5;* Grant, *Chrissie's Song*	Lighthouse theme. Connection to other resources

Comments and future directions

Mary's PCL-5 post score of 34 was still above the suggested cut point score of 33 for PTSD diagnosis (Weathers et al., 2013). She worked *in* all three Herman stages as evidenced by her ability to: connect to inner-resources, identify trauma impact, and explore themes of identity and connection in the world but a protocol of ten sessions was not an adequate dosage to successfully work *through* all stages. Though we tenuously engaged in modified GIM, it was always in a RO manner. Music & Imagery work was on RO and IO levels. She was easily overwhelmed and we actively used music to manage PTSD symptoms within sessions. She would have benefited from additional MI and GIM sessions with extended time at the RO level in order to master the safety and trust needed to move through the next Herman stages. However, she did report finding meaning and support in the nine individual sessions and one focus group she completed. At the end of the research study time, she was provided with several community music resources and she continued to receive support from a therapist. Upon follow-up a year later she was in ongoing CBT treatment for her continued PTSD symptoms.

6.6.3. KAREN

Brief profile

Karen was in the military from 1986-1988. During her participation in the study, she also received individual therapy with a psychologist at the VA. The therapy sessions began at about the same time as her study participation and were her first experiences in any type of therapy. She was not receiving any medication.

PCL-5 pre score: 14 met criteria in 2 symptom clusters (d- negative cognition/ mood, e- alterations in arousal and reactivity); PCL-5 post score: 8

Introduction

Karen was a military police officer who had not experienced MST, but engaged in cases that involved MST. She expressed interest in participating in the study and we chose to include her to widen the profile of participants. Her PCL pre score was low, though she met PTSD criteria in 2 out of 4 categories. Karen was in a transition housing program after previously being homeless for some time and living out of her car. During participation in the study, she disclosed abuse from childhood. Another theme for Karen was grieving the loss of her mother who died when Karen was a teenager. Karen had been told that she played guitar at some point, though since having a head injury some years ago, she has no memory of playing. Her own identified goals for the sessions were to work on low self-esteem issues and to maintain focus on the steps she was taking to move out of transition housing and further her career in law enforcement/ criminal justice. During her time in the study, she also received support from a psychologist at the VA. She had no previous experiences with therapy.

Progression through sessions

During the first session, Karen easily shared music with me from her collection. When we moved to the topic of resources and what she might need, she thought about her mother and a certain energy and "spunkiness" she possessed. We listened together and identified a song that connected with that image. During a RO-MI experience, she was able to connect with a specific positive memory of her mother. But when Karen returned the following week, her confidence and self-esteem were reportedly low. Finding inner resources felt difficult to her. The music selections she brought up were focused on failed relationships. After several attempts of using her music to connect her to an inner resource, we used very supportive music from my collection and a supportive, relaxing induction to structure a brief experience with her inner world. With verbal processing following the music, she was able to connect her images of the stars and surfing with a peaceful quality in herself.

In the third session, Karen came in requesting a similar experience to the week before. She found it relaxing and enjoyed the music. She also requested that I choose the music. I agreed that a similar experience would be helpful for Karen. Interacting with

her inner world was new, so we were proceeding slowly. Using a supportive induction and supportive music, Karen engaged in a brief RO-GIM session. She connected the images of hiking and pioneering to her current task of finding work and getting her career "back on track." Session four, Karen came in feeling sad about some news she had just received connected to a family member. I encouraged Karen to stay with her feelings. She had experienced several positive interactions with her inner world, but admitted that she preferred to avoid her feelings. She requested GIM, preferring not to draw, explaining a negative association with drawing. I chose mixed (supportive and challenging) music from a GIM program and used an IO induction and image to examine the relationship and sadness. Note, this relationship was a positive ongoing relationship, not someone connected to her abuse. Through the music experience, she gained some perspective on the relationship, her feelings and frustrations.

Karen entered the fifth session feeling anxious about a job interview. When we checked in further, she was able to identify a resource to help and connected it to an image. Her ability to easily connect with a feeling and an image were new to her, things that in the past had been difficult to identify. We listened to music from her collection together and she chose a song that resonated with the confidence and peace she wanted to enhance. She agreed to draw, though she was not feeling confident about it, which brought in some tension as well as a parallel process to the feelings she was examining between confidence and anxiety. So this was an interesting example of all the factors that overlap and create the intention of the session. We used an image and music she connected with confidence, but she was aware of the anxiety mixed in, both about the drawing and about the interview. Her drawing represented a place she liked to sit and relax. Through talking about the drawing, she acknowledged her difficulty with sitting and being with her situation and her feelings. This is an example of the use of supportive music and induction that resulted in a more IO level process.

In my effort to connect her sooner to her feelings, we started session six with a musical check in rather than a verbal one. I was aware that she preferred to talk about things and was trying to support her to go into the music and her feelings sooner. She chose to write to supportive music that I chose. Following the music, she told me parts of her story I had not heard before. She also spoke about her feelings of low self-esteem from being homeless and being "in the system". She was emotional and able to express her feelings during this verbal processing. What stood out about this session was that the use of music at the *beginning* of the session allowed her to be more emotionally present in her verbal processing that followed. It was not a full MI experience, but the brief time with the music provided a more authentic starting point for verbal interaction. Karen had a great sense of humor, and she admittedly used it to avoid discussing other things. When we started with music, it seemed to bypass that defense and in doing so allowed her to be present in her feelings of grief related to past experiences.

Session seven she was tired and feeling low in energy. She wanted to connect more to her ambition and motivation to move forward and out of the system. She experienced this feeling as an image of a purple block. Although motivation and ambition are empowering images, she felt disconnected from them, so the intention of the session was to gain new perspective on that disconnection. Through an IO-GIM session she examined a feeling and impulse of wanting to run away to something new, rather than sitting with and engaging with her present challenges.

At this point there was a break of three weeks until our next session due to scheduling issues. During the prelude of session eight she expressed feelings of being scared and anxious about upcoming decisions and going back to school. She described the anxiety as like "being behind bars and trying to get out." Through the use of supportive music from her collection and an RO-MI session, she connected to issues around trust and making the "wrong" decisions. The intention was a RO session, but she actually experienced comfort and peace as bringing up her anxiety about previous relationships and anger and grief over losing her mother at a young age. I suggested that she spend some time with that and perhaps listen to the music (previously identified as a resource) that reminded her of her mother while writing a letter to her before our next session.

She returned the following week with a letter for her mother. After reading it to me, we took her feelings of anger and sadness into the music through an IO-GIM session where she expressed many of her feelings to her mother.

Session ten was an integration of the previous sessions, through a RO-MI experience. Karen's sessions are summarized in table 6-6.

Table 6-6 Summary of sessions, Karen

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
1	RO-MI	Energy and spunk; image of mother dancing	Client Chosen: B. Seger, *Night Moves*; P. Cline, *Crazy*	Connection to mother as inner resource
2	RO-MI	Connecting to peaceful aspects of self in relation to others	Therapist music chosen by client: Shostakovich, *Piano Concerto no.2, andante*	Relaxing at night on the beach Able to engage in imagery
3	RO-GIM	Positive energy connected to images of forging own path Pioneering	From Caring Program: Haydn, *Cello Concerto in C, adagio* Puccini, *Humming Chorus*; Bach, *Shepherd's Song*	Connected to current career planning Able to tolerate a longer supportive GIM session

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
4	IO-GIM	Observing interaction w/ daughter Starting image of being on the beach together	From Nurturing Program: *Rhosymedre*; Berlioz, *Shepherd's Farewell*; Puccini, *Humming Chorus*; Massenet, *Scenes Alsaciennes*; Lauridsen, *Les Chansons des Roses no. 5*; Holst, *Venus*	Some insight into patterns from her early relationships to present
5	RO/IO-MI	Confidence, image from "Ice Age"	Client chosen: J. Bay, *Let It Go*	Tension in Sitting vs moving forward
6	Talk session	Brief use of music and check in of current state	Therapist chosen music, P. Metheny, *America*	Expressed grief Shared additional trauma from childhood
7	IO-GIM	Purple Block; tension around ambition/ motivation	Positive Affect Program	Awareness that it is difficult to sit with present feelings/ challenges
8	RO-MI	Confidence Dancing on the front porch	Client chosen: J. Taylor, *You've got a friend*	Insight into relationships, self-confidence and trust Expressed anger at mother and sadness
9	IO-GIM	Supportive image of beach and talking to her mother	Therapist chosen: Yo Yo Ma, O'Connor: *Appalachia Waltz*; D. Grant *Chrissie's song*	Shared letter, and imagery of mother Able to use the music to express feelings
10	RO-MI	Integration and synthesis of previous work	Chosen together: D. Grant Celtic lyrics	Kayaking through a tunnel, hope for future

Comments and future directions

For Karen, it was new and challenging to engage in the inner world of images and feelings. She was comfortable outlining steps to accomplish a goal, but needed support to interact with her feelings. She used humor as avoidance and readily admitted to "door knob conversations" and preferred to talk about "someone else's feelings rather than my own." Issue-Oriented work was minimal in that it was difficult for her to engage with the tensions and feelings. For her, engaging with even relaxing or positive empowering feelings was a tense experience. What would normally be thought of as supportive or nurturing music was sometimes difficult for her because even holding in a supportive way, brought up the lack of nurturing in her life. Karen would have benefited from more sessions in order to have time to process some of her early life experiences and their impact on her current life. But she was also in a time of major transition and the mainly supportive and some issue oriented work that she

did, provided an opening into further therapy. When I spoke to her a year after our sessions ended, she had started a new job, joined a community music group and was teaching herself to play guitar again.

6.6.4. PAM

Brief profile

Pam served in the military from 2005-2010 and was deployed to the Middle East several times. During her participation in the study, she also received individual cognitive therapy with a social worker at the VA. She was receiving multiple medications for physiological issues, mood disorders and substance abuse withdrawal.

PCL-5 pre score: 70 met criteria in all symptom clusters (b- intrusion, c- avoidance, d- negative cognition/ mood, e- alterations in arousal and reactivity); PCL-5 post score: N/A

Introduction

Of the participants, Pam was the most recently enrolled in the military. She had been stationed in several countries and had been deployed to Iraq twice. When Pam joined the military, she felt she was shutting a door on her history of childhood abuse, but her encounter with MST left her feeling that "I couldn't get a break." She reported the attack while in the Army and was discharged. She stated "I was diagnosed with PTSD and told I had issues with male authority figures." Upon returning to civilian life, she had many challenges.   She loved to draw and do anything related to creativity, especially the visual arts. She used drawing to manage her anxiety. Pam had played several instruments growing up, but was not currently playing. I felt that participating in the research would be beneficial to her though I anticipated that sessions would remain at a supportive level due to her current level of instability.

Progression through sessions

It was evident through her verbal check-ins and also through her music choices that Pam experienced the world as a hostile environment. Music for her held positive and negative feelings and often her listening choices were connected to difficult memories. In the first session, it was challenging to find a positive resource, but she was able to connect to a song that held for her the ability to re-invent herself and keep going in the midst of challenges. She was also able to name one person who had been a positive mentor in her life. In the second session, she entered upset, angry and emotional due to a negative meeting with her parole officer. She was not in a place where she could identify resources or feelings, other than anger and frustration. She worked on a drawing that she had brought with her as we listened to a song she had been listening to during the week. Her verbal check in had been so emotionally charged and angry but drawing helped her to focus. She was able to identify images of strength and beauty in the drawing. I suggested a brief listening music experience in order to enhance those qualities. I played several pieces for her from my music collection.

She easily identified what elements seemed to connect with strength and beauty for her, and she had a strong preference for one of the pieces. During the music she briefly connected to a memory of her 10 year-old self, playing the piano and being carefree. After the music experience, she was left feeling connected to an aspect in her drawing she had only briefly mentioned- faith. She connected the flowers in her drawing to faith and wanted to use flowers as a visual reminder of faith during the coming week.

There was a break between session 2 and 3, during which time she was hospitalized for a suicide attempt. She felt overwhelmed by a separation with her husband, and from working with a new therapist, which required re-telling her history. She also shared some trust issues with previous therapists. I checked in regarding our work here and her stress level. She stated that art and music was a relief for her. The verbal prelude was focused on how she had been labeled from her felony and the way she was treated by others as a result. She was able to identify qualities in herself that she wished others saw- kindness and empathy for others. We worked to connect to kindness and empathy and let go of the labels, but she repeatedly came back to issues connected to her relationship and separation. We settled on and then abandoned several song choices because they were enhancing negative feelings. We turned to my pool of music where she found an example of something that she enjoyed listening to and identified as "happy" sounding. Through an RO-MI session using that music she was able to see the beauty she had drawn in her picture. "There's no violence. It's all beautiful. I just want a space with no violence."

In session four, Pam arrived very upset. She had placed a restraining order on her husband and she reported that her therapist had terminated therapy, stating that Pam was not compliant or committed to therapy (she had an additional therapist through VA services). She felt that she had no support and felt lost about how to move forward. She was trying to not sink into depression. She had also just returned to taking college courses. We listened to a piece of music she chose from her music pool that she felt connected to. The music was a country song and held themes of returning to someone you love. I was concerned that it would enhance the feelings about her abusive relationship and her tendency to return to it, but as we listened together, she shared her feelings that she was comfortably on a path though she didn't know where it would lead. This led her to concepts of faith and trust. We used the music and an RO-MI experience to enhance the feelings of being present and connecting to faith and trust that the path would unfold. The focus was on safety and support and being able to feel safe and supported even though she didn't know what was going to happen next in her life. We identified concrete steps she could take for herself during the week.

She cancelled the following week, but when she came in the week after, she appeared to have more energy. She had spent time on her appearance and seemed more relaxed. She had not reconciled with her husband and she was making plans to move closer to

her family when her parole time was finished in about one year. She had brought music with her for the first time as well (previously we had been using the internet to find pieces she identified). She reported that she had sunk into a depressed state for a few days since she had seen me last, but she had a moment of insight where she was able to reflect on how she wanted to move forward in her life and she felt strongly that she wanted to be a survivor, not a victim. She had written a paper for a class where she was able to articulate and expand on that theme. Using her music (Lincin Park), I used an RO-MI experience to connect with and enhance feelings she identified: self-acceptance, peace and comfort with who she is. She cancelled the following session, which would have been her last session. She confirmed that she would be at the focus group, but did not attend. Table 6-7 summarizes her sessions.

Table 6-7 Summary of sessions, Pam

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
1	RO-MI	Connecting to support	Client chosen: Lincin Park, *In the End*	Able to identify support person Themes of determination Music held positive and negative feelings for her
2	RO-MI x2	Strength and beauty image from her drawing	Client chosen: N. Furtado, *I'm Like a Bird*; Therapist chosen: Yo Yo Ma*: Dolce De Coco*	Initially upset, able to use music and drawing to connect to faith Accessed a positive memory.
3	RO-MI	Strength and independence	Client chosen: Eminem & Rihanna, *Love the Way you Lie*; Therapist Music: P Gabriel, *Shaking the Tree*	Able to state goals around safety and steps towards happiness
4	RO-MI	Connecting to direction and a path forward	Client chosen: Rascal Flats, *Broken Road*	Upset, anxious and needed support. Articulated concrete steps to stay safe and move forward
5	RO_MI	Self-acceptance	Linkin Park, *Leave Out All the Res*t	Acknowledged desire to be a survivor, not a victim Increased positive outlook, more energy Insight regarding self-acceptance

Comments and future directions

Pam frequently missed appointments, arrived to sessions appearing anxious and fearful, was in an unstable, abusive relationship and currently in treatment for substance abuse. Her external world was chaotic and she felt a complete lack of control over her life. But it was clear that art was a reprieve for Pam, and it became one way to therapeutically connect.

Pam's music was rap or country. Music that some would consider strong - the lyrics were strong or the themes told stories of breakups and violence. It was challenging to have that as her pool of music to work with while trying to focus on inner resources. But I had to let go of any judgement of the music and learn how she heard it and experienced it. For example, when we listened to Eminem and Rihanna sing of domestic violence, it was the violence re-enacted in Eminem's lyrics that stood out to me, but for her, Eminem's lyrics allowed her to take on the perspective of her husband and also to reflect "where is there room for me to be me" in that relationship. The music provided space for her to consider her own sense of self and safety and in that sense, provided a powerful insight that may have contributed to her subsequent separation from him.

Establishing trust and safety were the main aims of the sessions. Pam attended five sessions, over approximately 3 months and was just at the starting point of establishing some safety and trust. Sessions remained at a RO level. Establishing that she could reliably come and have a safe, non-threatening experience where I was not going to label her or lecture her was important. Music listening helped us to forge that relationship, as did the sharing of her artwork that she would bring in and describe. At the end of the study time she sent an email thanking me for including her in the study. She said that she would try to attend the focus group, but did not attend. She did not respond to any other attempts to contact her.

6.6.5. JUDY

Brief profile

Judy was in the military from 1974-1980 and1998-2013. During her participation in the study, she was not receiving any other therapy and was under no medication.

PCL pre score: 27 met criteria in all symptom clusters (b- intrusion, c- avoidance, d- negative cognition/ mood, e- alterations in arousal and reactivity); PCL post score: 4

Introduction

Of the participants, Judy had been in the military the longest, having retired 2 years before we met. Her overall PLC-5 pre score was below the cut-off point, but she met the provisional diagnosis criteria for PTSD given the presence of symptoms in all clusters. She loved music, was learning how to play guitar, and heard about the research study through another study participant. She had engaged in some cognitive

therapy previous to study participation. She was self-employed and in a stable long-term relationship. Judy had multiple trauma experiences growing up and in the military. One of the strongest experiences of MST happened early in her military career but, she had repressed it until recently. Some of the trauma experiences that seemed less traumatic on the surface in terms of severity of event, were ones she reported had the most lasting negative effect. She was insightful regarding the impact of past trauma on her current life. In addition to the PTSD symptoms, of which hypervigilance was the most disruptive, Judy was aware of issues around trust. One of her stated goals was to move through her life with authenticity and integrity, without feeling that her past experiences had power over her present decisions.

Progression through sessions

During the interview, I learned that Judy had recently started writing songs and playing guitar. Throughout the research time, she shared updates regarding her songwriting. This is not mentioned in the summary that follows, but it was an important part of her musical development. In the first session I asked Judy to share a song that represented her before her military experiences. She chose one from her music pool and we used it for an RO-MI experience. She was able to connect to the music and drew an image that represented her innocence at the time, along with an energy that held both light and dark aspects. She reflected on the trust she has had to work to develop, beginning with learning to trust herself and her intuition. I acknowledged the amount of trust it took to engage in the RO-MI experience, something she stated she would not have been able to do five years ago. At the end of the first session, I had a good sense that she was able to work with music and imagery. When she returned the second week, she reported that she had spent the week thinking more about her experiences and how they had affected her developmentally. When we checked in, she had a strong image of a printer's box with multiple letters that could be placed various places. The image represented the way she compartmentalized things. She described:

> I think there are too many boxes and I can't get to all of them and I don't even know what's in all of them. There's a lot of boxes here. And I think that some of the boxes might be overflowing and some of them might even be empty. And I think that maybe I'm more concerned about the ones that are empty than the ones overflowing. Maybe I'm just trying to hold onto stuff that doesn't need to be there anymore.

