

THE BONNY METHOD OF GUIDED IMAGERY AND MUSIC (GIM) AND EATING
DISORDERS: LEARNING FROM THERAPIST, TRAINER, AND CLIENT EXPERIENCES

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by
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Abstract

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The purpose of this study was to explore the use of The Bonny Method of Guided Imagery and Music (GIM) in the treatment of individuals with eating disorders. There has been a recent growth in the literature describing the use of GIM with individuals with eating disorders in a variety of settings. Two online surveys were distributed to three groups of individuals: GIM practitioners, GIM primary trainers, and individuals who have experienced an eating disorder who have participated in GIM sessions. Results indicated that GIM practitioners who have worked with individuals with eating disorders have employed a number of adaptations or alterations to various aspects of the GIM process including inductions, guiding language, physical environment, and others. Special considerations in assessment and use of GIM, as well as common characteristics that practitioners have found among individuals with whom they have worked were also indicated. While responses from primary trainers were limited, respondents indicated special considerations for individuals with eating disorders that they teach in their

advanced trainings. Responses from clients were also limited, but revealed information about the individuals' courses of GIM treatments and perceptions about helpfulness of participating in the GIM process.

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CHAPTER 1

Introduction

Taking in nourishment through eating is an act that is essential to our health and survival. For the many individuals who have an eating disorder, this act brings great difficulty and distress. Eating disorders are characterized by unhealthy patterns of eating and harmful attitudes toward food, eating, and body image (SAMHSA, 2011). In the United States alone, at least 20 million women and 10 million men will experience a clinical eating disorder at some point in their lives (Wade, Keski-Rahkonen, & Hudson, 2011). Among adolescent females in the United States, eating disorders are the third most common chronic illness (Kalisvaart & Hergenroeder, 2007). While global health reports have historically failed to include eating disorders, the 2013 Global Burden of Disease Study assessed the health impact of anorexia nervosa and bulimia nervosa around the globe and found that both diseases are responsible for significant health loss, disability, and mortality (Erskine, Whiteford, & Pike, 2016). The same report also found an increase in the impact of eating disorders in low and middle-income countries (Erskine, Whiteford, & Pike, 2016). Eating disorders can and do affect individuals around the globe, and include people of all genders, ethnicities, and socioeconomic backgrounds (Academy for Eating Disorders, n.d.-a; Hudson, Hiripi, Pope, & Kessler, 2007).

Eating disorders are complex and serious conditions that affect all aspects of an individual's life, including their physical, mental, and emotional health. Many health professionals consider eating disorders some of the most difficult disorders to treat. In over fifty

percent of individuals with eating disorders, the disorder develops into an enduring and severe stage of the illness, with decreasing response to treatment once the disorder has become severe and enduring (Treasure et. al, 2015). Additionally, while eating disorders can be successfully treated, only about one third of people with an eating disorder ever receive treatment (Hudson et. al, 2007).

Assessment, Characteristics, and Risks of Eating Disorders

The three major eating disorders defined by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, American Psychiatric Association, 2013a) are anorexia nervosa, bulimia nervosa, and binge eating disorder.

Anorexia nervosa. The current diagnostic criteria for anorexia nervosa are summarized as follows: a) a “restriction of energy intake relative to [the body’s] requirements” that leads to a weight that is “less than minimally normal”; b) an intense fear of gaining weight, or persistent behavior that prevents weight gain; c) disturbance in one’s experience of their body shape or weight, “undue influence” of one’s shape or weight on the way one evaluates oneself, or “persistent lack of recognition” of how serious their low body weight is (American Psychiatric Association, 2013b). Individuals may receive a diagnosis of mild, moderate, severe, or extreme anorexia nervosa; severity is determined primarily by current body mass index, but may also be determined by symptoms, degree of disability, and need for supervision (American Psychiatric Association, 2013b).

The nutritional deprivation associated with anorexia nervosa can cause numerous medical and somatic complications, including muscle weakness, cardiac and vital sign abnormalities, skin problems, circulation problems, peripheral edema, constipation and other digestive problems, amenorrhea in females, and loss of bone mineral density, along with other complications

(Gilbert, 2014). While some physiological effects are reversible with treatment, others, such as loss of bone density, are not reversible with treatment (American Psychiatric Association, 2013b). According to Arcelus, Mitchell, Wales, and Nielsen (2011), anorexia nervosa has one of the highest premature mortality rates of any psychiatric disorder.

Individuals with anorexia nervosa often display a strong desire to control their environment, rigid thought patterns, and obsessive-compulsive features both related and unrelated to food (American Psychiatric Association, 2013b). Individuals with anorexia nervosa frequently report the presence of an anxiety disorder or anxiety symptoms prior to the onset of anorexia (American Psychiatric Association, 2013b). Although, anorexia nervosa commonly begins during adolescence or young adulthood, cases of later onset do occur (American Psychiatric Association, 2013b).

Bulimia nervosa. The current diagnostic criteria for bulimia nervosa are summarized as follows: a) recurrent binge eating episodes, which are characterized by the consumption of an amount of food that is larger than what most individuals would eat in a similar period of time, accompanied by a feeling of lack of control; b) recurrent behaviors to compensate for binge eating and to prevent weight gain, including fasting, self-induced vomiting, use of diuretics or laxatives, and excessive exercise; c) the binge eating and compensatory behaviors occur an average of once a week for 3 months; d) undue influence of one's shape or weight on the way one evaluates oneself; e) behaviors do not occur exclusively during episodes of anorexia nervosa (American Psychiatric Association, 2013b).

Although individuals with bulimia nervosa often are of average or higher than average bodyweight, significant health concerns occur as a result of the cycle of bingeing and purging behavior that is characteristic of this eating disorder (American Psychiatric Association, 2013b).

According to the National Eating Disorders Association (n.d.), health consequences may include electrolyte imbalances that can affect heart function, inflammation and damage of the esophagus and the entire digestive tract, dental problems, gastrointestinal problems and stomach pain, and pancreatic function. Like anorexia nervosa, bulimia nervosa also commonly begins during adolescence or young adulthood (American Psychiatric Association, 2013b).

According to the *DSM-5*, individuals who experienced physical or sexual abuse in childhood are at increased risk for developing bulimia nervosa (American Psychiatric Association, 2013b). Individuals with bulimia nervosa often have co-occurring experiences of depressive symptoms and disorders, anxiety symptoms and disorders, and substance abuse (Berkman, Lohr, & Bulik, 2007).

Binge eating disorder. The current diagnostic criteria for binge eating disorder are summarized as follows: a) recurrent binge eating episodes, which are characterized by the consumption of an amount of food that is larger than what most individuals would eat in a similar period of time, accompanied by a feeling of lack of control; b) binge-eating episodes are associated with three or more of the following characteristics: eating more rapidly than normal, eating until uncomfortably full, eating large amounts when not physically hungry, eating alone because of feeling embarrassed, feeling depressed, disgusted with oneself, or guilty after eating; c) significant distress because of presence of binge eating; d) occurrence of an average of least once a week for three months; e) behaviors do not occur exclusively during episodes of anorexia nervosa and are not associated with the compensatory behaviors present in bulimia nervosa (American Psychiatric Association, 2013b).

Thornton et al. (2016) found that individuals who have experienced binge eating disorder at any point in their life are at increased risk for an array of comorbid health conditions. Binge

eating disorder has been found to be strongly associated with diabetes and other metabolic issues as well as circulatory diseases, including high blood pressure. While some individuals who have binge eating disorder are also diagnosed with obesity and experience increased negative health risks, Thornton et al. found that many of the somatic comorbid conditions occurred in individuals with binge eating disorder independent of obesity. Similar to anorexia nervosa and bulimia nervosa, binge-eating disorder also typically has onset in adolescence and early adulthood, although for reasons unclear individuals with binge-eating disorder who seek treatment are often older than those with other eating disorders who seek treatment (American Psychiatric Association, 2013b).