She identified sadness as the feeling connected to the image. She was also unsure about opening the boxes because she wasn't sure what she would find there. It was a beautiful metaphor for the beginning of therapy, and also spoke to the trust issues. She identified courage as what she needed, but she felt that it was far away and was most in touch with the sadness. After she described what the sadness sounded like, I suggested we add some music. I used music close to her description to acknowledge her sadness as she described it further to me through a brief GIM experience. I shifted the music that had a lighter quality without as much tension and her imagery shifted

to an experience of trust and being cared for. I then began a RO-MI experience with an induction that repeated some of her latter images of trust and used the same music that had been used when those trust images were generated. This session was an example of using music to acknowledge the more difficult feelings before focusing on the resource part. Acknowledging the sadness felt important because she had stated that the courage was far away and I didn't think she would've been able to connect to it in the music without acknowledging the sadness first. In this case, we started with a brief GIM session that connected to the sadness before moving into a RO-MI session focused on courage.

During the week that followed, she acknowledged the importance of being able to identify and acknowledge the sadness and its connection to her loss of trust. When she checked in at the beginning of the third session, she was aware of the sadness and curious about it, but also a little afraid of the unknown and of trusting the process, as well as me. She described the sadness as a door that needed a key to open it. Together, we listened to music from my collection in order to identify a piece that she felt could be her ally as she approached that door. She chose V. Williams, Rhosymedre and described it:

> this one feels different, the first notes put a kind of joy, like a coming home kind of joy, you know like you've been away for a long time, and now you are where you need to be. It reminds me of coming to a place of home. It definitely feels like I'd want to go there.

I used the music and a brief GIM session with interactive dialogue. Her imagery centered around a theme of coming home to herself. During an RO-MI experience that followed, she had an insight that she held the key in her heart to open the door, and the key was a level of trust in herself.

This session provides an example of the process I sometimes used when the client and I chose music together, even from the GIM programs. She had a strong connection to this piece, and we used it in subsequent sessions.

During the check in for session four, I asked Judy where she would place herself in her image from last week (path that led to heart and key), and she stated that she was right at the heart, with the key, ready to open it. She felt that her biggest barrier was how to get out of her own way so she could move forward. We explored that image further and the types of music that would connect her to that image. After listening to several pieces that matched her description, she resonated most with the Bach (see table 6-8). An interesting point, is that when we talked about the image of the path and listened to the V. Williams that was so supportive the week before, she said that she experienced the V. Williams as comfortable, but she knew it wasn't right for what she needed. She said that she needed something to help her venture out.

The IO-MI experience was filled with images of taking small steps forward, only to find more doors and led to an insight that there is still some trepidation about exploring new experiences (opening doors) and where they might lead. That experience was followed by using the V. Williams again, which she experienced that time as lonely. She described it as: "It's like, I know I need to do something but I don't want to do whatever it is and I don't know if I want to change that space."

Shortly before our fifth session, B.B. King died. Judy had a strong connection to blues music. We listened together to a B.B. King song and moved into a brief GIM experience where she was able to be in a crowded venue with a band playing and eventually found herself in the middle of the room where she felt a connection to the music and the players and the entire room as it moved to the music. That was a significant experience for her because she did not like to be in the middle of a room where she cannot see what is happening behind her. We used the same music in an IO-MI experience where she was able to gain new insights around trust.

Judy was tired and experiencing a headache during session six. She requested a music relaxation experience. I tried to structure a RO-GIM experience focused on relaxation and support, but Judy had difficulty connecting to the music. Nothing felt right to her and then the session had to end a little early due to a work commitment she was called away for. Later, Judy reported that she learned a lot about music that day and choosing music, so from a psychoeducational perspective, it was beneficial. During that session, she also reported that during the previous week, she had experienced less hypervigilance since her BB King imagery session.

In session seven, Judy was processing a situation in her current life involving trust. We listened to music in her collection that interacted with trust in different ways, not only in how it resonated with the situation but also starting from the perspective of choosing music that she trusted. This was important connected to the issue but also connected to the previous week where the feeling was that it was difficult to find the right music. After choosing a piece, she participated in an IO-MI experience focused on trust where she gained some insight into how she approaches trust as well as how previous experiences have impacted her ability to trust others and most importantly, herself.

Prior to session eight there was a break of one month due to travel and scheduling. During that time, she had bought materials to build a drum. She described a feeling that had been strong the last few weeks that she wanted to do more with music. She stated that her mind consistently goes to musical places. But also continuing to process a current conflict in her life, she described herself as feeling stuck, unable to move. I suggested actively playing music together as a starting point. My thought was to use her strong connection to the drum and wanting to do more with music to explore feeling stuck. I used an induction for her to musically explore an image she brought up that represented feeling stuck in the middle. Judy began on drums, playing

for about five minutes. When she finished, she described imagery that she had during the process. From that description we chose one particular aspect to improvise further, with me playing with her. The experience provided some insight into the types of motivation and support she felt she could accept and integrate. The description of motivational styles centered around masculine and feminine styles of support she had felt previously in her life. It was a shorter session that day, so the active playing took up the session time.

In Session nine, Judy was in touch with some sadness around a difficult relationship interaction in her current life. She used an IO-MI experience to connect to the sadness and express the grief she was feeling. Towards the end she experienced the sensation of letting go of the situation she was trying to hold onto. But her experience of the music and the imagery felt somewhat unresolved. I supported her through an RO-MI experiencing using music she had previously identified as being like home for her. In that experience she was able to feel herself being nurtured and it felt more resolved. She had gained more insight into the situation and felt a release of emotions.

Session ten was the final session and focused on reflection and closure form the previous sessions. She chose music to support the reflection. Her images reflected a spirit of exploration and looking forward to new things to come. Table 6-8 summarizes Judy's sessions.

Table 6-8 Summary of sessions, Judy

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
1	RO-MI	Connection to energy of exploring Image of self at 21 years	Client chosen, Cups: *You're gonna Miss Me When I'm Gone*	Shared story of abuse and the impact on her life now
2	IO-GIM; RO-MI	Sadness, trust	D Grant: *An Gille Ban, Chrissie's Song*; YoYo Ma, *Appalachia*	Supported expression of sadness Felt trust, comfort, a universal connectedness
3	RO-GIM; RO-MI	Trust	V. Williams: *Rhosymedre*	Path to trust Insight re: struggle with trust issues
4	IO-MI x2	At the door with the heart and key Examining blocks	Bach: *Passacaglia and Fugue*; V. Williams: *Rhosymedre*	Exploring clarity; activating the explorer
5	IO-MI	Trust; relation-ship; PTSD symptoms	Client Chosen: BB King, blues instrumental	Experienced music as empowerment

Sess-ion	Level/ Method	Induction	Music	Themes and Notes
6	RO-GIM	Supporting image (pond)	Tried various pieces from therapist's collection	New awareness of music What worked and what didn't
7	IO-MI	Trust	L. Cohen, *Hallelujah*	Insight regarding different levels of trust and what impacts ability to trust
8	Active "music-ing"	walking forward in a confined space	drum and piano	Masculine/ feminine qualities
9	IO-MI; RO-MI	Cloud of smoke, representing sadness Coming home	Arvo Part, *Spiegel im Spiegel*; V. Williams, *Rhosymedre*	Able to use imagery to experience sadness and release Experienced self-nurturing.
10	TO-MI	Refection on sessions	BB King, Instrumental blues piece	Articulated new insights re: impact of sessions on her life and moving forward.

Comments and future directions

Judy's post PCL-5 score was 23 points lower, demonstrating a clinically meaningful reduction of PTSD symptoms. From the beginning of sessions, she was focused on exploration while simultaneously acknowledging the impact of previous experiences on her life. The main theme throughout her sessions was trust. There was a sense that she was working through the three Herman phases simultaneously, but upon closer inspection, it is clear that there was a passing through each phase. Initially the focus was trusting the process and the therapeutic relationship. The middle sessions were more focused on building trust in herself and her ability to move forward into the things she wanted to explore. Part of that process was providing space for expressing sadness, which previously had only been expressed as anger. During the final sessions, her focus on how she was engaging externally with her community and music manifested in various ways. After ten sessions, it felt like an appropriate time to end. Judy felt her ability to be open and her perspective of herself and others had changed significantly as a result of her increased awareness of her relationship to music. After the research participation time ended, she continued to acquire instruments, make music and share music with others.

6.6.6. CASE VIGNETTES SUMMARY

The trajectory of sessions differed for each woman, however all began with RO-MI and Herman stage one of building trust and support. Additionally, they each entered therapy from a different baseline. One could see this in the PCL-5 pre-test scores, but

also from their unique profiles and approach to healing. In a sense they were in different Herman stages when they began therapy, yet sessions still started from the perspective of the first stage in order to ascertain that each client was well-resourced before moving forward. Mary, Pam and Karen were in Stage One of Herman's trauma healing model, but each from a different perspective and focus. Mary was actively struggling with PTSD symptoms and the demands of her daily life, yet she was aware of the struggle and actively seeking out ways to cope. She benefited from the psychoeducational aspect of the sessions and learning active ways to use music for coping. The sessions also reconnected her with her love of art and drawing. Pam was also struggling with PTSD symptoms, but had only started to gain awareness of how that was impacting her daily life. Her life was chaotic but she was not yet in a place where she could imagine taking steps to change her circumstances. There was a strong focus on containment and establishing safety and she seemed to benefit from the experience of being with someone without judgment. Though Mary and Pam both talked frequently about their previous abuse, the centrality of their daily experience was navigating the here and now. Karen was not as strongly impacted by her current PTSD symptoms, but was in a time of instability and transition in her life. She was also new to therapy and the process of connecting to feelings and her inner world. She benefited from being able to emotionally process the loss of her mother and begin to connect the impact on her current life. Because being held in even positive feelings was new to her and something she acknowledged avoiding previously, the majority of her sessions focused on establishing safety and trust of that process.

Sue and Judy entered therapy at a time of actively exploring how to move forward in their lives while also continuing to process the impact of the trauma. Sue was experienced in therapeutic work and began sessions while simultaneously engaged in cognitive therapy. Participating in the research study provided a safe space to express anger and sadness regarding her abuse and a creative way to explore her identity moving forward. Her first few RO-MI sessions connected her with a motivation to recapture a vitality for life that had been recently missing and GIM provided a container for exploration. Sue processed feelings from previous abuse while maintaining a focus of how she wanted to move forward in her life. Judy also entered therapy from a point of exploration. While she processed previous experiences and the impact on her life, she was very conscious of having left the identity of being a victim and was exploring ways of being in her life. Though she had minimal previous experience with therapy, she naturally worked psycho-dynamically, and was insightful about the therapeutic relationship and her relationship with music. She benefitted from actively exploring issues of trust and from engaging authentically with music. Her insight that music allowed her to access different perspectives opened a new sense of being in the world for her. Table 6-9 illustrates a vertical comparison of the participants' progression through sessions. The color gradient shows the progression from more supportive (lighter color) to more complexity (darker color) in method and level.

Table 6-9 Participants progression through levels and stages

Session	Mary	Pam	Sue	Karen	Judy
1	RO-MI H-1	RO-MI H-1	RO-MI H-1	RO-MI H-1	RO-MI H-1
2	RO-MI H-1	RO-MI H-1	RO-MI H-1	RO-MI H-1	IO-GIM; RO-MI H-1
3	RO-MI H-1,2	RO-MI H-1	RO-GIM H-1,2	RO-GIM H-1	RO-GIM; RO-MI H-1
4	RO-GIM H-1,2	RO-MI H-1	RO-GIM H-1,2	IO-GIM H-2	IO-MI H-2
5	RO-GIM H-1,2	RO-MI H-1	IO-GIM H-2	RO/IO-MI H-1,2	IO-MI H-2
6	IO-GIM H-2		IO-MI/ IO-GIM H-2	RO-MI H-2	RO-GIM H-1,2
7	RO-GIM H-1,2		IO-GIM H_2	IO-GIM H-2	IO-MI H-2
8	IO-MI H-2		IO-GIM H-2	RO-MI H-1	IO H-2,3
9	RO-MI H-1-3		TO-GIM H-3	IO-GIM H-2	IO-MI H-2,3
10			TO-GIM H-3	RO-MI H-1	TO-MI H-3

Note: RO= resource-oriented, IO= issue-oriented, TO= transformation-oriented, MI=music and imagery, GIM= guided imagery and music, H=Herman stage

Reflection

In writing up the case vignettes, assigning a level of working that occurred in each session was difficult because it was a not a finite decision based on the music chosen or the induction but a combination of all elements. In addition, the level in which the client worked was not always the level intended by the therapist. In those instances, clinical judgement was used regarding whether to follow the client's lead or be more directive in terms of maintaining a particular working level. The level that I assigned in the tables summarizing the sessions, was a combination of the intention of the session and the actual level of working. It is clear in each case vignette that sometimes a supportive induction was used, but the music included mixed supportive and challenging music. My feeling after completing the feasibility study is that the process is more fluid than it would seem when described. I tried to highlight that fluidity in the manual that would be used for the RCT therapists.

Another insight from examining how each woman worked within the Continuum Model was that there is a general pattern in how sessions progressed, but that pattern does not reveal the uniqueness of the individual progress accomplished by each client. Individual growth and progression was a combination of the client's baseline at the beginning, previous experiences with therapy and capacity for insight-oriented work. Previous therapies for trauma endorsed by the VA are structured into 10-12 week programs and research indicates a reduction of PTSD symptoms following that

dosage. In this current study all participants who completed the measures demonstrated a decrease in symptoms, but they remained at very different places in their therapy process, some only barely beginning the process of engaging with the trauma memories or impact from the trauma. Mary, Pam and Karen would have benefitted from more sessions. Sue and Judy appeared to be at a logical stopping point. This would be a challenge for the protocol in the future RCT. The proposed dosage of 10-12 sessions might show statistical improvement and non-inferiority to CPT treatment, but not indicate whether individual clients have received the level of support needed in order to terminate therapy. This becomes an ethical discussion then of how to connect the participant to continued resources, if needed.

CHAPTER 7. INTERLUDE

It is not often that the challenges of a research study are highlighted. The aim of presenting the challenges here is two-fold: one, to highlight what was learned regarding planning and recruiting for an RCT; and two, to orient the reader to a radical shift in research paradigm and methods moving forward.

7.1. CHALLENGES

The feasibility study aided in understanding how participants experienced MI/GIM sessions, helped to inform the intervention manual and documented feasibility issues related to recruitment and retention; but studies on that scale do not sufficiently inform larger scaled studies that require additional funding, research personnel and large-scale recruitment. There are identified barriers to conducting research through the VA that are related to participants' perception of the VA as well as required procedures the researcher encounters (Surís, et al., 2016). Identified barriers and failed attempts to find a co-investigator within the VA system, led to a decision to conduct the RCT through community services.

At this point in the research process, the study protocol was submitted and granted IRB approval. Six therapists who would conduct the sessions were given materials related to session protocol and recruitment. Recruitment efforts targeted community centers that served veterans and civilian trauma populations. Recruitment occurred in four states, mainly through phone and email contact with staff at community centers. Recruitment also occurred online in closed female veteran groups that met through social media. Clinician referrals are a highly successful recruitment strategy as participants are more likely to enroll if referred (Roberge, Benedek, Marx, Rasmusson & Lang, 2017). Recruitment for this RCT was occurring at multiple locations from a distance with no face to face contact with staff, which was likely a barrier to enrollment. After five months of recruitment led to an inadequate number of participants, the RCT was delayed to a post-doc study when time constraints would not be an issue.

7.2. A NEW DIRECTION

The tone of the thesis in Chapters Two through Six was primarily shaped by the intention to conduct a post-positivist, objectivist study. The systematic literature review led to the formulation of research questions that implied the need for both qualitative and quantitative data gathered through a feasibility study to help inform a larger clinical trial. The Continuum Manual was created to ensure therapy fidelity in the implementation of the Continuum Model when multiple therapists would be used

in a larger trial. Results from the feasibility study also helped to modify and strengthen the RCT protocol.

The decision to postpone the RCT and to then examine one of the research questions collaboratively in more depth, required an unanticipated shift in methodologies. With a focus on the collaboration, the research design was more participatory and the paradigm was more transformative. This shift was jarring to the researcher but can also be incongruous to the reader who has been in one research landscape and is now entering another. The chapter that follows details research from first person and second person perspectives, employing an arts based research method. The tone is different as more first person language is used and a creative writing portrait is included. How these perspectives integrate into the overall research is addressed in Chapter Nine, the discussion.

CHAPTER 8. A PORTRAIT THROUGH FILM AND STORY

This chapter presents a collaborative inquiry with Trish, a participant from the feasibility study. Cooperative or collaborative inquiry is a term most often seen in participatory action research and feminist inquiries. In the original intent of a collaborative inquiry, there is no distinction between participant and researcher who function as co-researchers throughout the project (Riley & Reason, 2015). Embarking together as co-creators, the project had four aims: to further examine meaningfulness and benefits from the feasibility study, to empower Trish through telling her story, to engage in equal collaboration, and to raise awareness. The collaboration also served as a medium to examine how our roles had changed from researcher/ therapist and participant/client to co-creators. The purpose and aims are further detailed in section 8.2. The chapter begins with the methodological foundations for this type of inquiry before moving into an explanation of the process and description of the project. The writing style changes, moving into more creative first person language for the portrait reflection.

8.1. METHODOLOGY: PORTRAITURE

> The portraitist wants to document the specifics, the nuance, the detailed description of a thing, a gesture, a voice, an attitude as a way of illuminating more universal patterns. A persistent irony recognized and celebrated by novelists, poets, and playwrights is that as one moves closer to the unique characteristics of a person or a place, one discovers the universal (Lawrence-Lightfoot, 2005, p. 12).

All phenomenological research methods are concerned with the lived experience of the participants. Though common themes of that experience are possible and expected, each experience is unique to the individual, therefore multiple realities are possible. The original intention of descriptive phenomenology was to approach an individual's experience with as much objectivity as possible, bracketing out any assumptions on the researcher's part so as not to influence the relaying of the participant's experience (Harper, 2012). Interpretive phenomenological approaches, such as hermeneutic inquiry, go beyond description and into interpretation and meaning of situations where the meaning is not apparent (Gadamer, 1977).

Narrative inquiry is an approach that is grounded in phenomenology and hermeneutics. Polkinghorne (1995) writes about analysis of narratives versus narrative analysis as two different processes in narrative inquiry, the former being a method of analyzing stories or narratives for themes and meaning; the latter being a gathering of events into a story-line or narrative configuration. Analysis of narratives,

which is narrative research in the most common practice, is rooted in interpretive hermeneutics and seeks to present the complexity of what it is to be human, as opposed to treating the gathered data as facts (Josselson, 2006). However, distinctions between the two processes are not so discrete. There are types of narrative inquiry that employ both through gathering events into a narrative configuration before analyzing them to discover the essence or meaning.

Lawrence-Lightfoot's (2005) reflection on her earlier life experiences of sitting for two portraits lent to her creation of Portraiture, a process for narrative inquiry that sought to capture: the essence of the person or subject being presented *and* the relationship between the researcher and the subject.

> From these two experiences of sitting for portraits, I learned my first methodological lessons. I learned, for example, that these portraits did not capture me as I saw myself, that they were not like looking in the mirror at my reflection. Instead, they seemed to capture my "essence"; qualities of character and history, some of which I was unaware, some of which I resisted mightily, some of which felt deeply familiar. But the translation of image was anything but literal. It was probing, layered, and interpretive. In addition to portraying my image, the piece expressed the perspective of the artist and was shaped by the evolving relationship between the artist and me. (p. 5)

Portraiture seeks to merge science and art in order to present the complexities and dynamics of an experience (Lawrence-Lightfoot & Davis, 1997). Rich descriptive data is gathered through various sources such as interviews, transcripts and observation. The data is then sifted through and presented as a story or portrait of the individual or the experience, with the intent of communicating the essence of the story. Portraiture is narrative analysis because it builds a narrative from collected data, but it is also an analysis of narrative because it seeks to construct the story in a manner that reveals its essence. There is an emphasis on micro and macro as the details from raw data are examined in order to best relay an overall picture, or much like a musical composition and the wide variety of tones and textures that create a whole.

> I wanted the written pieces to convey the authority, wisdom, and perspective of the "subjects"; but I wanted them to feel as I had felt, that the portrait did not look like them but somehow managed to reveal their essence. I wanted them to experience the portraits as both familiar and exotic so that in reading them, they would be introduced to a perspective that they had not considered before. And finally, I wanted the subjects to feel "seen" like I had felt seen—fully attended to, recognized, appreciated, respected, and scrutinized. I wanted them to feel both the discovery and generosity of the process as well as the penetrating and careful investigation. (Lawrence-Lightfoot, 2005 p. 6)

In portraiture, the written stories seek to give voice to the participants who are subjects of the stories, not objects- as is the case in some other forms of research (Lightfoot & Davis, 1997). When an individual's story is told there are two types of information being conveyed, one is the facts of the story and the other is the feelings and attitudes behind the facts. Depending on the information being gathered, the role of the investigator- in this case the researcher- also changes. When listening to a story for information, the researcher is more of an ethnographer, listening to the details in a receptive way in order to convey the participant's story. But a researcher using portraiture is interested in distilling the essence of the story, which would involve more of an engaged position in shaping the aesthetic. The voice of the researcher, or portraitist, plays a central role in how the final story, and thus the meaning, is conveyed.

8.1.1. FRAMING THE PORTRAITS

In addition to the voice of the portraitist, the primary aspects of portraiture are context, relationship, emergent themes and aesthetic whole. The five components provide a frame for creating a portrait with the aesthetic and scientific rigor that Lawrence-Lightfoot sought to infuse in a qualitative method (Lawrence-Lightfoot, 1997). A definition of each framing component follows and is further discussed in the findings from the portraits.

Context can include the physical setting in which the portrait occurred as well as the personal context of the portraitist and subject of the portrait. Attention to context is an acknowledgement of how the surroundings as well as the researcher/ portraitist's perspective and voice constructs the portrait. The social and historical context during which the inquiry took place, which includes how one situates themselves in the research, influences the construction as well as the audience's reception of the portrait.

The *relationship* between portraitist and subject evolves during the portrait's creation and is critical on multiple levels. In the development of the relationship is a building of trust that fosters the co-creation of knowledge and enhances access to the essence of the subject (Lawrence-Lightfoot & Davis, 1997). In this project the relationship was multi-layered as it involved a previous relationship where portraitist and subject had different roles, and a collaborative inquiry approach to building the portrait. Because of the multi-layers and shifting roles, relationship is one of the most prominent framing features for this project and is highlighted in its own portrait.

Emergent themes are found in the interview or the story that is being told and used to structure the portrait. Emergent themes in portraiture are not seen as a process of coding themes that may be generalized. Rather emergent themes are a manner of highlighting details that are unique to an individual portrait and presenting them in a manner that the audience will resonate with as a universal theme (Lawrence-Lightfoot, 2005).

Aesthetic whole refers to the artistic process that goes into creating the portraits with enough subtlety that the audience can be drawn in and relate to the essence, rather than being lost in an analysis of themes. The emphasis on aesthetics is one aspect that is unique to portraiture from other narrative inquiries. Aesthetic whole is made up of the voice, context, relationship and emergent themes.

8.1.2. RATIONALE FOR PORTRAITURE

There are many practices emerging that integrate the arts and research. Portraiture was chosen for this project in part because of its position as one of the first methodologies in that landscape, and therefore one that has been subject to both criticism and positive regard. The following tenets regarding portraiture aligned with the goals of this project:

1. Portraiture highlights strengths and resilience.

A unique aspect of Portraiture is its focus on goodness. It documents strength and resilience in a situation, as opposed to pathology highlighted in many science practices. It is not searching for what is wrong and is not seeking to fix a problem.

> We want to document what's strong and worthy, in great detail so that we might figure out ways of transporting those 'goods,' that goodness, to other settings and transforming them as well. That begins to describe some of the central tenets of portraiture. (Lawrence-Lightfoot, 2016, p. 20)

One of the aims for this project was to further understand the benefits of participation in the feasibility study. The inquiry was focused on the positive, so a research method was chosen that focused on the "good."

2. Portraiture uses artistic processes and seeks to maintain scientific rigor.

Lawrence-Lightfoot anticipated that there would be researchers who would take advantage of the artistic component as a way to avoid rigor. *The Art and Science of Portraiture* (1997) was written as a guideline to conduct portraiture with the method, criteria and ethics to create a rigorous documentation. Initially introduced in the context of educational research in 1983, where it was "embraced and criticized by the scholarly community" (Lawrence-Lightfoot, 2005, p. 7), it has endured and is now used in many fields, including music therapy (Beer, 2015; Merrill, 2010; Swamy, 2011).

3. Portraiture is transparent about the relationships involved in the process.

Lawrence-Lightfoot was attuned to the pivotal role that a portraitist has in shaping a portrait. In portraiture, there is a paradox that the voice of the portraitist is everywhere as they are choosing what to include in a way that brings the subject's voice forward.

Ideally the portraitist is shaping content while simultaneously not interfering with the process, so the authentic voice of the subject can emerge (Lawrence-Lightfoot, 2005). In this project, the portraitist and subject had previously interacted in different roles. As the film collaboration was also a medium for exploring how the relationship changed, it was important to use a method that captured the essence of the relationship as well.

4. Portraiture seeks to impact the community through reaching an audience beyond academia.

Portraiture embraces another paradox, that it uses the intimacy of storytelling to engage public discourse. "We engage in acts (implicit and explicit) of social transformation, we create opportunities for dialogue, we pursue the silence, and in the process, we face ethical dilemmas and a great moral responsibility" (Lawrence-Lightfoot, 2005, p. 12). The possibility of transformative impact on community was a primary aim for the researchers, and telling the story through film was chosen in order to increase the potential to reach audiences.

8.1.3. ARTS IN CONTEXT

Portraiture was established prior to the emergence of Arts Based Research (ABR), but some researchers have situated the methodology as an arts based research (Merrill, 2010) or used components of it to inform arts based research projects (Scotti & Gerber, 2017). The current project used film as the vehicle for producing and disseminating the portrait. In that role the use of film and the portrait is functioning more as performative social science (PSS). In ABR, artistic process is the primary method for understanding and examining phenomena and the arts are incorporated at every stage of the process (McNiff, 2008). But PSS is slightly different in that is uses the artistic process "to illuminate, articulate, and circulate obscure or obfuscated facets of meaning, nuances of emotion, and constructions of reality" (Beer, 2016 p. 34). The use of the arts in PSS are more related to ways of understanding the data and translating the data to society. Kip Jones, who first described PSS, used actors in film that portrayed the stories of research participants. His interest in using PSS in research grew from wanting a more creative manner of disseminating research data, particularly for conference presentations and connecting to audiences in general (Jones, 2006). There are areas of overlap in portraiture, ABR and PSS in that all seek to use the creative process to find meaning in concepts that may be difficult to describe in traditional academic writing, and all seek to translate findings and start dialogue with a larger audience.

8.2. PURPOSE AND AIMS

This project used portraiture in a collaborative inquiry to further explore the benefits and meaningfulness of engaging in the feasibility study sessions. The purpose and

research question related to overall Research Question 1.2: What are female veterans' perceptions about the meaningfulness and helpfulness of the GIM intervention? The motivation for this inquiry however, was to go into more depth related to RQ 1.2. As a researcher, I was curious specifically about the continued musical development Trish was experiencing and how it was intersecting with her personal growth. There seemed to be some interaction between the internal GIM work and her external community music participation. The specific research question for this project was: What is Trish's experience of the benefits of GIM sessions in relation to her increased musical and personal growth? In addition, there was an overall aim to empower a participant to be an equal collaborator in sharing her story. The additional aim's objectives were related to transformational research approaches (such as portraiture and collaborative inquiry): empowerment, equal collaboration and raising awareness. Figure 8-1 demonstrates the research question and aims.
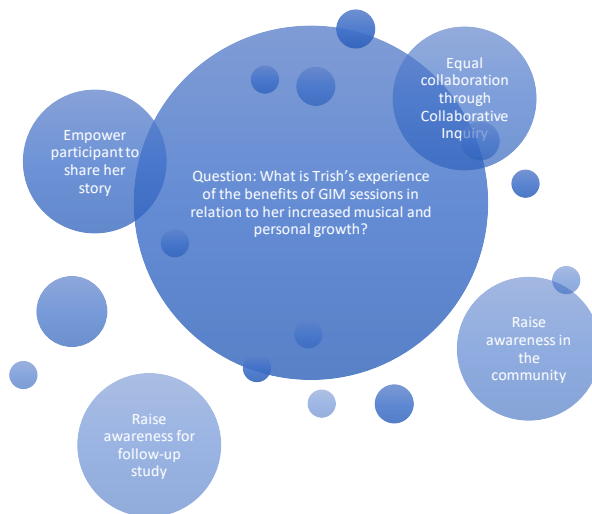
Figure 8-1 Research question and aims for portraiture project

8.3. RESULTS: PORTRAIT PRESENTATIONS

There are essentially two portraits in this project. There is the portrait of Trish presented through the film and there is a portrait of our relationship that is a subtext of the film. Through presenting a portrait of the relationship, the making of the film is described and provides the framework for the film. Portrait one is the film, "Soldier Sings the Blues: Healing Through Music" (link provided below). The second portrait is *The Basics of Modulation*, a written narrative that explores the relationship and making the film. Like the film, the written piece is also a creative exploration and veers from formal academic writing. It is recommended to watch the film first and then read the second portrait. In portraiture, the portraits are the results of the research

inquiry but for further academic clarity, the results are explained in the discussion and findings.

Data collection for the portraits was comprised of reflections on participation in the study and subsequent impact on Trish's life as well as reflections on the collaboration. Data collection occurred during the process of filming the documentary, from phone conversations in the months prior to filming, during editing, and through journal reflections.

8.3.1. PORTRAIT ONE: PRESENTED THROUGH FILM

Introduction and Invitation

The film you are about to view is Trish telling her story and the impact of music in her life. I also appear briefly in the film as a player in the process. Though it is most natural perhaps to view the film through the lens of a researcher and the academic community, Trish and I invite you first to view the 7 ½ minute film as a general audience member. We invite you to be drawn into the story, into the themes of how music has benefitted Trish, and the essence of the story for you. Many of the potential questions regarding the making of the film are answered in the second narrative portrait and in the discussion.

Click on title link below to view. The video is password protected, password is: Portland

 Soldier Sings the Blues…

8.3.2. PORTRAIT TWO: PRESENTED THROUGH STORY

Portrait Two: Trish's story was told in the short documentary film. The story that follows is a portrait of the making of the film and the changing relationship Trish and I navigated from researcher/ therapist and participant/ client to co-collaborators. The story is told from my perspective, hence the view is more into my process and was reviewed by Trish for accuracy of details related to her process.

The Basics of Modulation (or my change from therapist/ researcher to co-collaborator/ documentary film maker)

January, 2017: Finding the Project
The first years of my study followed a specific path that were to lead to a specific research study, a non-inferiority RCT. Though I employed a mixed methods approach, much of the interpretivist research was conducted in order to inform the RCT. Stakeholders in the process were considered when I proposed the research plan. I wanted to begin to build evidence for the United States Veteran's Administration

(VA) that would ultimately improve services for women veterans. And I knew from my reading of VA endorsed approaches that only well-planned and carried out RCTs were considered as evidence to support their recommendations. The protocol had been approved by the University Institutional Review Board but after six months of recruitment, no viable participants were enrolled. I was discouraged and began to look elsewhere for inspiration on how to move forward. I turned to music and imagery.

> I have an image today of myself as a person standing against a huge building with no door or windows. There is absolutely no way in and that is the purpose. On the other side I am also standing with a group of women, participants in the study and there are all of these flowers that have grown out of the ground- they are beautiful and full and colorful- and I want to look at the flowers closer and smell them and talk about them. The large building and the people inside are unaware of the flowers, the quiet gatherings, the empowerment that is happening outside. I need to walk away from the big building with no doors and no windows. It doesn't matter how I approach knocking- there is no place to knock. There is no way in. That's the point of the design. (Maya, journal entry after a MI session).

My journal entry reflects frustration at the time with the recruitment process and trying to collaborate with the VA system, but it also reveals some of my beliefs. I was viewing the VA as an institution that was not collaborative and impossible to penetrate, beliefs that may have been contributing to my failed recruitment. That may or may not be true, but it was clear that I was not in a position to keep trying because there was not time in the scope of my studies to navigate the collaboration. I realized that I needed to return to the women and their stories more directly. And I wanted to do it collaboratively. I wanted to examine the flowers together.

Stories of the women I worked with were still deeply with me almost two years after the study. Results detailed the overall experience of the women, but did not speak to the depth. It was like a small window or picture into one piece of a very interesting and complex mural, and I wanted to know more. I had stayed in touch with some of the women since the study's completion, emailing them with notification and request for permission to use material when I was presenting at a conference. One woman, Trish, had continued to thrive and her musical development seemed to be significant. I was curious about this and about looking further into the benefits and meaning for her. But I didn't want to be the one to tell her story. I felt that her voice was extremely important and that telling her story for her would be taking away her power. I emailed her.

Hi Trish- I am continuing my PhD work and have had many issues around recruitment for the next study I had planned. In the meantime, I am continuing to work with the material from the sessions in Portland. Several times over the last few months I have thought of you and how much you have integrated music into your life. What I actually was thinking was how much I would like to write about your perspective from your words regarding the music and imagery work and your story in general….would you be interested in collaborating in some way? It could be as anonymous or transparent as you would like. If this interests you, let me know and we can find some time to talk more about it.

Hi Maya- I am grasping music theory more and more by writing songs. It amazes me. It is like I was in a box and didn't know it. Then the box unfolded and there is a whole new world around me. My latest song is Club Soda Blues. I would love to collaborate with you. Let me know when you would like to talk about it.

(February 2, 2017- email excerpts)

May 18, 2017: First Meetings as Co-Collaborators

And that's how I found myself in Portland, walking through the Lower Hawthorne District to meet Trish at Artichoke Music- a quirky non-profit, music school, store and weekend performance café. Having left behind the manicured lawns and uniformity of Northern Michigan, the diversity of colors, smells, architecture and landscape stood out in a way I had taken for granted when living here. But after a two-year absence, these visceral elements found their way back into my body and allowed me to breathe deeper. Portland has its own unique flavor from neighborhood to neighborhood but the "keep Portland weird" mentality underscores the city as a whole. It seemed fitting that this creative collaboration, a step that I would consider to the far left in the research world, would take place here.

Figure 8-2 Lower Hawthorne Neighborhood

But as I walked up Hawthorne, I felt a little nervous. I hadn't thought about that part, about meeting her again after so much time and our work together. We had discussed

the changing roles, but now away from the rational explanations, I was experiencing the feelings behind that shift. There was a brief moment as I approached our meeting spot when I thought, what if I'm asking too much, what if she doesn't come? It was a moment in which I also wondered if I was reverting back into a role of being her therapist. I considered whether it really would be possible to shift our roles. Hand on the door, I took a deep breath and walked through. And she wasn't there.

February, 2017: Setting the Intention
On a cold, snowy February day, driving back North after lecturing and meeting with students, I pulled over at a rest stop to call Trish and discuss a collaboration. I proposed co-writing an article about her experience as a research participant, and mentioned that a film was also possible. In both cases, she could determine her level of disclosure in terms of details of her story and her anonymity. Trish was open to making a film and sounded excited about the prospect. I relayed to her how important it was that the process be a collaboration each step of the way, with Trish approving of the content and able to back out at any time. We discussed how the collaboration would require different roles than our previous research/ participant roles and confirmed that direction moving forward. Trish expressed appreciation that those things were being taken into consideration and relayed an experience where she had been interviewed for a large city newspaper and was surprised by the finished content that was published. Parts of her story were already "out there" and she was looking forward to telling it her way. She said that if even one person saw the film and resonated, it would be worth it. I was committed to finding someone to make the film and asked Trish to consider her role and level of transparency in the project. We agreed to speak by phone in a few weeks. I was feeling a sense of being open to possibilities and a strong decision to shift perspectives.

When we spoke some weeks later, Trish had been scouting possible film locations and writing journal reflections about her participation and process in the previous study.

> My response to music is different depending on the type. Some I simply listen to quiet soothing but not emotional, some I find myself holding my breath, some evoke childhood or teenage memories, some remind me of my parents or grandparents. I've been exposed to music my whole life, but until recently the only effect I realized was memory provoking. Sure, I've been moved to dance, to sing along and applaud, even do karaoke but music has always been some mystical magical superpower that some select few had but not me. Then I joined Soldier Song and Voices, and taking guitar lessons and learning about song writing and poetry and performing, well it was frustrating and fun and hard and confusing, but I was committed.

> Then a friend told me about Maya Story, a music therapist that was doing a project involving female military veterans and music visualization and art. Something happened. I started seeing and hearing and feeling music

in a different way. Music, and in particular blues and drums along with visualizations and strange drawings started having an awakening in me, in my core. It was like a veil of mystery hiding the magic of music was falling away along with a veil of mystery that was suppressing the magic of me. The true me, the better me was unfolding.

When it comes to blues there is something raw and real about it that seems to reach deep and move me in a transcending way without taking away from the moment. It evokes a simple, primal, visceral response or joining with the music. The more I open up to the music, the more open and honest I become with myself. The veils of victim and even survivor have covered, protected the explorer, the true me but also hid joy and wonder and fully living from my sight, my vision of myself. I knew I wanted more, but I couldn't see or figure out what it was or how to get it, how I could hang onto something so out of reach for me. Now, it's like music and I are partners, hiking along the path of discovery. As music mysteries unfold, so do my own mysteries unfold. (Trish, Journal Reflection)

As I listened to her read, I felt proud of her and of the work accomplished together, but I didn't feel she needed anything from me as a therapist. Our roles had begun to shift. Trish was an equal collaborator and she was clearly contributing through her planning, thoughts and creative expression. Moving forward felt right. Over the next months, details were set in terms of meeting times and filming while leaving all content undecided.

May 18, 2017: Waiting to Begin

As I paced around the store, glancing at sheet music and guitars, waiting for her to arrive, I wondered if I had made a mistake. I felt I had no precedence for this sort of collaboration in the academic world and was somewhat feeling my way through the dark. But I realized that my caring for her well-being during the process was not reverting to the role of a therapist or placing her in the role of client. It was being ethical in how I moved forward in our collaboration. We take people into their stories in different ways, through different processes. Trish and I explored her story in metaphor and music through the research sessions. But now we were going to re-visit it- the broken pieces and the resilience and transformation- documenting it in a manner that would continue to exist in the form of a film for others to see. There was a different set of ethics and caring in our new roles, situated and flexible, driven by certain aims and truths that we agreed to follow when we embarked on this collaboration.