The Bonny Method of Guided Imagery and Music

The Bonny Method of Guided Imagery and Music (GIM) is a depth-oriented approach to music psychotherapy that “combines the inherent structure, movement, and [energy] of music with an individual’s own creative process of imagery” (Ventre, 1994). With roots in humanistic, experiential, Jungian, and transpersonal models of psychotherapy, the method operates strongly on the premise that music is able to “initiate movement in the psyche, reveal realms of consciousness, evoke imagery, and promote integration of mind, body, and spirit” (Clark, 2002, p. 23). Created, developed, and pioneered by Helen Bonny beginning in the 1970s, the method has since been carried forward by therapists, practitioners, and educators in a variety of settings and disciplines worldwide. GIM sessions are dyadic in format and typically consist of multiple parts: (a) a preliminary conversation or *prelude*, (b) the induction, (c) the music listening period, and (d) the processing period or *postlude* (Ventre, 2002).

The preliminary conversation, often called the *prelude*, is similar to the beginning of a verbal therapy session. During this time the client (commonly called the ‘traveler’) checks in

with the therapist (commonly referred to as the ‘guide’) about thoughts, events, feelings, experiences, issues, or anything they wish to share. The client’s verbal and nonverbal cues are key, and guide the therapist’s choices in the session (Ventre, 2002). Based on the focus that arises in the preliminary conversation, the therapist selects and guides the client through an induction to assist the client in shifting to an internally focused state. The induction varies in form and structure, and may include suggestions to aid in relaxation or help focus on bodily sensations or emotions, engaging “both the body and the mind” (Ventre & McKinney, 2015, p. 199). Often, therapists will suggest a ‘focus image’ as a starting place for clients as the next part of the session, the music listening, begins. During the music listening, specifically programmed classical music is selected by the therapist to stimulate a “dynamic unfolding of inner experiences” that allows the client to explore and integrate thoughts, feelings, bodily sensations, memories, and personal and transpersonal relationships (Association for Music and Imagery, 1990; Ventre, 1994). As the client listens to the music, they report their experiences to the therapist. An active dialogue between the therapist and the client is maintained throughout the session to help the client engage fully with the experience. During the music listening, the therapist typically keeps a written transcript of the session. Following the music listening, the therapist assists the client in returning to a more ordinary state of consciousness, in which the client can review their personal experience, often verbally or by creating art (Ventre, 2002). Key components of the Bonny Method include (a) an altered or non-ordinary state of consciousness, (b) imagery, (c) the music, and (d) the role of the therapist (guide).

Altered or non-ordinary states of consciousness. The inward focus in the process of a GIM session is supported by entrance into an altered or non-ordinary state of consciousness, which is characterized by “qualitative and quantitative shifts in the perceptions of time, space,

and energy” (Ventre, 2002, p. 32). Taylor (1995) emphasized that non-ordinary states of consciousness are commonly experienced, but are not commonly named as such and are “important to our functioning as human beings” (p. 12). Experiences such as “daydreaming, intense concentration, prayer, meditation,...sleep, dreaming, [and feelings of] creativity [and] unity” are common experiences of altered states (Ventre, 2002, p. 32). In GIM, an altered state supports the emergence of client images and experiences. The induction, which often includes relaxation and focusing of attention, functions to assist clients to enter into an altered state of consciousness. Music also plays a key role in helping the client to “relinquish usual controls” and enter more readily into sustained states of non-ordinary consciousness (Bonny, 2002, p. 86).

Music. Music is central to the process of the Bonny Method. Specially designed sequences of recorded music called ‘programs’, which consist primarily of music from the Western classical canon, are used in this method. Over a period of 16 years, Helen Bonny developed the original 18 programs of music that are considered to be at the core of practice in the Bonny Method (Grocke, 2002b). A number of other GIM therapists have developed additional programs of music. Within the programs, musical elements such as pitch, rhythm, tempo, melody, harmony, and instrumentation create opportunities for a range of experiences within the music. The programs are organized “to allow for a natural beginning, middle, and end with opportunities for tension and release, conflict and resolution” (Ventre & McKinney, 2015, p. 199). Adjustments or changes to programs of music may be made in the course of the session to “match the affect, energy, and emerging imagery of the client” (Ventre & McKinney, 2015, p. 199).