The familiar buzz of my cell phone alerted me of an incoming text from Trish, who was navigating her way through traffic. Fifteen minutes later she arrived at Artichoke Music carrying her guitar. Her comfortable smile and easy laughter permeated the small shop as she introduced me to the individuals who worked there and explained that I was the one making the film with her. This was clearly her space and a shift

from the therapy roles where she had come into my world, trusting me to guide her through the process. Now I was entering her world and she was guiding me. After showing me around we settled onto a couch in the back nook of the performance space to talk about details of the next two days. We discussed other film locations, the semi-structured way of approaching the filming, and about the power differentials still present as she would be the one sharing details of her life while I safely remained on the other side of the camera.

She had invited me to an open mic performance later that evening and as we drank tea and waited for her name to be called, we listened to other locals share their music. Though she had performed before with other veterans at veteran events, this was her first open mic among other musicians. We waited for more than two hours, but finally her name was called. She sang of loss and remembering and I reflected on her courage to step out, again and again. I was touched by seeing a part of her musical life and development that I had heard about in our sessions together, but not witnessed first-hand.

May 19, 2017: The Team
The following day I met Peter, the film maker, at the airport and introduced him to Trish over lunch at a café in North Portland. Up to this point I had served as a mediator between Peter and Trish, talking about one to the other and hoping there would be a resonance among the three of us when filming. I trusted Peter, having known him since we were teenagers, playing piano in my living room and relaxing on South Beach and downtown Miami after school. In the decades that had passed, he had become a film maker and music producer, married with two children and living in Los Angeles. He also was creative director of a non-profit that helped individuals with special needs express themselves through the arts. I knew he could be a sensitive contributor, but in the back of my mind I was remembering several times when Trish mentioned that one of the reasons she was able to work with me and trust me was that I was a woman. I wondered if she would feel comfortable talking about her process while Peter filmed. This lunch meeting was my first opportunity to sense how we would all work and whether Trish and Peter felt comfortable with each other.

Everyone at the Tin Shed seemed to know Trish and we were quickly led to a table on the patio, navigating around the dogs relaxing at the feet of their owners at this dog-friendly café. The colors and vibe of the café matched the diversity of the neighborhood. It didn't take long for Peter and Trish to develop a relationship of their own. They easily spoke with one another and seemed to align in their opinions regarding aesthetics around filming, something I was happy to hand off so that I could focus more on allowing the content to emerge. Trish shared with me that she felt comfortable with Peter, that he felt a little like a brother. And Peter found Trish to be delightful and possessing a certain quality he recognized as being comfortable in front of a camera. The following day we would film.

May 20, 2017: Filming
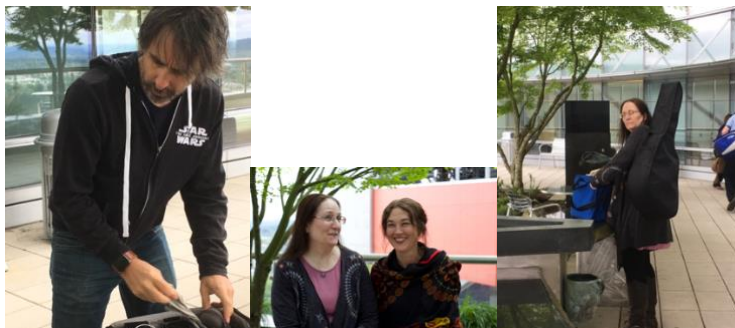
Figure 8-3 Setting up to film

The filming occurred in five different locations, all of which held some significance. We met at the Oregon Health and Sciences University (OHSU) Hospital, which is also near the Veteran's hospital. This location, suggested by Trish, was important to her because it bridged two areas of her life. The veteran's hospital represented her identity as a veteran and OHSU hospital represented her current work as a doula where she sometimes supported women in labor. Besides the personal significance, it was an amazing location. To get there, we drove up small winding forested roads and when we arrived, took the elevator up to an outdoor deck that housed a tram connecting the hospital to downtown Portland. There was a view of the Willamette River and the foothills surrounding Portland, providing a scenic background as Trish settled in to tell her story. We filmed for several hours there, and then returned to Artichoke Music, where Trish had played in the open mic and where the community music group, Soldier, Songs and Voices met. What OHSU offered in expansive views and openness, Artichoke Music balanced with a cozy venue and a small well-equipped stage. It was there that Trish spoke of her trauma and recovery through music and where we also filmed her playing some of her compositions. It was an emotional experience for all of us as Trish told her story. I had worried about filming these intimate details and was concerned and careful that Trish not feel manipulated in any way. At times during filming, I was listening and dialoguing with her but sometimes I was just listening and getting out of the way, providing space as her story and her music emerged. Though I was there to prompt the conversation, I felt I had little to do with shaping the content. I was there as a witness, as her voice surfaced with authority. I mostly stood by and admired her courage and ability to speak out, as Peter gently reminded me of my duties as director, such as checking the shots, calling "cut" and remembering to feed them.

Figure 8-4 Filming at Artichoke Music

After lunch, we staged a mock music and imagery session in order to film Trish and I in our work together and former therapeutic roles. We used the opportunity for Trish to share with me some drawings she had done in the previous weeks that were reflections on her process. But what unfolded in the moment became an opportunity to use music to check in about the current process of filming. She was able to authentically acknowledge the risk-taking and vulnerability she felt while simultaneously recognizing her commitment to the process and to raising awareness. It provided the opportunity for me to support her and to further talk about our roles and the power differentials that we couldn't escape, inherent in the project. Although a "mock" session, it became an important time of connection and reflection in the midst of the day. The next filming stop was Sellwood- a small neighborhood on the Willamette River where I had lived and Trish had often worked. We shared a cup of tea at the infamous "share-it" intersection and Peter filmed us walking through the neighborhood.

At the end of the day we drove across the Columbia River to Vancouver and finished by filming Trish where she lived, showcasing her instrument collection that had started with one guitar and now consumed a large amount of her living space with drums, guitars and singing bowls. It was clearly an external manifestation of her musical development over the last few years.

June – October, 2017: Editing

Editing the film occurred online mainly between Peter and I with periodic check-ins with Trish. I built the narrative in two different ways and the three of us chose the one that felt best. Peter had the editing equipment, so we would meet online and through screen sharing technology, I would make suggestions and Peter would implement them in real time and I would approve the edits. Before leaving Portland, I met with Trish one last time as we looked at the agreement for moving forward and discussed editing and assembling the film. Trish preferred to stay out of the creative decisions, but I felt it was important that she approve of her story and the way it was being presented. Over the next few months as Peter and I edited the film, I periodically sent her a link to the most recent version and asked for her feedback. This seemed to

work well for all of us and editing went as smoothly as filming. Though most of my communication with Trish during the editing process occurred through email, there were a few phone conversations. These turned out to be vital to the process because it allowed time for dynamic discussion regarding the details that was not possible through email. During one such discussion for instance, Trish realized that she regretted one of the things she said on film. After much reflection between us, a decision was made to remove that content from the film.

Postlude

I reflect now on whether we had been successful in shifting our roles with each other. I believe that we were as I now think of Trish as someone I created a film with, more than someone who was a participant in my research study, although both remain true. In a phone conversation with Trish, I asked for her reflections on how it was to work on the film together. She said that even though she was the subject of the film, she felt part of the creation of the content in a way that she was allowed to say what she felt and it was respected. She also felt that our therapeutic relationship naturally allowed this sort of collaboration. This was eye opening for me as I was mostly focused on our previous therapy relationship hindering an equal collaboration. Expanding on her comment about our therapeutic relationship, she stated:

> I felt the relationship worked because of who we are individually. Because I trusted you even enough to tell you I didn't trust you and you respected that and you weren't pushy. Respect was a big deal. You always let me know what was going on in the process. It was very open from the beginning. I saw the big picture from the very beginning in the sessions. I knew it was a creative process that could open me up to something and I saw that as we went along. I was a little skeptical, but when I saw it working, it (the skepticism) fell away.

Trish felt that the way I approached therapy and her as an individual set the groundwork for future collaboration. The film took on a life of its own outside of the PhD research process. Trish, Peter and I each began to show the film to friends and colleagues for feedback. It was well received and submitted to a film festival. Each time I was going to show the film, I would call or email Trish and ask her for permission. One day she said to me, "you know, you don't have to keep asking me every time you are going to show the film. It's okay, and if it ever becomes not okay, I will let you know." I reminded her of our contract and informed consent, and then hung up the phone and smiled.

8.4. DISCUSSION OF FINDINGS FROM PORTRAITS

8.4.1. THEME AND ESSENCE

The research question was related to the original RQ 1.2: What are female veterans' perceptions about the meaningfulness and helpfulness of the GIM intervention? Specifically related to this project, the question was: What is Trish's experience of the benefits of GIM sessions in relation to her increased musical and personal growth? Portraiture was used to examine the question and present a film portrait in Trish's own words of the impact of participating in the research study. The film footage was edited to build a coherent story that included emergent themes from collected data. The emergent themes, as identified by Maya and confirmed by Trish, were:

- The importance of the combination of internal process through GIM and external process through songwriting in a community
- A change in identity and perspective
- Increased empowerment

Each of the themes are present in the film portrait. Though Trish provides a context through relaying her history of trauma, the larger story she told was of the combined participation in the community outreach group (Soldier, Songs and Voices) and in music and imagery sessions, which changed her perspective and opened up a different way of being and moving through her life. The meaningfulness and helpfulness she identified cannot solely be attributed to the GIM sessions, though she does acknowledge that she had previously been songwriting and it was the addition of music and imagery that widened her perspective. She stated in the film that she didn't have a way of expressing herself and felt that her life was in a certain boxed-in routine. Introducing music into her life provided her a path of expression. Of the MI/GIM sessions she stated: "that took me to a different level...expressing myself in a way that I didn't know was available to me" (Story & McEvilley, 2017, time point 4:18). She continues by addressing the combined impact of the MI/GIM sessions and the songwriting.

> …so the combination of those has opened me up in an incredible way. It's allowed me to say no, it helped me to not hold on but let go and letting go was a big thing and once I did music came… and it didn't stop. It had a lot to do with opening up my mind and my heart to whatever comes along (Story & McEvilley, 2017, time point 4:30).

This combination of internal receptive music work and external music manifestations is discussed further in Chapter Nine.

Portraiture seeks to capture the essence of what is being studied. The themes may contribute to that essence, but the essence can be thought of as the larger picture or

integration of parts that make the larger picture. It is looking at something from the integrated whole, as opposed to the individual parts. Trish and I each had our own manner of describing what we felt the essence was, yet they shared a sense of authentically being present. For me, the essence was a sense of being liberated to be one's self after being restricted. With that sense are feelings of joy, excitement and a deep sense of peace. Trish felt that one scene, about 5 minutes and 52 seconds into the film, captured the entire essence.

> My favorite part is when I'm playing guitar and you see my boots. The rhythm- tapping without thinking about it. It's just good to be there and just be. I don't have to think about proving anything or impressing anybody, it's just me in that moment. It ties it all together (Trish, phone conversation, 2017).

Audience dialogue and feedback are also important components of portraiture. The identified themes and overall essence were compared to those identified by individuals who viewed the film and completed written feedback. In addition to directing the film discussion, the written feedback also served towards demonstrating credibility of the identified emergent themes and essence of the film. Table 8-1 lists common feedback among the eleven responses, many of which are similar to our findings.

Table 8-1 Film feedback

Visceral Response to the film	Essence	Themes
Initial sadness/ anger/ shame/ sympathy	Restriction to liberation	Secrets and shame
Emotional/ Touched	Growing beyond trauma	Reframing/ re-inventing a life
Joy	Healing through creativity	Liberation/ breaking free/ awakening/ resilience
Freed/ liberated/ breakthrough	Power of Music	Healing through music/ creativity
Connected to Trish/ empathy	Regaining self	Self-empowerment

8.4.2. ADDITIONAL AIMS

In addition to the research question, there was an aim to empower Trish to share her story through a collaboration, which she accomplished successfully through participating in the film. This was an aim that primarily came from me. Many of the women in the feasibility study had not reported their trauma while in the military out

of fear of not being supported, of being blamed or being demoted or discharged. When pondering the rationale for engaging in this further inquiry, it became clear that I hoped to provide a space for one of the women to tell her story in a way that would be empowering for her.

Prior to making the film, we had not decided how it would be shared, other than with the academic community. Trish and I spent much time in discussion about the potential impact of this project on each of us and on the community. The content of Trish's story was personal and political and thus had the potential of creating strong feelings and discussions, but the aim of raising awareness was important to Trish and frequently mentioned in our conversations. Portraiture and PSS seek to impact an audience beyond academia, resonating with our aim to raise awareness. Thus we were provided with a research aim and personal aim that aligned. The film is being submitted to film festivals in order to increase community awareness and stimulate discussion.

8.4.3. FRAMING COMPONENTS: RELATIONSHIP AND CONTEXT

Relationship and context are central components of this portrait and are described in the piece, *The Basics of Modulation*, as a subtext to the film. Parallel themes and essence that are similar to the essence of Trish's experience stated in the film are present in the subtext. The essence of *The Basics of Modulation* is breaking the limitations of our former roles in order to collaborate. It is not the same magnitude as Trish's breaking through limitations in order to authentically be herself, but it is a radical breaking through that allowed us to work together in a new way.

Lawrence-Lightfoot (2005) maintains that in the shift away from more traditional paradigms and how we name research questions there has also been a shift in the relationships forged in research.

> Much of the new research has sought to become more participatory, collaborative, symmetric, dialectic . . . and these newly emerging relationships not only have reshaped the design and practice of inquiry but also have raised complex and vexing interpersonal and ethical challenges. (p.9)

Examples of collaborative approaches to research and practice have appeared in music therapy more regularly in the last ten years, particularly in participatory approaches, community music therapy, and the health musicing literature (Ansdell, & DeNora, 2016; Bonde, Ruud, Skånland, & Trondalen, 2013; Fairchild & Mraz, 2018; Rolvsjord, 2010; Schwantes, 2011; Stige, Ansdell, Elefant, & Pavlicevic, 2010). As these collaborative forms of research become more common, guidelines and considerations are emerging that speak to some of the challenges of conducting such research, but there is a need for more examples of actual practice and better structures to support such research (see ethical considerations, section 8.4.4).

Beyond structures and institutions that support collaborative research, there is the barrier of our identity and how we position ourselves in certain roles. The meanings of researcher/ therapist and subject/ client do not have a static definition. How those roles are defined largely come from how we view ourselves and our clients. Kenny was exploring "radical mutuality" as a perspective of connection in clinical work.

> We have to put aside various aspects of our own identity, like "position", or "healthy" to engage fully. How do we colonize ourselves intra personally as Music Therapists so that this deep connection cannot be realized? Then how do we subsequently colonize our patients and clients?

> This type of engagement flies in the face of most Western notions of a therapist's "place" in the therapeutic encounter. We learn in our training that the therapist is the healthy one, knows the best tools to involve the patient, has been highly trained and has many more resources than the client. The therapist is in a community (culture) of practitioners who share similar competencies. And the list goes on and on.

> How can we put aside such a position of privilege to become free enough to experience a deep sense of wonder with our patients and clients, the wonder that brings transformation and change? How can we really "play" when burdened with the many complexities of our own identity? (Kenny, in Stige, McFerran & Hadley, 2017, para. 9)

This idea of "radical mutuality" can be transferred to research collaborations as well. For the collaboration to be successful, Trish and I had to relinquish our roles of researcher/ therapist and participant/ client and move forward with an openness to new identities and ways of being in our collaboration. Partly that was made possible through the groundwork occurring in the therapy sessions, as Trish described in the postlude of *The Basics of Modulation.*

Rolvsjord has also written about therapeutic relationships that strive to be more egalitarian in her book, *Resource-Oriented Music Therapy* (2010), listing mutuality, equality and participation as qualities that may help foster such relationships. In the feasibility study, therapy was approached as a collaborative effort and used feminist principles to address the relationship, seeking to be transparent about the hierarchical roles and power dynamics that were present in therapy. Participants in the feasibility study were seen as being the voices of their experiences, and I as a witness and supporter in their process of finding their inner wisdom. These principles were brought into the portraits as well, as Trish and I viewed the project as a collaborative inquiry and sought to make the process as egalitarian as possible. As I stated in *The Basics of Modulation,* I initially viewed creative collaboration following a therapeutic relationship as a potential problem for the process. As evidenced in the text, there were challenges we navigated, but the groundwork from our previous roles was a resource, not a hindrance.

8.4.4. ETHICAL CONSIDERATIONS

Trish's data had been confidential and protected for the feasibility study, but as co-creators of a film in which she chose to share her story transparently, we were embarking on new ethical territory. There is some literature regarding ethics in documentary film-making but often the subjects of the film are not treated as equal collaborators. Some researchers have called for a new type of human subject's review for non-traditional types of research such as participatory and collaborative research (Friend & Caruthers, 2016; Petrarca & Hughes, 2014; Zeni, 2001).

Ansdell and DeNora (2016) provide a model for negotiating ethics in participatory research through a combination of formal and informal ethical processes. They describe "real-world research ethics" that require negotiation in real time as situations emerge in unpredictable ways (p. 213). For our project, an informed consent and contract was reviewed and signed that outlined in what manner the film would be shared and that Trish could withdraw participation and sharing at any time (see appendix). That contract served as a formal process in addition to the original IRB process. There was also an attention to "real-world" ethics that we negotiated in the moment, such as those described in *The Basics of Modulation* when we chose to change the content of the film. It was important to me, having been the researcher but now acknowledging a co-collaboration, to keep ethics at the forefront of our conversations. During the editing process of the film for instance, the decision to periodically call Trish rather than email was ethically motivated. It was to allow space for emergent conversations that are not possible in real time through email communication. In another phone conversation, we acknowledged that my need to continually ask her for permission to show the film was highlighting a power differential that would always be present. As much as we considered the project an equal collaboration, she was experiencing the greater risk in telling her story. For us the negotiations felt natural and did not present difficulty, but it is something that researchers and collaborators need to consider prior to embarking in non-traditional research.

8.4.5. CONCLUSION

Through a collaborative inquiry, Trish and I looked closer into the benefits of her participation in MI/GIM sessions and the continued impact on her musical and personal growth. We used an ethnographic narrative approach to create a portrait of Trish that was presented on film through a short documentary. The process of making the film and the shift in relationship was described in a creative writing portrait. The finding from the inquiry is that Trish experienced a shift from being restricted to being liberated to be herself. She acknowledged the following themes:

- The importance of the combination of internal process through GIM and external process through songwriting in a community

- A change in identity and perspective
- Increased empowerment

The overall aims of the project supported aims commonly found in other transformational research paradigms. They were to: empower Trish to tell her story, engage in an equal relationship of collaboration, and raise awareness. We were able to successfully transition from researcher/ therapist and participant/ client to co-creators and equally contribute to the project. The transition was possible, in part, due to the trust and atmosphere created in the feasibility sessions where therapy was approached in a manner that sought to balance power differentials.

CHAPTER 9. DISCUSSION

The discussion chapter expands on material that was introduced in Chapter Five, the feasibility study and continued in Chapter Eight, the collaborative project. This chapter begins with a summary of the results, organized by aim and research question. Findings are compared to previous research conducted with trauma populations and GIM. A further finding from the collaborative research project will be presented: the uncovering of creative impulses and implications for clinical practice. The validity of the study will be discussed followed by a brief introduction of integral methodological pluralism (IMP) as a rationale for the multiple methods and perspectives employed in this study. The chapter concludes with implications for clinical practice, limitations of the research and future recommendations.

9.1. SUMMARY OF FINDINGS

This research had an overall aim to explore and evaluate MI/GIM as a treatment modality for female veterans with MST related PTSD. This new clinical population had previously not been researched in the field of music therapy, therefore the course of inquiry was designed to understand the needs of veteran women and their experience of MI/GIM as a treatment modality. A set of specific research questions guided a systematic literature review that led to a better understanding of the issues that women encounter in the military and on return to civilian life, including impact of MST, and current services available to them. Conclusions from the literature reviews led to a conceptual framework for the research, initial research questions, and an overall design. A feasibility study was implemented, and through a process of analyzing recorded audio from the individual sessions and focus group interviews, female veterans' experiences with the MI/GIM method were explored. Results from the feasibility study are listed below, organized by each research question.

Research Question 1.1: How do female veterans experience components of the MI/GIM sessions (music, imagery, creative processing)?

- Music: Participants experienced music as a tool to regulate emotions, decrease arousal, express feelings and connect with others.

- Imagery: Participants experienced imagery as a resource for grounding, a reminder of goals and a mediator to insights.

- Guiding: Participants experienced being guided through the music as a supportive, structuring and empowering element.

- Creative Processing: Participants experienced the creative experiences (drawing, journaling, dancing) as a way to continue processing between therapy sessions.

Research Question 1.2: What are female veterans' perceptions about the meaningfulness and helpfulness of the MI/GIM intervention?

Participants found the MI/GIM method to be meaningful and helpful through increased coping skills, increased self-awareness and increased empowerment.

Research Question 1.3: What is the change in self-reported PTSD symptoms following MI/GIM sessions?

A decrease in PTSD symptoms was found in all participants who completed pre/post-test measurements (PCL-5).

Research questions under Aim Two related to the feasibility and acceptability of the study.

Research Question 2.1 How many female veterans consent to participate in the study after being introduced to the study details? Five out of six women consented to participate.

Research Question 2.2 What percentage of MI/GIM study sessions do participants complete? Three out of five participants completed all sessions. One participant completed nine out of ten, or 90% of the sessions. One participant completed 50% of the sessions.

Research Question 2.3 What percentage of study measures do participants complete? Four out of five participants completed all measures. One participant did not complete the post PCL-5 measurement and did not attend the focus group interview.

RCT Protocol and Manual
Experiences and feedback from the feasibility study were used to refine the RCT protocol (found in section 4.3) and to help inform the manual (Appendix A), whose purpose is to enhance therapy fidelity for the MI/GIM intervention for a future RCT.

Collaborative Inquiry
Upon reflection of participants' experiences in the feasibility study, a follow-up collaborative inquiry and project related to the meaningfulness and helpfulness of the MI/GIM sessions (Chapter Eight) was carried out. This led to an additional research question, that would be a sub question under RQ 1.2:

Research Question 1.2.1 What is Trish's experience of the benefits of MI/GIM sessions in relation to her increased musical and personal growth?

Portraiture was used as the method for presenting Trish's story. The process of portraiture seeks to distill the essence of the phenomena being examined, as well as the themes. The overall essence was a portrait of being transformed from being restricted to being liberated to be oneself. The following themes were identified:

- The importance of the combination of internal process through GIM and external process through songwriting in a community
- A change in identity and perspective
- Increased empowerment

9.1.1. FINDINGS IN RELATION TO PREVIOUS RESEARCH WITH CLOSELY RELATED POPULATIONS (GIM AND PTSD)

Previous studies which used modified GIM methods with trauma populations garnered similar results to this study including: improvement of PTSD symptoms with large effect sizes, similar themes regarding music and imagery, use of music outside of sessions, and overall acceptability and feasibility of the method. Table 9-1 lists the most closely related studies and the similarities in results, followed by a discussion of relevance to the current study.

Table 9-1 Results compared to similar studies

Study	Population	Similar Finding
Beck et al., (2017)	Individual trauma-focused GIM w/ Refugees w/ PTSD	Decreased PTSD symptoms Used music and imagery for coping outside of sessions Some preferred their music Found GIM acceptable and helpful
Bishop (1994)	Individual GIM with adults w/ sexual abuse	Improved functioning Self-empowerment Connection to positive images
Blake (1994)	Individual GIM with 8 male veterans w/ PTSD	Increased relaxation Connection to positive images
Gao (2013b)	Individual modified MI/GIM (MER) with adults w/ PTSD	Decreased symptoms Connection with inner resources
Körlin (2007-2008)	MB and GIM-comparing 9 case studies of adults w/ PTSD	Decreased PTSD symptoms Connected to inner resources Used components of method outside of sessions

Study	Population	Similar Finding
Maack (2012)	Individual GIM w/ women w/ Complex PTSD	Decreased PTSD symptoms Experienced music as connection, calming and helpful Used imagery as a resource outside of sessions
Rudstam et al., (2017)	Group trauma-focused GIM with women w/ PTSD or Complex PTSD	Decrease in PTSD symptoms Found GIM helpful and acceptable

This present study echoes previous GIM studies with trauma populations and findings that the use of GIM is a helpful, acceptable and feasible intervention for clients with PTSD. The feasibility study produced a large effect size (within group effect, *d=1.0,* presented in the published article). This mirrors other large effect sizes from several of the above studies, however the majority were pilot studies with small samples and further research is warranted with larger samples and control groups. Interventions used in the above studies were modified versions of GIM and most used a phase-oriented approach to trauma healing, which demonstrates that there are multiple ways to approach a phase-oriented approach to trauma healing through the modification of The Bonny Method.

Maack's (2012) study was the most similar to the present feasibility study in qualitative inquiry because the interviews also addressed specific components of the GIM process. Themes connected to how participants experienced the music, imagery and guiding in GIM, namely that music was perceived as relational, helpful and used for calming between sessions and imagery was used as a resource. In this PhD feasibility study, participants also used music and the images that were generated as a resource between sessions. This provides support for further research in regards to how individuals with PTSD incorporate components of MI/ GIM outside of sessions in order to manage symptoms.

In the study by Beck and colleagues (2017), participants also used music and imagery as a resource between sessions. Twenty-five percent of participants had a preference for working with music from their culture (although culture was a direct theme as the clients were refugees). This provides some support for using client-preferred or client-chosen music, particularly since musical preference is often related to cultural considerations. Two of the women in the present feasibility study were from other cultures and one of them began the first session with music from her country. Eighty percent (four of the five) of the women in the study had little if any exposure to Western classical music. None of the women expressed resistance to classical music, but starting with music that they were familiar with was a way of meeting them in their territory, rather than mine. One participant expressed that over the course of the

study, the variety of music she listened to expanded and started to include music in the classical genre.

As seen in the systematic literature review, meta analyses have thus far failed to show sufficient support for group therapy for PTSD, however group GIM with a trauma focus was feasible and reported as helpful in the study by Rudstam and colleagues (2017). In the current feasibility study, the participants who attended the focus group appreciated the support from veteran peers. This merits more research, as group therapy is more cost effective and provides outlet for social interaction, which is often an issue in individuals with PTSD.

Individual case studies were not included in the above chart, but it is notable that three individual case studies, detailed in the literature review (Chapter Three), used Herman's theory to describe how the sessions unfolded in stages of establishing trust, working with a trauma narrative and moving into an exploration of identity and one's community reconnection from a new perspective (Bunt, 2011; Moffit, 2003; Ventre, 1994). This demonstrates that there are other therapists using a phase-oriented approach to GIM and trauma that may overlap or differ in comparison to the continuum approach used in the present study.

There are several components that make this study unique from previous studies. This was the first study that addressed the use of GIM with female veterans who have experienced MST. This study is the only research thus far that utilized individualized music selections for modified GIM and MI sessions, chosen by the client and therapist from the client's preferred music. In music therapy studies there are emerging examples of use of client preferred music, but research has predominantly been with adults in medical hospital settings, or nursing care facilities. One exception is a music listening protocol developed initially for post-op management, but more recently used with other populations, including veterans (Wellman & Pinkerton, 2015). Music 4 Life uses client chosen music and preferred genres along with therapist chosen music to help clients regulate emotions. The client-chosen song in Music 4 Life is included at the beginning "in order to increase adherence to the listening protocol and ease him/her into the sequence" (Wellman & Pinkerton, p. 35). The Music 4 Life listening protocol differs in its approach to music and regulation from this current study because it begins with music that matches the unresolved conflict of the client as opposed to beginning with strengthening inner resources. Music 4 Life appears to be primarily a therapeutic listening protocol where the client listens at home and checks in with the music therapist for support but it is one of the few emerging examples of the use of music listening to address PTSD symptoms and warrants further research. The use of client-preferred music has been addressed with other populations in music therapy sessions with mixed results, which demonstrates a continued need for further research in this area (Burns, Meadows, Althouse, Perkins & Cripe, 2018; Clark et al., 2006; Pelletier, 2004; Silverman, 2003). Most often the existing studies utilized the client's preferred genre or clients were provided with a list of music from which to choose,

rather than identifying specific songs from the client's collection. When working with medically fragile populations or individuals with difficulties in communication, it may be necessary to make the process of identifying patient-preferred music simpler, and may be the reason that the use of individualized choice in music is not researched more often. This present PhD research begins to demonstrate that the use of music from a client's collection can enhance trust in therapy and be empowering for the client, acknowledging the existing music relationship and providing an accessible way to use music as a coping tool outside of sessions. Client-chosen music is further discussed in section 9.5, implications for clinical practice.

9.2. ADDITIONAL FINDING: UNCOVERING OF CREATIVE IMPULSES

The PCL-5, the quantitative tool used in the data collection, demonstrated that PTSD scores decreased. Furthermore, the participants' qualitative reports gave perspective regarding *why* the PTSD symptoms were reduced: because the experience of music regulated emotions, the imagery was a source of grounding, and so on, as detailed in above results. The further qualitative inquiry into Trish's experience revealed a surprising finding: the activation and uncovering of her creative impulses. This finding is perhaps the most unique contribution of this research.

Underneath the overt changes, there was a mediating internal shift taking place within Trish. Specifically, an internal shift that was contributing to increased creative expression. In the film, she described how restricted she felt in her life and that music was the way out for her. She had attended the community songwriting group for some months before we first met, but prior to that she would not have described herself as artistic.

> I never thought of myself as artsy. I think all of us have it in us, art and expression, like I like to dance, but I'm not expressing it on the stage. One of the guys in our Sunday group will say, you know if you ask a room full of 6 year olds who can sing, every hand will go up but with adults, nobody will raise their hand. I'm the adult who's been shut down too many times to draw or play an instrument. But I am at an exploratory stage of my life where I am exploring these things, so I think that part is coming out, but I didn't come into this feeling that I was artistic. (Trish, comment in focus group interview)

The nature of internal processes is that they are difficult to express and uncover, but one possible interpretation of this activation of creativity is that the MI/GIM internal work fosters a connection to hidden creative impulses. Again, Trish stated in the film regarding the MI/GIM work: "that took me to a different level...expressing myself in a way that I didn't know was available to me" (Story & McEvilley, 2017, time point 4:18). When I reviewed other session transcripts from the feasibility study, there were

numerous incidences when participants expressed creative impulses outside of the sessions, such as dancing, creating art with someone else, sketching and learning to play an instrument.

The idea of increased creative expression in music therapy is documented in the clinical literature, particularly in active music therapy (Amir, 2004; Daykin, McClean & Bunt, 2007; Turry, 2005; York & Curtis, 2015), and is also a foundational premise for certain music therapy concepts. Nordoff and Robbins (1977) concept of the music child is an example, where the natural musical impulses are activated as a source of health. Kenny's (1989) *Field of Play* theory is another example in which safety is established in the musical space and creative processes are explored as new ways of being are found. But perhaps not surprisingly, in most examples the emphasis is on the creative process contributing to healing and external life changes, rather than increased creative expression outside of therapy. Community Music Therapy is one of the few, if not only models in music therapy where there is a clear connection to bringing the individual or groups' artistic process into the society at large. Creativity is also a topic in GIM literature, in particular the experience of creativity in sessions and how the creative process experienced in GIM can contribute to an experience of wholeness (Lawes, 2017). The interest that surfaced from this present PhD research finding is more focused on a particular aspect of creativity, namely how the experience of MI/GIM *uncovered* a creative impulse that was acted on *outside* of sessions.

Bonny stated of her own experiences with music and her motivation to develop GIM: "My premise was that the magic could happen to others, as it had for me, if a way might be found to enter and uncover the creative potential in each person through the use of carefully chosen music" (Bonny 2002c, p. 7). She may have been referring to the innate potential that is present in everyone and which we all aspire to achieve, as articulated in Maslow's (1943) hierarchy and pinnacle of self-actualization. But what stands out to me now is the word *creative* in the phrase *creative potential.* Early in the development of the Bonny Method, she described GIM as a technique that, among other things, could *foster creativity* (Bonny, 2002b).

Documented incidences of creative expression outside of the GIM sessions are sparse, as most researchers are focusing on the creative potential of the method itself, but there are a few examples. Two participants in Bonde's (2005) study with cancer survivors were inspired to write poetry from their sessions. "For these two participants, imagery was an act of creativity that stimulated expressivity in other domains" (p. 176). One of the themes from participant interviews in the Rudstam et al., (2017) study was that "it enabled creativity and playfulness" (p. 212), suggesting a connection to creative impulses, though it is unclear whether the participants experienced the creativity and playfulness outside of sessions. Trondalen (2016) examined a resource-oriented GIM process to uncover creative health resources for musicians. Her participants reported increased creativity and used creativity for coping. However, as musicians, participants from the Trondalen study were already

expressing creative impulses. In this PhD research, the participants were not musicians or artists from other media but were experiencing an increase in creativity, which may have contributed to their healing, but of specific interest is the uncovering of that creative impulse and the externalization outside of therapy.

Maack (2012), in sharing some of her experiences in GIM, wrote about the connection between exploring solutions within her imagery and creativity. "For me as survivor, this kind of inner trying out is very important, because it widens possibilities and makes creativity possible…" (p. 133). My interpretation of her statement in this case is that she is referring to being creative in one's thinking about finding solutions, as opposed to the act of artistic creative expression. In terms of creative solutions and also artistic acts of creativity, MI/GIM work has a unique position in that the aesthetic of the music listening experience and the activation of imagery experiences allow possibilities to explore potential that may not be possible in real life or with existing skills. For instance, Judy (case vignette, section 6.6.5) used familiar music from her collection (B.B. King) and an image was activated in which she walked into a crowded room and experienced a positive feeling of being in the room and listening to live music- a situation that would have potentially produced anxiety in the past. She experienced positive feelings in being there and listening to music. In addition, a creative impulse was activated and she followed through with playing her own music before a crowd. In another example, Sue (case vignette, section 6.6.1) shared her music that inspired her to dance and helped her to feel empowered. In later GIM sessions in which therapist-chosen music was used, her dancer and other playful images appeared repeatedly as resources that accompanied her metaphorical confrontation of her attacker. Her ending synthesis of her sessions was a motto "I want to dance a new dance." She was exploring new ways of being in her life. She was also literally exploring opportunities to dance outside of therapy sessions.

One possible interpretation of uncovering creative impulses could be related to Stern's vitality forms as they are experienced in music listening and articulated in the imagery (described in section 2.3.2). Vitality forms are about *how* we experience, not what or why we experience. Stern described music as a dynamic event that unfolds over time and involves the elements of movement, force, space, intention and time (Stern 2010b). For clients who have experienced trauma and are disconnected from their feelings, this experience of vitality forms is important and reflects Van der Kolk's argument for prioritizing a body-mind integration before verbal processing. One of the implications for vitality forms in clinical practice is the stimulation of neural activity leading to a re-shaping of mental models (Stern, 2010), which is essential for reclaiming a sense of self and reconstructing the inner map of the world (Van der Kolk, 2014). The music provides trauma clients an opportunity to experience these vitality forms in a positive, non-threatening manner and re-connects them to the dynamic elements they may be disconnected from in their daily lives. Still, the question remains of how that experience is also stimulating creativity in their external lives.

Smeijsters (2012) writes about the felt vitality affects from listening to vitality forms that are present in music and argues that "music is impossible to experience without evoking vitality affects in the core self" (p. 233). Vitality forms are established in the body and the mind and are an ever present part of life, as well as artistic creations (Stern, 2010a). Clients in the feasibility study experienced vitality forms present in music, that due to trauma may not have been active in their external lives. Trish talked about the struggle of trying to express herself and having no way to do it, that if she could just stay in her predictable box, everything would remain safe and contained. She experienced that breaking out of the box, and walking through previously unopened doors, first in MI/GIM sessions and then by following through on the creative impulses activated by the music. The encounter with creativity inside and outside of the sessions potentially enhanced the recovery of a sense of play and other experiences of vitality that may have been dormant or buried as a result of trauma. It may not be that external artistic creative expression is always the manifestation of that recovered sense of play, but in this PhD research, it was an identifiable component with each participant.

The experience of vitality forms and creative impulses also has potential to be empowering. It is likely that trauma clients have experienced these vitality forms in a negative sense as an intention to harm. These are elements that have contributed to their withdrawal from dynamic life experiences. The use of music that they trust in the MI/GIM sessions, provides the opportunity to experience the dynamic forms in a positive manner. The activation and uncovering of creative impulses provides a further tool for them to take back some of the control that was taken from them and the empowerment to externalize the creative impulses in an experience that is life affirming.

9.3. VALIDITY AND EVALUATION OF THE RESEARCH

Though this study used mixed methods for the overall design, the majority of the data collected thus far was qualitative, therefore the evaluation will be approached from that perspective. Triangulation is one method of demonstrating validity in qualitative research, but according to Creswell and Miller (2000) there are a variety of methods for establishing validity. The chosen methods are dependent on the lens of the research as well as the paradigm. For instance, triangulation would be from the lens of the researcher while member checking would be from the lens of the participant. Creswell and Miller maintain that triangulation is from a post positivist, systematic paradigm; alternatively, a critical paradigm would employ researcher reflexivity as the method of establishing validity. This thesis relayed details of a study that used multiple paradigms and methods. Likewise, multiple processes were used to improve the validity of the study. Criteria first proposed by Lincoln and Guba (1985) will be used to evaluate the qualitative components of the study. Within that criteria, methods from multiple lenses and paradigms will be identified. Under each of the Lincoln and Guba criteria (credibility, dependability, confirmability and transferability) are the

methods used for this study, adopted from strategies identified by Shenton (2004). There is some overlap in the use of methods to address the four criteria. The methods are described most thoroughly under credibility. Following the qualitative evaluation, triangulation will be used to converge the various data types.