The music serves to “stimulate the flow and movement of the imagery experience” and also to contain and provide appropriate boundaries or spaciousness for the client’s experience

(Grocke, 2002a, p. 93). Many consider the music to be the primary therapist and catalyzing agent within the process (Ventre, 2002). The therapist/guide must know the music intimately both through study and personal experiences with the music. In the session, the therapist selects music that reflects the needs of the client/traveler as well as the client's readiness to enter into experiences that may be evoked by the music (Bonny, 2002). As mentioned previously, the music also serves a primary role in sustaining an altered state of consciousness; Bonny (2002) described music as a vehicle of exploration, an elevator "taking you from floor to floor...allow[ing] you to explore new levels of awareness" (p. 87).

Imagery. The process of the Bonny Method is rooted in the premise that all healing comes from within; as such, an important aspect of the process is that all imagery is generated by the client (Bonny, 2002). An "exploration of consciousness", the GIM process allows opportunities for the wisdom of the individual's psyche to bring forth images and experiences that are relevant and in service of growth and wholeness (Bonny, 2002). Experiences of imagery may bring to light intrapersonal truths and conflicts, interpersonal dynamics and processes, and opportunity to connect to the transpersonal (Ventre, 2002). A broad definition of imagery is adopted; imagery may include visual imagery, other sensory imagery such as sounds, tastes, and smells, affective and emotional experiences, somatic experiences and bodily sensations, kinesthetic imagery or a sense of movement through space, or imagery based in memories or lived experiences (McKinney & Ventre, 2015).

Role of the therapist/guide. A primary role of the therapist (guide) is to encourage and support the "unfolding" of the client's experience in the imagery (Meadows, 2002). Verbal interventions are used to help support, clarify, and offer opportunities for the client to engage more deeply with their imagery experiences. The therapist's role is not as interpreter of the

client's experiences; rather the therapist helps the client to create their own meaning and understanding of their experiences (Meadows, 2002, p. 67). While the therapist has a responsibility to create a safe container for the client's experience, the therapist must place trust in the innate wisdom of the client's unconscious process, the function of the programs of music, and in their own intuitive responses supported by their intensive training and personal experiences (Bonny, 2002).

Therapists or practitioners who use the method undergo extensive training within a program approved by the Association for Music and Imagery. Training programs in the Bonny Method are offered around the world, and currently include at least 21 programs in the United States, Australia, Canada, Denmark, Germany, Singapore, South Africa, Sweden, and the United Kingdom (Association for Music and Imagery, n.d.-a). While the curricula of the training programs all vary slightly in content and approach, most programs are completed in 3 to 4 years, and all adhere to the core elements of training in the method, which broadly include knowledge of metaphoric imagery, non-ordinary states of consciousness, music, and experiential training in the use of the Bonny Method (Association for Music and Imagery, 2004, 2015a, in press). Commonly included in training is study of the historical development of the Bonny Method, published clinical research on the use of the Bonny Method with various populations, psychological theories, psychopathology, transpersonal concepts, music history and literature, symbology, myth and archetype, ethics, therapeutic dynamics, and counseling skills (Association for Music and Imagery, 2015b). Training experiences commonly include a combination of didactic and experiential learning, personal growth experiences, readings and written reports, and supervised clinical experience (Association for Music and Imagery, 2015b). Those who complete the training receive the designation of "Fellow of the Association for Music and Imagery; "

according to the Association's website, there are currently at least 280 fellows worldwide (Association for Music and Imagery, n.d.-b).

Purpose

Although The Bonny Method of Guided Imagery and Music was initially developed as a process for exploring consciousness with healthy adults, numerous applications for the use of the method in the treatment of psychological challenges have emerged, with a substantial body of supportive research literature (McKinney & Honig, 2016; Ventre & McKinney, 2015). Others have considered the prevalence and negative health effects of eating disorders and have used GIM to treat individuals with eating disorders (Clark, 1991; Heiderscheid, 2013, 2015, 2016b; Justice, 1994; Noer, 2015; Papanikolaou, 2015; Pickett, 1991; Trondalen, 2016). Still, the body of research is relatively narrow in regards to GIM and eating disorders. The purpose of this study is to explore GIM in the treatment of individuals with eating disorders in order to widen the body of research related to GIM and eating disorders and to help practitioners gain awareness and sensitivity in working with people diagnosed with eating disorders.