Credibility

Credibility is the process of demonstrating that the findings are accurate or truthful. Triangulation (from the lens of the researcher) and member checking (from the lens of the participants) are two methods for establishing credibility. Other methods used in this study are: familiarity through early and prolonged involvement with the culture of the phenomena being studied, iterative questioning, rich descriptive narrative, examination in relation to previous research, debriefing sessions with supervisors, and peer feedback. In the explanation of strategies that follows, the methods are italicized for easier identification.

Familiarity with the topic occurred early through several informal and formal processes. Before concretizing my research proposal, I met and interviewed several veteran women in the community who worked in various capacities with female veterans. This provided a more informal view into the culture than what I was encountering as a music therapist supervising practicum students at the VA hospital. Early in the research process, a systematic review of the literature provided important background into the culture of female veterans and presenting issues through the lens of previous researchers. Additionally, in order to recruit for the feasibility study, I attended several community events where I met and spoke with female veterans. The first was at a transitional housing organization where I attended their weekly community meal and gathering. The second was at a meet-up group for female veterans, where I met and spoke with a small group of female veterans. The meetings, as well as the informal interviews mentioned above, were perspectives into the culture from the lens of the veteran women.

There was *prolonged involvement* with the data in the study on multiple levels due to multiple identities as researcher, therapist and eventually co-collaborator. As the therapist, I facilitated the MI/GIM sessions and focus group with the five participants. As the researcher, I transcribed and analyzed the content of the forty-four sessions and focus group. In the analysis I used *rich descriptions* of direct quotes from the participants in order to support the identified themes of the components being examined. For *member checking*, I shared these themes with the participants for their comments and confirmation. The collaboration with Trish involved prolonged involvement with the culture, consistent checking and confirmation of included information, aesthetic choices, and manner of dissemination. *Triangulation* was used through the use of statements from individuals in the therapy session and the responses in the focus group. *Iterative questioning* was used in the focus group interview. The open nature of the questions and structure of the discussion afforded an emergent

conversation in which I was able to re-phrase questions as needed in order to gather a more complete and coherent picture of the phenomena.

As part of the PhD program at Aalborg University, I regularly presented on the research methods and findings, engaging in dialogue and receiving constructive *feedback from peers and faculty* throughout the research process. The *debriefing sessions* with faculty supervisors, following the presentations, facilitated clarity of the themes and transparency in the research through a type of audit trail of the process. The qualitative process and results of gathering themes through meaning condensation was also shared with three supervisors who are experienced GIM facilitators, trainers and researchers. *Comparing the findings to previous research* (section 9.1.1) provides a confirmation of similar findings.

Dependability
Dependability is the issue of whether the research is reliable or replicable. Dependability is difficult to align with an ontological stance that there are multiple perspectives on reality, because presumably findings from two studies could not be exactly replicated. But dependability can also be viewed as the stability of the findings within the study and from that stance, it is possible to approach dependability from the lens of the researcher and the consistency of the processes employed. Lincoln and Guba (1984) maintain that ensuring credibility helps to ensure dependability. In that sense, many of the processes listed above add to the dependability of the study. An *audit trail*, through the use of detailed methods, raw data and *rich descriptions* of the researcher's process were used throughout the study to help demonstrate dependability and potentially facilitate a replica of the study design. Stability of the findings can also be demonstrated through the *triangulation* of the findings from the feasibility study with the findings from the collaborative inquiry. The findings examined and articulated in the collaborative inquiry supported and went into more depth concerning the initial finding: that the MI/GIM sessions were helpful in increasing coping skills, self-awareness and empowerment.

Confirmability
Confirmability is related to objectivity and demonstrates that the research findings are a result of the clear detailed processes of examination, as opposed to the researcher's bias and opinion. The epistemological stance of this research posited a high level of interaction between researcher and participant, therefore the axiological premises of the researcher would influence the presentation of outcomes, if not the outcomes themselves. There were strategies in place, however, to be transparent regarding the process and to check the findings through an external lens separate from the researcher and participant. Engaging in personal MI sessions prior to beginning the research and throughout the process, increased awareness of my strong feelings and allowed an examination of my values and beliefs. This *researcher reflexivity* is what Creswell and Miller (2000) identify as a validity procedure from the lens of the researcher. The process of *collaboration* in the film project is a strategy from the lens of the

participants, and *peer and supervisor debriefing* is a manner of confirmation from an external lens. Examining the research from these three lenses helps to confirm validity of the results.

Transferability

Transferability is similar to external validity in quantitative approaches and concerns the degree to which results can be generalized or transferred to other contexts. In studies that involve a small sample and are highly contextual it is dependent on the researcher to provide rich descriptions of the process and enough contextual information so the reader can infer transferability. This was provided in the feasibility study through a detailed description of the methods, and more so in the collaborative inquiry, which emphasized context. Context was one of the framing components of the film portrait and portraiture relies on *rich description* in order to convey the essence of the phenomena.

Triangulation and Convergence of Results

Through a process of method triangulation and data source triangulation, the results can be viewed from a blended perspective. Data source triangulation occurred through multiple sources: participant interviews, therapist notes, member checking through sharing findings with participants for comments prior to dissemination, review of themes from the feasibility study by three GIM therapists and film responses from eleven professional colleagues. Method triangulation was employed through multiple methods of gathering data: Meaning condensation analysis of session audio recordings and a focus group interview, PCL-5 change scores, and the collaborative inquiry with one participant. The decrease in PTSD symptoms according to PCL-5 scores mirrors the participants' reported benefits of increased coping skills. All participants reported increased self-awareness and empowerment, further detailed in themes from the collaborative inquiry: change in identity/ perspective and increased empowerment.

In examination of the various types of data and content gathered for this study, it is important to look beyond a delineation of a mixed methods study that gathered qualitative and quantitative data. Rather this study sought to gain a fuller understanding of veteran women and their experience with MI/GIM. This was accomplished through the use of different lenses or perspectives in the research process (researcher perspective, participant perspective, and external perspective). After initial grounding in previous evidence with this population through the literature review, emphasis was placed on the women's descriptions of their experiences, on their interaction with the research and the researcher, and on the aesthetics of a creative project to empower and raise awareness. The types of data yielded from the inquiries included quantitative score changes, qualitative condensed themes, and arts based artifacts. The blending of perspectives allows a more holistic presentation of the phenomena, while also highlighting points of interest that garner further investigation.

9.4. INTEGRAL METHODOLOGICAL PLURALISM

"The boundaries that we draw between scientific and artistic representations of reality not only produce distorted caricatures of each realm but also blind us to the similarities and resonances between them" (Lawrence Lightfoot, 2011, p.13).

This thesis detailed five aspects of a research project: a systematic literature review, a feasibility study, a manual, an ABR film project and a RCT protocol. The approach to research was dialectic, employing pragmatic and transformative paradigms. Various methodologies were used, which required a shifting between objectivist and interpretivist research and the underlying philosophy of each. The paradigm and methodological stance was initially introduced in section 1.8. What follows is an explanation of how the various approaches integrate. Integral Methodological Pluralism (IMP) will be used as a framework to explain the various perspectives in the context of a holistic presentation of the research.

Integral Theory is a cross-disciplinary and cross-cultural framework that seeks to investigate phenomena and human development through a synthesis of perspectives (Esbjorn-Hargens, 2010). The scope of this paper does not allow space to fully explain Wilber's theory, which has been explored in over twenty-five books that have been translated in multiple languages and used in a range of fields and disciplines. Wilber's Integral theory has been detailed in music therapy literature to frame meta-theory, models, clinical practice, evidence and program evaluation interview questions (Abrams, 2010; Bonde, 2001 & 2011; McFerran & Campbell, 2013; Meadows, 2011). One aspect of Wilber's theory used in IMP is a quadrant model used to view experiences from various perspectives. The four basic perspectives or dimensions are subjective, objective, inter-subjective and inter-objective (figure 9-1).
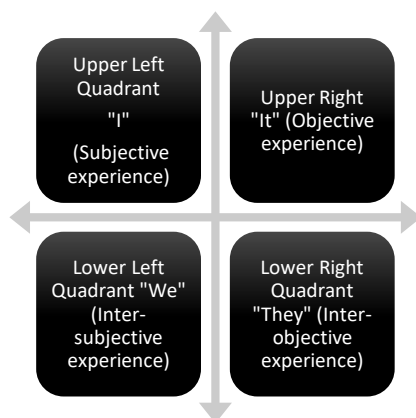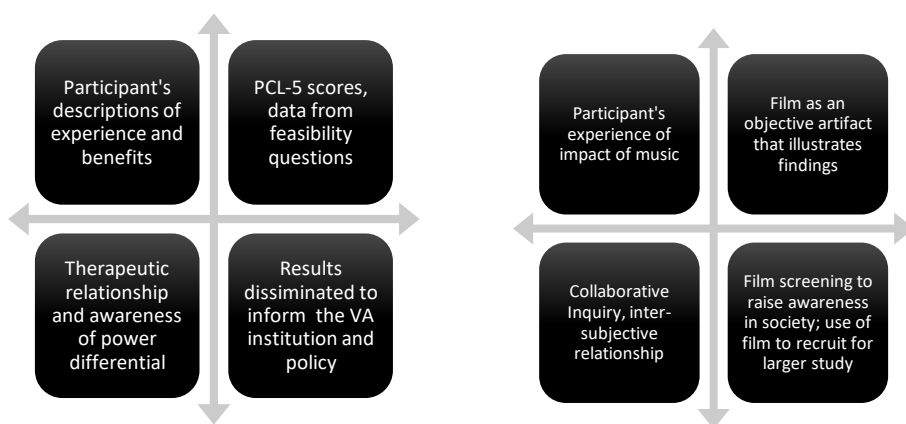

Figure 9-1 Wilber's Quadrant

From a perspective of multiple research methodologies, there are certain research methods that would correspond with the investigation of different aspects of phenomena. For instance, phenomenology would be used in the upper left subjective perspective, experimental design in the upper right objective perspective (McFerran & Campbell, 2013). The present PhD research is one that attempted to go beyond mixed methods to a quadrant perspective that examined the issue through individual, group, internal and external perspectives. An integrated perspective could be used to examine many aspects of the research process including the approach to the literature review, formulation of research questions, study design, data collection and interpretation of results; but in this case, I will limit the discussion to the overall concept of methodological pluralism and the use of various approaches. Figure 9-2 shows four aspects of the PhD research and how they might fit into particular quadrants or perspectives.
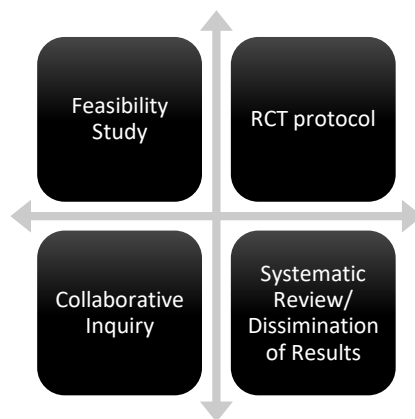
Figure 9-2 A quadrant view of the PhD research

When using Wilber's quadrant, it is common to become overly focused on how phenomena can fit or be categorized into a particular quadrant/ perspective when the actual intention of Wilber's integral model is on the synthesis of perspectives and how one can view things as an integrated whole. Quadrivia perspective is a process of examining phenomena in a particular quadrant from four perspectives (Wilber, 2006). For example, from a quadrivia perspective, phenomena categorized in the inter-subjective quadrant could also be viewed from a subjective, objective and inter-objective perspective. Two examples from the PhD study further demonstrate a quadrivia perspective (figure 9-3).

Participant's descriptions of experience and benefits	PCL-5 scores, data from feasibility questions	Participant's experience of impact of music	Film as an objective artifact that illustrates findings
Therapeutic relationship and awareness of power differential	Results disseminated to inform the VA institution and policy	Collaborative Inquiry, inter-subjective relationship	Film screening to raise awareness in society; use of film to recruit for larger study

Figure 9-3 Quadrivia view of feasibility study and CI project

The first is from the upper left quadrant- feasibility study, which was primarily a phenomenological method that used the subjective experience of participants. The second is from the lower left quadrant- the collaborative film project, which was primarily a form of narrative ethnography that used an inter-subjective experience. Each perspective includes its own integration of perspectives. This could go on, resulting in perspectives on perspectives and would appear as a nested process with a figure showing quadrants within quadrants. The aim of IMP is not to place various aspects into discrete categories, rather it is to embrace plural methodology as being able to co-exist in order to create an integrated whole. This is the weaving and shifting process referred to in section 4.2.2 when stressing the importance of creating an RCT that was also transformative. It is the shifting of perspectives in order to best observe an aspect of the research, but it is also a weaving and blending in order to integrate the perspectives. Regarding what this means for an epistemological stance, IMP, Wilber (2006) writes:

> It explicitly finds room for premodern truths, modern truths, and postmodern truths, all in the integral framework not of conclusions, but of perspectives and methodologies. Moreover, it doesn't "cheat" by watering down the various truths in such a horrid way that they are hardly recognizable. It takes all of those truths more or less as it finds them. The only thing it alters is their claim to absoluteness, and any scaffolding (and metaphysics) meant to justify that unjustifiable claim. (p. 20)

When different methods were implemented and different types of data gathered, there was an attempt to hold an awareness of all of them and how they might intersect, even in the midst of the single focus occurring in the moment. It is like being on top of a mountain affording different views. Depending on the direction faced, one may see forest, ocean or residential neighborhoods and one may need different tools to explore each landscape. But when you turn to face one view or descend in one direction, you

do not forget the others are there. They are all part of the integrated experience. In this PhD research there was an overall aim to learn more about women who have been in the military, experienced military sexual trauma and participated in a continuum of MI/GIM sessions. The phenomena examined was explored from various perspectives and with various audiences in mind: the women's reported experiences, their change in PTSD symptoms, the processes that contributed to those experiences, the relationship of collaborative inquiry, the impact on community and the development of a protocol that could contribute to the larger scientific community and impact services in the military where the women live and work. All of these perspectives integrate to form a more complete presentation of the women who participated in the study and help to inform services for veteran women.

9.4.1. RESEARCH PERSPECTIVES AND GROWTH

Examining phenomena from an integrated perspective allows a holistic perspective that is completely its own, but in order to reach that, the individual parts first needed to be examined. Prior to engaging with veteran women in therapy sessions, a systematic review revealed the current issues, practices and recommendations from the institutions that interpret data and set standards, namely scientific research and the veterans administration. That type of data informs how systems function and would be considered a lower right quadrant perspective. The systematic review provided the background and foundation to form research questions, but the studies were primarily comprised of clinical trials and surveys, showing general effects and trends that help to set standards and recommendations. One of the larger goals for this research was to have a study that could contribute to the data that informs large policy changes. In that sense, the systematic review functioned as a background and history while also providing a future goal or endpoint for the research program. But being a new client population, other perspectives and ways of examining the phenomena were needed.

The feasibility study used data gathered from the participants' descriptions of their experiences, an upper left quadrant perspective. In addition to the themes generated from participant descriptions, the feasibility study also gathered objective data (PCL-5 questionnaires and the numerical data regarding recruitment and attrition rates), an upper right quadrant perspective.

From my initial perspective as a researcher, these results were meant to be followed with an RCT to ascertain if the effects were similar with a larger population. Instead, due to recruitment and funding issues, the focus shifted to the experiences of one participant in order to learn more about the impact of the sessions. In doing so, a lower left perspective was embraced where we collectively examined her inner experience (her upper left perspective) and the impact on her life. I believe that in doing so she experienced further benefits from her participation in the research, and I experienced an unexpected shift in perspective as we worked towards a common goal to raise awareness. My initial goal had been focused on influencing institutions and

policy change, but the end project also had aims to raise awareness thus impacting society and cultural views. Both, I believe are important impacts of research.

Parallel process

From an epistemological standpoint, it was interesting to observe the alignment and paradoxes of various approaches and issues inherent in the study. There was an awareness of the attempt to fit together concepts that are often kept apart: quantitative and qualitative, transformative and randomized controlled, science and art. The study participants were also products of a paradox and examining the dichotomy of being women in a career historically reserved for men.

Identity issues connected to typical masculine and feminine qualities frequently surfaced in the sessions. As I examined my own research process, my personal Music and Imagery sessions often dealt with the masculine/ feminine balance in research approaches and ways of working. This surprised me, as I had not previously viewed research approaches as having inherent gender-stereotyped traits, but indeed, there is published literature that draws attention to these differences.[3] Masculine qualities are typically identified as structured and purpose-driven, whereas feminine qualities are described as relational and process oriented. I observed that when I made plans with an end result as a goal, the process seemed to stall, but when I attempted a more intuitive or implicit manner of working, there was a more natural flow to the work. This led to a more collaborative approach to the research. The intention is not to state that I abandoned a more typically masculine approach to working, but rather I allowed a more feminine approach to be present as well, and both were vital to the overall process. This was an important realization for me because it allowed an awareness of the parallel process in terms of identity issues to the women in the study. They struggled with their own balance of masculine and feminine qualities as women in the military. From an integral approach to research, this awareness is important to acknowledge in order to be more inclusive of multiple perspectives. From a research growth perspective, it helped me to recognize points of alignment with my participants and increased my understanding of subtleties of the issue.

Pre vs post study understanding

Engaging in this research has broadened my understanding of relationships in ways that were unanticipated.   In particular, I came to a new understanding of the importance of the client's existing relationship to music, the manner in which it is positioned in therapy and how that impacts the therapeutic relationship (concepts discussed in section 5.4.3, *use of client chosen music*). Section 1.8 presented my methodological stance as a researcher and acknowledged the interaction between researcher and participant. When I first articulated an interest in transformational

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[3] See Gerber, G. *In Defense of Empirical Research: A Feminist Response to a Feminist Critique,* http://www.columbia.edu/~hc137/prs/v4n1/v4n1!3.htm for an interesting perspective on the issue and her argument for not using interpretivist methods in gender studies.

research and resonated with approaches described by Mertens (2007), my focus was on implementing an ethical RCT without marginalizing veteran women. I did not know at that time that I would engage in a collaborative inquiry with a participant. Doing so afforded a first perspective view into the influence and impact of shifting and re-defining roles between researcher and participant. In addition, the finding of uncovered creative impulses was completely unanticipated and opens up a perspective to new directions for this work. Throughout the study, I have drawn attention to the multiple methods and blending of perspectives that were used, often encompassing paradoxes such as objectivism and interpretivism, science and art, client and co-researcher. This required an openness and suspending of previously held ideas regarding roles and functions in research and clinical work. The benefits of working with music in therapy and outside of therapy is another line that was blurred and led to a reforming of my beliefs. This is explored further in the section that follows, *Implications for Clinical Practice*.

9.5. IMPLICATIONS FOR CLINICAL PRACTICE

Findings from the study provide support for using MI/ GIM continuum sessions in clinical practice with clients who have experienced trauma, in order to help reduce PTSD symptoms and provide tools for coping. In addition, there are findings related to the therapy process, how we situate ourselves and our clients in positions of power and implications that may have for our approach to therapy.

> One of my gradual realizations as a music therapist (and I'm embarrassed at how late this came), was that there is a fluid continuum between how music helps in everyday life and how it helps within the specialist field of music therapy (and other professional and semi-professional practices which harness music's helpful affordances)…I needed patients to point out to me how they had already been engaging in musical practices that were health promoting before they knew about or engaged in music therapy…(Ansdell, 2013, p. 5)

Reflecting on the experiences from this research has allowed me to view the process as a continuum that begins with the clients' existing relationship with music, *before* they enter therapy, during therapy and outside of sessions, as they deepen their relationship to music and their creative selves. Cultivating that awareness has implications for how we practice and how we view the different relationships in therapy.

Using a client's music has been mostly foreign in the GIM method, in which, traditionally, therapist-chosen music is utilized. Through GIM training, therapists acquire extensive knowledge of music and learn how to choose from core programs and how to design programs of music to facilitate transformation and healing. It is understandable then that we often situate ourselves as the music experts. But if I begin

therapy by choosing the music for clients, it is possible I am missing an opportunity to find out more about them, help them recognize themselves in their music, and discover what types of music are self-affirming for them. It is a meeting of the self in music that they very likely have already experienced and are capable of sharing as a starting point to deepen that relationship.

Like many music therapists, I have been interested in understanding the music we use and what musical elements lead to transformations in therapy. Knowing that the same music may interact with each individual differently, I understood it is a complex matrix of *choosing* the right music, which is based on factors such as timing in the trajectory of therapy, ego strength and needs of the client, and the intention of the session. Instilled from years of GIM training and trusting the music, I believed that if I understood music well enough I could choose an appropriate piece to support a certain emotional resolution. But I was failing to consider a pivotal factor- the client's relationship to music. I was coming at the music question backwards. "How can I choose the best music for my client?" has now become, "how can I teach my client to choose the best music for them?" And "how can my client teach me how to choose the best music for them?"

When we choose the music, we are presenting the client with a more serious challenge in regard to trust and surrender to unfamiliar music. This is not to say that therapist-chosen programs should not be used in MI and GIM, but it depends on the intention of the session. At some point in the feasibility study, clients surrendered to the process and the music. I also, as a therapist, had to surrender some of my control of the process and the music. This awareness of balance (or imbalance) of power in the therapy process is important with this population who have trauma as a result of abuses of power from individuals they had been taught to trust. They also come to therapy with a person in authority who they are expected to trust. Part of my role was to provide an environment that could empower *their* voice again. By building a bond with familiar music prior to using unfamiliar music, clients in the feasibility study seemed more willing to trust me and the music and that "impacted their ability to more fully utilize other components of GIM, such as imagery and creative processing, as a resource" (Story & Beck, 2017, p. 99). I would add now that it also impacted their ability to trust and connect with their own creative impulses and potential outside of sessions.

The implication for clinical practice is that use of client-chosen music helps to develop trust: in the music, in the process, in the therapeutic relationship and in their own authority. Furthermore, uncovering creative impulses allows clients to continue to deepen the creative potential experienced in the sessions. Therefore, the use of client's relationship to music is both an inviting of their existing knowledge into the therapy room and an encouragement to continue deepening that knowledge outside of therapy. It requires a shift from thinking that therapy occurs in a room where an expert therapist is sharing knowledge and providing space for healing and transformation. Although

that is true, it is also an acknowledgement that what is being brought in and taken out of the room is *as* important. And an acknowledgement that our ability as therapists to surrender our roles as experts and engage in what Kenny termed radical mutuality (Stige, McFerran & Hadley, 2017) is as important as our knowledge and tools.

9.6. LIMITATIONS

One of the criticisms of integral research is the priority of breadth over depth. In order to gain multiple perspectives, resources such as time and funding are divided into multiple facets of the study. This PhD research primarily focused on the "I" and "We" perspectives through the feasibility study and the collaborative inquiry film project. The more objective facets were through the written non-inferiority protocol and creation of an intervention manual, though the experimental design is yet to be implemented. As such, this is a view into four participants' experiences with a continuum of MI/ GIM sessions. The reported experiences as gleaned through session transcripts, the focus group interview and a collaborative inquiry were all directly relayed to me as the therapist and researcher for the study, which may have influenced the shared experiences in a positive direction. There was an emphasis on meaning and benefits as well as inner resources in the inquiry. Perhaps that emphasis led to a neglect of problem-based or outcomes-based models, which also provide important perspectives on the issues.

The feasibility study was for the purpose of intervention development and had a very small sample. A sample of five allowed a careful examination into the experiences of five women with unique profiles and how they utilized the MI/GIM sessions. A study with this small of a sample is not meant to be generalized or even exemplified as evidence of effectiveness, but it provides important insights regarding female veterans and the use of MI/GIM as a treatment modality and builds support for further investigation.

9.7. RECOMMENDATIONS FOR FUTURE RESEARCH

Based on results from this feasibility study, modified GIM in a continuum model that begins with client-music and strengthening of inner resources before moving into issue-oriented and transformation-oriented sessions is a feasible intervention to use with women veterans who have experienced MST and PTSD. Implementation of a non-inferiority RCT is recommended in order to build evidence that this intervention is not inferior to current recommended trauma exposure therapies for reduction and continued management of PTSD symptoms. With an adequate sample size, resilience and social support could also be analyzed as moderators to PTSD symptoms. Based on need and feedback from study participants and presentation attendees, it is also recommended that the study be re-designed to include men as well as women. This may require a pilot study in order to obtain potential unique differences in the needs of men who have MST and their experience of MI/ GIM. Finally, in light of the

additional finding of uncovered creative impulses, it is also recommended that data connected to external creative activity be gathered as part of the study. This may be facilitated through post study interview questions, or through a participant completed journal or log of experiences between sessions. Understanding the role and intersection of creativity and the healing process would have implications into the practice and applications of creative arts therapies.

9.8. CONCLUSIONS

This research begins to fill a gap in the literature regarding female veterans with military sexual trauma and their experiences with MI/ GIM as an intervention. The feasibility study gathered rich descriptions that generated themes regarding how veteran women experienced the music, imagery, guiding and creative process in MI/ GIM sessions as well as what they found to be helpful and beneficial about the process. Participants found the MI/GIM sessions to be beneficial as a coping skill, a method to increase self-awareness and a tool for empowerment. Results from the research helped to refine the protocol for an RCT and informed a manual created for intervention therapists in the RCT. This proposed larger clinical trial is a pivotal step in the effort to expand and improve services for veteran women who have experienced military sexual trauma and PTSD.

Further exploration of meaning and benefits through a collaborative inquiry with one participant revealed an increased connection to creativity for that participant and allowed an examination of roles and power dynamics in research. The project also resulted in a short documentary film to raise awareness of MST and the healing potential of music for this population. The finding of uncovered creative impulses merits further research regarding the internal processes of MI/GIM work and the interaction with external creativity, the implications of which may impact multiple fields related to human potential and creativity.

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APPENDICES

Appendix A: Materials Related to the RCT Intervention Manual
Appendix A.1 The MI/GIM Continuum Model for Trauma and Recovery

Purpose and Use

The MI/GIM Continuum Model for Trauma and Recovery (CM-GIM) aligns the continuum model with Herman's stages of trauma recovery. The intervention manual was created for use in a Randomized Controlled Trial that examines a continuum of MI and GIM as an intervention for female veterans who have experienced military sexual trauma. This manual is intended for the therapists of the study who have had previous training in music and imagery modifications. It is therefore assumed that the therapists have previous knowledge of working in a supportive, re-educative and reconstructive manner in both MI and GIM methods. The manual provides guidelines for utilizing the MI and GIM methods in a manner that supports trauma healing in alignment with Herman's stages. A brief introduction will be given to explain the alignment of the levels with the stages, followed by protocol steps for the study sessions.

Introduction and Background

One of the overall aims of the feasibility study was to develop a manual to use in a Randomized Controlled Trial (RCT). The manual is informed by the MI and GIM methods detailed in Summer's (2015) Continuum Model to support the client through Herman's (2001) three stages of trauma recovery. The structure of sessions in the feasibility study were informed by the Continuum model, but there were no guidelines or decision tree to guide the therapist in how to move through the process. The feasibility study strongly emphasized the Resource-Oriented sessions as a starting point for therapy. Subsequent sessions were determined by each client's unique profile and manner of progressing in therapy. Knowledge gained through data from the feasibility sessions have helped to structure a set of protocols or guidelines for using the Continuum Model in trauma healing. Rather than a prescriptive detailed process, the manual provides guidelines for the RCT study therapists to utilize a client-centered approach that tailors the MI or GIM process to the client's stage of healing.

Herman's trauma recovery model details three stages worked through in the process of healing. Stage one establishes trust and safety before moving into stage two of remembering and mourning the trauma, and finally stage three of exploring reconnection and one's place in the world. Table 2 below briefly outlines Herman's stages of recovery.

Table 2: Herman's Stages to Trauma Recovery

Herman Stage	Primary Task
1: Safety and Stabilization	To gain internal and external control through establishing safety and self-care
2: Remembrance and Mourning	To begin to make sense of experiences
3: Reconnection	To re-define oneself in the context of meaningful relationships

The Continuum Model of MI and GIM can serve as a method for working through the Herman stages as it begins with the most supportive MI method through providing a contained manageable way of engaging with resources before moving into more issue-oriented and open manners of working. The goals of Resource Oriented, Issue Oriented and Transformation Oriented levels of working support the goals of the Herman Stages. Table 3 provides a visual representation of the alignment.

Table 3: Herman stage and continuum model

Herman Stage	Goal	MI/GIM Level (Summer, 2009)	Goal
1: Safety and Stabilization	To gain internal and external control through establishing safety and self-care	Supportive/ Resource-Oriented	To establish trust and engagement in therapy; to discover and integrate inner resources
2: Remembrance and Mourning	To begin to make sense of trauma experiences through building a narrative	Re-educative/ Issue-Oriented	To address issues or symptoms and increase self-awareness of maladaptive life/interpersonal patterns and self-understanding
3: Reconnection	To re-define oneself in the context of meaningful relationships	Reconstructive/ Transformation-Oriented	To explore meaning; address underlying existential and spiritual questions

Herman Stage One: Resource Oriented MI and GIM

In Herman's first stage, regaining a sense of safety, the primary task is to gain internal and external control. Survivors of trauma must learn to regulate their autonomic nervous system's responses of hyper arousal and intrusive symptoms. Doing so

allows the individual to return to their normal rhythms of eating and sleeping. The focus in this stage is to provide concrete strategies to decrease sympathetic arousal, which can result in an increased sense of control and safety (Zaleski, Johnson & Klein, 2016). Through establishing a trusting therapeutic relationship and enhancing self-coping strategies, the therapist supports the client to learn self-care. Resource Oriented Music and Imagery (RO-MI), the most contained level and method in the Continuum, is a supportive MI process that uses a client's relationship to music to connect and enhance inner resources, build trust and provide a music resource for self-care. If the client is able to tolerate a larger container, RO-GIM would be indicated at this stage as well.

Herman Stage 2: Issue-Oriented MI and GIM

The second Herman stage, remembrance and mourning. explores the trauma through building a narrative in order to begin to make sense of the experiences. Verbalizing the memory of trauma brings it into the present and allows the client to grieve, but not all survivors find benefit in re-telling their trauma story. The use of metaphor and a here-and-now focus on the impact of trauma are ways to build narrative without directly going into the trauma. Issue Oriented Music & Imagery (IO-MI) is a re-educative process that allows this building of narrative in small manageable pieces. If tolerated, this is also the stage where Issue Oriented GIM would be indicated. Clients are not taken directly into a trauma memory with MI or GIM work, but trauma memories *may* emerge during the music listening through actual memories or metaphors. Verbal processing or creative modalities are then used to explore the memories and metaphors. It is also common however, for the client and therapist to identify an issue *connected* to the trauma such as anxiety around daily transitions or fear of being in a crowded room, rather than a direct memory, that will then be explored through an IO-MI or IO-GIM method.

Attention to regulation of the autonomic nervous system continues to be important during this stage. Though the client has learned coping skills for regulation during stage one, engaging with the trauma narrative may activate the body's responses to trauma and increase symptoms. When this occurs, the therapy process must be slowed down to a tolerable level. Trauma therapies highlight the importance of relaxation techniques in order to manage PTSD symptoms of hyper-arousal. In the RO level work, emphasizing the client's relationship to music and increasing her awareness to music choices provided her with tools to use interventions such as music and relaxation to regulate emotions outside of the therapy sessions. During times of hyperarousal or dysregulation, the therapist can return to the earlier stage of establishing safety through an RO-MI experience, in addition to reinforcing music and relaxation techniques. More directive guiding may be indicated here in order to manage symptoms. When the client has returned to a more regulated state, the therapist can assess with the client whether to return to an IO level of working.
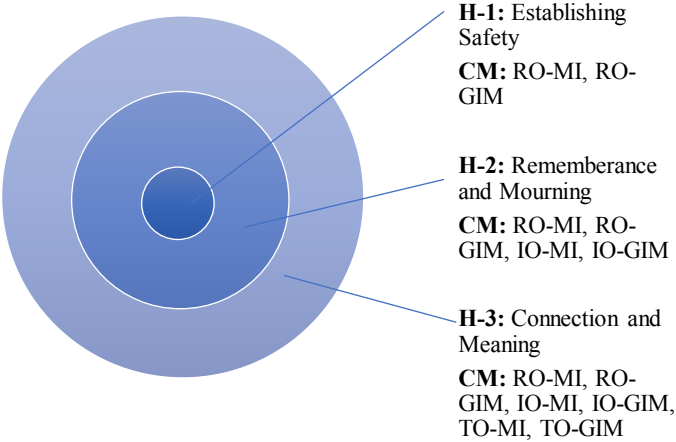
Herman Stage Three: Using Transformation-Oriented MI and GIM

The third Herman stage is reconnection and involves exploring meaning and one's identity in the context of relationships and engagement with community. Support groups, and outlets for increased community engagement can be resources during this stage of work; however, there is a continued need to explore meaning and one's place in the world through internal work and individual sessions. Herman states that in this stage the client reclaims her life and "faces the task of creating a future" (as cited in Zaleski, Johnson & Klein, 2016). At the reconstructive level of GIM, transpersonal experiences- experiences in which the client moves beyond the personal to consider her place within the community, are common and align with Herman's goal for stage 3.

Using the MI method at the TO level, provides a smaller container than GIM, and allows the client to see the images as they transformed during the drawings. Working at the MI level may also provide a greater sense of safety for trauma clients who are not comfortable or unable to tolerate an altered state of consciousness.

During this stage, IO-MI and IO-GIM and/ or RO-MI and RO-GIM may be indicated as tensions arise to be worked through or as extra support is needed. In this way it is less of a linear process and more of a layering on the methods and levels of working in the continuum. It is not uncommon to choose to structure at a specific level and then have a client work in multiple levels. We cannot control where the music and process take the client, but we can set up a container with the amount of holding to support their needs at various stages of recovery and either re-direct the focus or follow the client as needed.

A figure that shows the Herman stage and the indicated method and level of working in the continuum is included below.

H-1: Establishing Safety
CM: RO-MI, RO-GIM

H-2: Rememberance and Mourning
CM: RO-MI, RO-GIM, IO-MI, IO-GIM

H-3: Connection and Meaning
CM: RO-MI, RO-GIM, IO-MI, IO-GIM, TO-MI, TO-GIM

Figure 9-4 Herman Stage (H) and Continuum Method (CM)

In addition to being cognizant of the appropriate level of working with each unique client, there are also certain elements inherent in the GIM process that keep the material manageable and indicate to the therapist when a client is in need of more containment. "Defensive maneuvers" is a concept Goldberg (2002) named to describe the process of the client transforming a potentially overwhelming image into something less threatening. This is an unconscious way that clients manage difficult or traumatic material through transforming it in the imagery appearance. Defensive maneuvers are seen as a healthy coping mechanism used to avoid fragmentation. The presence of defensive maneuvers in client imagery is one indicator as to whether or not the client is ready to engage with traumatic memory or whether they would benefit from continued supportive work. Resource mobilization (Körlin, 2007) is a slightly different way clients manage material. In resource mobilization, a client may generate an image that represents some sort of helper in order to confront adversity. Resource mobilization could be an indication that the client is ready to engage with issues. So this provides two tools for assessment: one- to notice the level of work where the client has been successful, which would indicate they may be ready for the next psychotherapy level and two- look for instances of readiness in their imagery through the presence of defensive maneuvers and/or resource mobilization.

The continuum manual is outlined as a 10-12 week protocol based on timeframes of other published trauma interventions, but there is a need for further research in order to support this time frame. At this point, it is a suggested time frame that may be extended depending on the needs of the individual and their manner of moving through the stages.

Common Principles:

Specific principles to each stage of trauma work are listed below under the Protocol for Sessions. The following seven principles are considered essential and common in all stages of the CM-GIM, so they are listed here rather than repeated in each stage.

Recognizes the client's competence related to her therapeutic process.

Highlights the client's strengths and potentials.

Works with the client to identify specific goals for therapy.

Highlights the client's relationship to music.

Prioritizes work in the here-and-now.

Follows the inherent structure of a GIM session: prelude, relaxation or centering and induction, music listening, processing through creative and verbal methods.

Utilizes homework in order to help inner resources be more accessible to clients as a coping tool.

Protocol for Sessions

Each section begins with the Herman stage objective and Continuum method objective, followed by principles and inherent components (prelude, transition, music selection, induction, music listening, creative processing, postlude and homework) for structuring the session.

Stage One: Safety and Stabilization

Continuum Method and Level: RO-MI and RO-GIM

Stage Objective: To help client gain internal and external control.

Method Objective: Recognition and deepening of relationship to music and connecting to inner resources.

Time frame- suggested 2-4 sessions/ weeks, but flexible to client's needs.

1.1 RO-MI sessions focus on the client's strengths and potentials.

1.2 Highlights the client's relationship to music.

1.3 Prelude: Therapist helps the client to select an inner resource.

1.4 Transition: Therapist helps the client to identify a very specific image from the feeling connected to an inner resource.

1.5 Music Selection: Therapist and client listen to music together from the client's music sources (ipod, phone, CD's, internet streaming) to identify a piece of music that connects to the identified image.

1.6 Music Selection: Music can be of any genre, prioritizing the client's connection of the music to the feeling/image.

1.7 Induction: Focus is in the here-and-now.

1.8 Induction: Induction focus is on the identified image and allowing the music to enhance the connection to identified image of inner resource.

1.9 Music Listening: Client's relationship to the music and affect response allows the deepening of the connection to the inner resource as the music is repeated several times.

1.10 Creative processing during Music Listening: Uses additional creative processing (drawing, journaling, movement), as the music is repeated until it seems there has been adequate time for deepening and enhancing the image (approximately 20 minutes).

1.11 Creative Processing: Artifacts created during the music allow the projection of the resource.

1.12 Entire process may be repeated if client needs to be taken further into the image (connection to same image, repeat the same music again, continue or add a new drawing/ creative processing).

1.13 Postlude: Uses verbal and optional additional creative methods to integrate the experience more fully and connect to external life/ present issue.

1.14 RO-GIM sessions follow a similar format to above but with extended relaxation and active dialogue (rather than drawing) between therapist and client during the music listening to a supportive music program, which may be a shortened.

1.15 Homework: Therapist assists the client in identifying a way to use the music as a coping strategy between sessions (i.e. listening to the same music and work with additional creative processing).

1.16 Homework: Focuses on a psycho-educational component of use of music and music choices for emotional regulation.

Stage Two: Remembrance and Mourning

Continuum Method and Level: IO-MI and IO-GIM; RO-MI and RO-GIM as needed

Stage Objective: To support the client as she builds a narrative and begins to make sense of the traumatic experiences.