CHAPTER 2

Review of Literature

The following section describes recent changes to diagnostic criteria for eating disorders, as well as common therapeutic challenges faced by individuals with eating disorders. Factors that have been found to protect against the development of and negative impacts of eating disorders are also described.

Diagnostic Criteria of Eating Disorders

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5;* American Psychiatric Association, 2013a) introduced both major and minor changes in the categorization and diagnostic criteria for feeding and eating disorders. The previous edition of *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*, American Psychiatric Association, 2000) specified only two major eating disorders, anorexia nervosa and bulimia nervosa. Based on these diagnostic criteria, individuals who had clinically significant eating disorders but who did not meet the criteria for either anorexia or bulimia were assigned the formal diagnosis of eating disorder not otherwise specified (EDNOS); (Walsh, Attia, & Sysko, 2016). The *DSM-5* introduced the new clinical diagnosis of binge-eating disorder. Additionally, small but important changes were made in specific diagnostic criteria for anorexia nervosa and bulimia nervosa.

In the *DSM-IV-TR*, (American Psychiatric Association, 2000), feeding disorders were described in the section ‘Disorders Usually First Diagnosed in Infancy, Childhood, or

Adolescence'. In the *DSM-5* eating disorders and feeding disorders, including the newly named and redefined avoidant/restrictive food intake disorder, rumination disorder, and pica, were combined into one chapter. These changes highlight the reality that eating and feeding disorders can occur across the lifespan (Walsh, Attia, & Sysko, 2016). For the purposes of this paper, focus will be on anorexia nervosa, bulimia nervosa, and binge eating disorder.

Common Therapeutic Challenges of Individuals with Eating Disorders

Interoceptive awareness. The connection between mind and body is often greatly compromised in the life of an individual with an eating disorder. A low or compromised level of *interoceptive awareness* is common in individuals with eating disorders (Boswell, Anderson, & Anderson, 2015). Interoceptive awareness is described in research literature as the ability to identify physiological sensations (bodily cues) as well as emotional states. Individuals with eating disorders may have difficulty accurately identifying somatic experiences such as hunger or satiety as well as affective states such as anxiety, sadness, or anger (Boswell, Anderson, & Anderson, 2015). Merwin, Zucker, Lacy, and Elliot (2010) highlighted an important aspect of interoceptive awareness: as a clinician it is important to attempt to differentiate whether one is experiencing *lack of clarity* about what somatic or affective state one is experiencing or if they are experiencing *non-acceptance* (whether from fear, guilt, or any other emotion or cue) of their internal states. Merwin et al. also noted that individuals might experience *both* lack of clarity and be non-accepting of internal states.

A related and overlapping term relevant to individuals with eating disorders is *alexithymia*, which is characterized by “difficulty identifying feelings and differentiating between feelings and body sensations, difficulties communicating feelings, lack of fantasy, and a concrete cognitive style focused in the external environment” (Nowakowski, McFarlane, &

Cassin, 2013, p. 1). A critical review of literature related to alexithymia in individuals with disordered eating revealed that a majority of studies focused in this area have found higher levels of alexithymia in individuals with eating disorders and disordered eating habits when compared to control groups of healthy individuals (Nowakowski, McFarlane, & Cassin, 2013). Theorists have postulated that maladaptive eating patterns are commonly used as a way to cope with or avoid experiencing emotions. Early childhood experiences in which individuals learn that emotions are unacceptable may contribute to the development of alexithymia, and furthermore may contribute to disordered patterns of behavior and coping in response to affective states.