Method Objective: Continue to enhance client's relationship to music and use of inner resources to engage with material that holds more conflict. Re-build narrative and connection to present life.

Time frame: 6-8 sessions/ weeks, flexible to client's needs.

2.1 IO-MI sessions focus on current symptoms and impact of trauma.

2.2 Continue to highlight the client's relationship to music.

2.3 Prelude: Therapist helps the client to identify a feeling connected to a here and now issue or tension. Content may be focused on any issues or tension that arise for the client, not just trauma-related.

2.4 Transition: Therapist helps the client to identify a very specific image from the feeling connected to identified issue.

2.5 Music Selection: Music is chosen to allow expression and containment of the feeling/image of the issue

2.6 Music Selection: Continues to involve the client in the process of choosing the music. *

2.7 Transition: Remind the client of inner resources before going into the induction, drawing attention to safety before going into the issue-oriented induction.

2.8 Induction: The induction is issue focused.

2.9 Induction: Material may address previous trauma but the focus remains on the here and now impact of that trauma.

2.10 Induction: Client is not directly taken into the trauma with an induction, unless the client chooses to re-live the trauma memory as a focus of the therapy session. Material would continue to be related to the here and now impact.

2.11 Music Listening: A brief selection of music is played and repeated, allowing the music to foster a contained, manageable focus on the identified issue.

2.12 Creative Processing: Drawing or other creative processing may happen during or after brief music listening.

2.13 Creative Processing: Artifacts created during or directly after the music allows the projection of the issue.

2.14 Postlude: Trauma may have emerged through memory, metaphor, or current issues in the session. Trauma is processed more fully in the postlude with a focus on connection to present issue/ symptoms.

2.15 Postlude: Uses verbal and optional additional creative methods to integrate the experience more fully and connect to external life/ present issue.

2.16 IO-GIM sessions follow a similar format to above but with extended relaxation and active dialogue (rather than drawing) between therapist and client during the music listening to a supportive or mixed music program, which may be a shortened.

2.17 Homework: Reinforce the use of music as a coping skill between sessions for emotional regulation as relaxation.

* Note: Ultimately the therapist chooses the music, but with clients who have experienced sexual trauma, it may be important to allow the client to hear what is coming and to veto a music choice if they are fearful of engaging with the chosen music. This also allows the therapist to assess the client's reaction to the music and to discuss that reaction before making a final decision. Continuing to involve the client in this process increases a sense of trust and safety moving forward into more conflictual material. The use of music from the client's pool is not excluded from issue-oriented work, though more often it is music from the therapist's pool.

Stage Three: Reconnection

Continuum Method and Level: TO-MI and TO-GIM; RO-MI, RO-GIM, IO-MI and IO-GIM as needed

Stage Objective: To re-define oneself in the context of meaningful relationships.

Method Objective: Explore identity and transformation through a continuum of MI and GIM experiences. Synthesize work through MI sessions and further creative processing.

Time frame: 2-4 sessions/ weeks, flexible to client's needs

3.1 TO-MI sessions focus on exploration of identity and connection, post trauma symptoms.

3.2 Continue to highlight the client's relationship to music.

3.3 Prelude: Therapist helps the client to identify a feeling that may be connected to a re-educative or reconstructive issue.

3.4 Transition: Therapist helps the client to identify a very specific image from the feeling connected to identified issue.

3.5 Music Selection: Music is chosen that connects to the issue/ feeling.

3.6 Music Selection: Often by this stage the client is comfortable with the therapist choosing the music. Allowing the client to hear selections before going into the session is recommended, if needed.

3.7 Music Selection: Music chosen may encompass a larger range in order to allow for exploration of in a more open manner (supportive, mixed and challenging music).

3.8 Transition: Remind the client of inner resources before going into the induction, drawing attention to safety before going into the Transformation oriented induction.

3.9 Induction: Induction is focused on identity or connection.

3.10 Induction: Such images can be explored from an IO and/ or TO lens, using music imagery or GIM sessions.

3.11 Music Listening: For MI- Music is played and repeated, allowing the music to foster a contained, exploration of the issue.

3.12 Creative Processing (for music and imagery): May be during or directly following the music.

3.13 Postlude: Uses verbal and optional additional creative methods to integrate the experience more fully and connect to external life/ present issue.

3.14 Postlude: Active music-making is recommended during this stage as it highlights relationship and active roles in relationship.

3.15 TO-GIM sessions follow a similar format to above but with extended relaxation and active dialogue between therapist and client during the music listening to a supportive, mixed or challenging music program, which may be a shortened.

3.16 Homework: Continue to reinforce the use of music as a coping skill between sessions for emotional regulation and relaxation.

3.17 Homework: Begin to connect client to external resources for connection and continued musical development through community choirs, veteran-run songwriting groups, etc...

3.18 Summary and Closure with the research therapist: The final session is used to synthesize work accomplished during the series and to make a plan for support and follow-up services if needed.

3.19 Summary and Closure: If the therapist has the technology skills required, creating a music video with the client of his/her images, musical excerpts and subtitles is an effective way to synthesize the work and serves as a transitional object and reminder for the client.

Guidelines for progressing through the stages:

The beginning sessions are structured to highlight the relationship to music and to identify and deepen a connection to inner resources. The beginning sessions are also a time of actively learning how to utilize this process outside of the therapy sessions. Being able to use music to enhance inner resources provides a concrete tool to decrease arousal of the nervous system and cope with symptoms in between sessions.

The middle working sessions are structured to continue enhancement of inner resources while moving into more issue-oriented work as tolerated. Sessions would include IO-MI and IO-GIM sessions as well as RO-MI and RO-GIM as needed. Returning to RO sessions may be indicated if there is an increase of PTSD symptoms or other signs that the client is having difficulty managing IO work. It is also possible to work in a RO and IO manner in the same session.

The final working sessions are structured to continue to enhance a connection to music and inner resources, continuing IO work and adding more open TO-MI and TO-GIM sessions as tolerated with an intention of identity exploration and community re-connection.

It is important to recognize that the level of practice in a session is the intention of the therapist, but not always the result of the client's work. A client may engage in a RO session but develop insight regarding an issue during the process (Summer, 2009). In this way, it is not a completely demarcated practice of three levels of working. The session can be structured at a certain level to encourage a level of working that matches the corresponding Herman stage but we cannot control the inner process of the client.

The therapist in collaboration with the client will determine when to move into the next stage. The suggested time frames are based on outcomes from the feasibility study as well as informed by the structure of CPT, which works in a 10 to 12-week time frame. The process is not linear; however, the client must be able to work on a RO level, which is more contained, before moving into IO or TO level work. Appendix A.2 contains a form that will be used in the RCT in order to help therapists and the principal researcher document the continuum process that is being used as well as the corresponding Herman stage.

Addressing an Increase in Symptoms

When a client shows an increase of symptoms or other signs of distress during a session, the first priority is to shift the focus to decreasing the symptoms and increasing a sense of safety in the moment. Such incidences may be, but are not limited to: increased arousal of the nervous system, being overwhelmed by an emotional response, a dissociative response. In the feasibility study, there were times when a client could tell me they were feeling overwhelmed or panicked. Other times, I could assess signs through their breathing patterns, tone of voice, or body posture before they reported the symptom. If I perceived signs of distress, I checked it out with them verbally to see if they needed to pause and address them. In my experience in the study, these symptoms occurred during verbal interactions- usually during the prelude time, and not during the music listening time; it is possible though for an increase of symptoms to occur during the music listening. The following is a list of suggestions for working with a client through a time of overwhelming distress.

- Bring the attention to the body and physical sensations

- Focus on breathing

- Do something to engage the body such as stretching

- Shift to a music and relaxation intervention

- Draw attention to inner resources, if they are aware of them, or help them to become aware of them.

- If during the music in a GIM method, use more directive guiding to help them find a safe place/ image.

- Shift to a RO-MI approach.

- Keep the focus in the present

Many clients will have an idea of how they have successfully worked through these moments in the past, so having a conversation early on, such as during the first interview session will help the therapist proceed with the right intervention in that moment for that particular client.

Once the time of distress has passed, discuss with the client what was helpful or not during the occurrence and reinforce ways they can continue to practice coping skills at home.

The therapist and client can process together how to move forward; for instance, it may be indicative of a need to slow down the therapy process and return to a previous level/ stage of working, remembering that the 10-12 week time frame is a guideline but it is not necessary to complete all 3 stages in that time. Some clients may need to work at a resource-oriented level for all 10 weeks.

Appendix A.2 Therapist Post-session form

Session Form for research study (To be completed by therapist after each session)

Participant Number _____

Session # _____

Session Date _____

In the following, please choose one of the options:

This session was a:

_____	Music Imagery Session
_____	GIM session

I would consider this session to be:

_____	Resource Focused
_____	Issue Focused
_____	Exploratory (unfocused)
_____	Some combination (please list combination_____)

I would consider this client in this session to be working in (these are from the manual stages):

_____	Stage One: Safety and Stabilization
_____	Stage Two: Remembrance and Mourning
_____	Stage Three: Reconnection
_____	Other (explain _____)

Music was:

_____	chosen by the client from client's music collection
_____	chosen by the client from therapist's music collection
_____	chosen by the therapist from client's music collection
_____	chosen by the therapist from therapist's music collection
_____	chosen together (explain _____)

Music used (please note if pieces were repeated, may also list a program if from a GIM program):

_____
_____
_____
_____

Other creative modalities used in the session (please note if it was during the music or after as part of the processing)

____	Mandala or other art work
____	Creative Writing/ Journaling

___   Dance/ Movement
___   Active music making
___   Other (please list_____)

Content was best described as:
_____The here & now of the session
_____The last session
_____Recent events
_____Past events
_____ Some combination (explain _____)

Please summarize in 2-3 sentences the main focus of the session and please make any note of how this is situated in the overall client process and progression through the session series.

If the client titled the session or the art work, please include that here as it will be helpful for the optional video subtitles.

Any other notes you feel would be useful (especially pertaining to the decision making process during the session).

Appendix B: Article

Link to published paper: https://doi.org/10.1016/j.aip.2017.05.003

Contents lists available at ScienceDirect

The Arts in Psychotherapy

ELSEVIER

Research Article

Guided Imagery and Music with female military veterans: An intervention development study

CrossMark

K. Maya Story[*,1], Bolette Daniels Beck

Aalborg University, Denmark

ABSTRACT

Military Sexual Trauma (MST) is an issue among returning veterans that causes a significant amount of distress with a high occurrence of Post-Traumatic Stress Disorder (PTSD). There is a need to evaluate and develop treatment protocols for MST related PTSD.

Five veteran women participated in up to 10 music and imagery sessions and modified Guided Imagery and Music (GIM) and a post session focus group over the course of 3 months. Sessions were audio recorded and analysed through a process of meaning condensation to identify how female veterans experienced specific components of a continuum of Music Imagery and Guided Imagery and Music sessions. The PTSD checklist (PCL-5) was used to assess changes in symptom severity.

Participants reported using music and imagery to manage PTSD symptoms and several themes were identified related to the experience of GIM. Three out of four scored clinically significant reductions and one out of four scored a reliable reduction of PTSD symptoms.

Participants shared common themes in their experience of GIM sessions that led to development of a stronger protocol for a follow up study. This study adds to the understanding of female veterans with MST related PTSD and their experience with GIM as a treatment modality.

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Background

The U.S. Department of Defense has reported that women fill over 15% of the total military personnel, (DoD, 2015) and women are the fastest growing demographic among veterans (Women's Veterans Task Force, 2012). Men and women return from active military service with many challenges connected to re-integration in civilian life and stressful military experiences during deployment, but there has been increased attention to the needs of women as their numbers grow and specialized services have been lacking (Crompvoets, 2011; Middleton & Craig, 2012). Female Veterans receiving care in the U.S. have identified stressful experiences in the military as stemming from combat, military sexual trauma, and separation from family and support resources (Mattocks et al., 2012).

Military Sexual Trauma (MST) is a term used by the VA (Department of Veterans Affairs) to describe sexual assault or repeated sexual harassment encountered during time in the military (Koo & Maguen, 2013). Statistics in the U.S., based on care received through the VA Hospital, indicate that approximately one in every five women have screened positive for MST. However, there is a wide range of reported prevalence as indicated from a 2011 literature review (Allard, Nunnink, Gregory, Klest, & Platt, 2011) that found MST rates of 22%–45% and a meta-analysis that found rates of 38% (Wilson, 2016). Often rates are based on MST screening that has been mandatory in the VA since 1999, but actual numbers are thought to be much higher due to female veterans not accessing the VA for services. Barriers to care and a lack of reporting are due to: fear or shame, veterans' beliefs about mental health care, difficulty navigating the VA system, concern regarding not fitting in at the VA as a woman, military culture of power differentials and loyalty to unit (Koo & Maguen, 2013). There are high rates of distress associated with MST, the most common forms being Post Traumatic Stress Disorder (PTSD), depression, anxiety, and poor functioning (Allard et al., 2011). Women who have experienced MST are four times more likely to have PTSD (Women's Veterans Task Force, 2012) and comorbidity is seen at high rates especially depression, anxiety, substance abuse, and eating disorders (Cloitre, Jackson& Schmidt, 2016; Koo & Maguen, 2013).

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Appendix B.2 Co-Author statement

CO-AUTHOR STATEMENT

AALBORG UNIVERSITY
DENMARK

Faculty Office of Humanities and Social Sciences
Case No.: 2018-569-00023
Document no.: 110643 version 25/01/2018

Title of paper	Guided Imagery and Music with female military veterans: An intervention development study.
Journal	The Arts in Psychotherapies, 55, 93-102. https://doi.org/10.1016/j.aip.2017.05.003
Published	September 1, 2017

Description of PhD student's contribution
Name of PhD student: Maya Story

First author. Planned the study, carried out the data collection and analysis. Drafted the manuscript, and wrote the article in collaboration with co-author. Read and approved the final manuscript.

Description of co-author's contribution
Name of co-author: Bolette Daniels Beck

Contributed to the writing and content of the article. Read and approved the final manuscript.

Description of co-author's contribution (if applicable)
Name of co-author:

PhD student			
I hereby declare that the above information is correct	Yes ☐	No ☐	

7/20/2018
Date   Signature

Co-author	Bolette Daniels Beck		
I hereby declare that the above information is correct	Yes ☒	No ☐	

6/6-2018
Date   Signature

Co-author			
I hereby declare that the above information is correct	Yes ☐	No ☐	

Date   Signature

Co-author			
I hereby declare that the above information is correct	Yes ☐	No ☐	

Date   Signature

Co-author			
I hereby declare that the above information is correct	Yes ☐	No ☐	

Date   Signature

Page 2 of 2

Appendix C: Institutional Review Board Materials
Appendix C.1 Letter of IRB Approval

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MARYLHURST
UNIVERSITY

You. Unlimited.

December 31, 2014

Dear Maya Story,

The Marylhurst University Institutional Review Board has reviewed and approved your research proposal, "Guided Imagery and Music as a Treatment Modality for Female Veterans with Post-traumatic Stress Disorder and Military Sexual Trauma: A Feasibility Study". You may now proceed with your research.

Best,

Laura Beer, PhD, MT-BC, ACMT
Chair, Marylhurst University Institutional Review Board

Appendix C.2 Film contract and consent

The person in charge of this project is K Maya Story. Throughout this form, this person will be referred to as the "director."

Purpose of the project

My name is Maya Story. I am currently working on my doctorate degree in Music Therapy at Aalborg University. I am interested in the effectiveness of guided imagery and music as a treatment option to help with symptoms of post-traumatic stress disorder, specifically related to women exposed to sexual trauma, including military sexual trauma. As part of this research, a short documentary has been filmed to tell the story of one participant's experience with the musical process.

Informed consent has previously been signed related to the research. This second informed consent is related to specifics around dissemination of the material and confidentiality.

Overall Aim: To present Trish Woodbury's musical development/ identity and how it has overlapped with her participation in the GIM research project.

> Functions of the film:
> To raise awareness about the method
> To raise awareness about the issues facing veterans
> To serve as an artifact of an in-depth case study
> To use as a recruitment tool

What is involved in participation?

You previously participated in 10 GIM sessions. As follow up to that work, you have documented your story through filmed narrative accounts, art work, musical compositions, journal entries and a brief demonstration of a therapy session.

Description of the film process

Day one: Trish and Maya met to discuss details of filming and address any concerns.

Day two: Trish and Maya met with the videographer and editor to discuss the project

Day three: Participated in filming from 9 am to approximately 6:30 pm

Day four: Participated in reviewing footage from the filming

Moving forward, the director will work with you and the editor to finalize the film. You are invited to collaborate with the editing to the extent you are comfortable. You will be asked to approve the release of your personal information and your story in the edited versions.

What are the anticipated risks for participation?

Please know that there are minimal risks involved with your participation, and that you have the right to withdraw from participation in this project at any time. Potential risks include:

Participation in this study involves a potential loss of confidentiality. Please know that the director has taken measures to protect your identity and materials during the filming and editing process. These are detailed below under the heading "how will my information be kept confidential." Once you approve of the content, your story and identity may no longer be confidential.

The content for this film is almost entirely based on your story and reflections. This is very personal information and may make you feel uncomfortable. You do not have to release this film in any manner or to any venues that is uncomfortable. Details from this project will be released during a public presentation at Aalborg University in Denmark as part of a PhD defense. Should you choose to withdraw participation in the film, your case will be presented in a confidential anonymous manner through spoken details of the work, and no film will be shown.

You and the director will decide together if, when and where to release the film. Both you and the director must approve of any release of the film in any manner.

Are there any benefits to participating?

There is no financial compensation or benefits. This film has the potential to raise awareness and increase treatment options for individuals who have experienced trauma. You may experience some sense of empowerment from participating in the film and telling your story.

How will my information be kept confidential?

- All information gathered for the film, including film footage, still photos and audio files is kept on two locked computers- the director's and the film editor's. For editing purposes, the film will be shared through an online password protected sharing platform. Access to that password will be limited to you, the director and the editor.

- You will be given a copy of the movie and asked permission if you would like to share it and under what circumstances (as detailed above under risks).

I will make every effort to keep your information confidential, however, I cannot guarantee confidentiality. There may be instances where federal or state law requires disclosure of your records.

If, during your participation in this study, we have reason to believe that elder abuse or child abuse is occurring, or if we have reason to believe that you are at risk for being suicidal or otherwise harming yourself, we must report this to authorities as required by law. We will make every effort to keep your research information confidential. However, it may be possible that we have to release your research information. If this were to occur, we would not be able to protect your confidentiality.

The results of this research may be published or used for teaching. Identifiable information will not be used for these purposes without your permission.

Study contact information

If you have any questions about the project, you can contact the director, Maya Story, at kstory3@emich.edu, kmayastory@gnail.com, or by phone at 503-200-0079.

Voluntary participation

Participation in this project is your choice. You may refuse to participate at any time, even after signing this form, with no penalty or loss of benefits to which you are otherwise entitled. If you leave the project, the information you provided will be kept confidential. You may request, in writing, that your identifiable information be destroyed. However, we cannot destroy any information that has already been published.

Statement of Consent

I have read this form. I have had an opportunity to ask questions and am satisfied with the answers I received. I give my consent to participate in this research study.

Signatures

(signed hard copy on file)