Emotional regulation. If an individual has difficulty identifying and connecting to affective states, it would follow that they may also lack the tools and ability to regulate their emotional experiences. Emotional regulation is the way in which an individual responds to and copes with internal experiences of emotion. Healthy functioning of emotional regulation involves responding to a range of emotions in an adaptive and flexible way, and involves accepting an emotion and engaging in non-harmful behaviors to cope with the emotion (Gratz & Roemer, 2004; Paivio & Pascual-Leone, 2010;). Challenges in emotional regulation may include the presence of maladaptive strategies, the lack of adaptive strategies, or a combination of both (Danner, Sternheim, & Evers, 2014). Brockmeyer et al. (2014) found that difficulties with emotional regulation appear across the whole spectrum of eating disorders, including in individuals with anorexia nervosa, bulimia nervosa, and binge eating disorder. The maladaptive emotional regulation strategy of emotional suppression has been found to be common among individuals with eating disorders (Danner, Sternheim, & Evers, 2014). Researchers have suggested that lack of emotional regulation skills may play a particularly relevant role in binge

eating disorder, as episodes of binge eating appear to be triggered by “an immediate break-down of emotion regulation” (Munsch, Meyer, Quartier, & Wilhelm, 2012, p.118).

Body image disturbance. Disturbance of body image is considered to be a consistent and persistent characteristic of individuals who have eating disorders (Khodabakhsh, Borjali, Sohrabi, & Farrokhi, 2015). Indeed, disturbance in one’s experience of their body shape or weight or “undue influence” of one’s shape or weight on the way one evaluates oneself are current diagnostic criteria for both anorexia nervosa and bulimia nervosa (American Psychiatric Association, 2013b). Conceptualizations of body image historically have had a representational emphasis, considering body image as “a mental image of one’s body that could be captured in an objective way, almost as a picture” (Gaete & Fuchs, 2016, p. 19). However, researchers have, without general consensus, expanded the concept of body image to include factors such as kinesthetic feedback about bodily experiences, historical attachment factors, interpretation of interoceptive stimuli, attitudes about bodily experiences, and experiences of emotion in the body (Freedman, 2002; Gaete & Fuchs, 2016). In specific regard to individuals with eating disorders, Gaete and Fuchs (2016) highlighted the concept of *emotional bodily experience*, and proposed that disturbance in “body image” is really disturbance of *embodiment*; that is, negative objective representation of the body may result from a neglect of internal signals and emotions and result in an attempt to control internal experiences by focusing on the body as an external object.

Protective factors. Many researchers have begun to study variables that protect against eating disorders and distress related to eating and body issues. Tylka and Kroon Van Diest (2015) undertook a thorough review of literature and found the following variables to be protective factors related to the individual: (a) body appreciation, (b) awareness and responsiveness to internal hunger and satiety cues, (c) participation in sports that require neither

a lean body nor elite skills, (d) high self-esteem, (e) self-compassion, (f) ability to regulate one's emotions, (g) yoga practice, (h) typical neurobiological functioning, (i) a sense of autonomy, (j) relationship with a higher power, and (k) persistence. Cultural and environmental protective factors included (a) positive family relationships, (b) regular family meals, (c) education about negative effects of media, (d) exposure to voices in opposition of societal appearance ideals, (e) acceptance of one's body by family and community, and (f) feminist influences (Tylka & Kroon Van Diest, 2015). Tileston (2013) took a positive view of personality traits that are common in individuals with eating disorders and suggested that the creativity, intelligence, and resourcefulness required to maintain and survive their eating disorder could be harnessed to promote health and recovery (p. 406).

Treatment of Eating Disorders

Although federal law in the United States requires equality in medical benefits for eating disorders, eating disorders are often excluded from mental health parity, resulting in undercoverage of vital psychological care for those with eating disorders (American Medical Association, 2016). Although the recent Patient Protection and Affordable Care Act (2010) in the United States requires that mental health treatment services be included in health plans, the parity provisions fail to apply to all diagnoses outlined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; effectively, each state and the insurance carriers within the state are able to create their own criteria for treatment of eating disorders (National Women's Law Center, n.d.). This discrimination does appear to be happening, as the National Women's Law Center (n.d.) shared data from 2010 that showed only 10 states within the U.S. required health plans to cover eating disorders on the same basis as other mental health disorders. In December 2016, the *21st Century Cures Act* was passed by Congress and signed into law by Barack Obama

(Eating Disorders Coalition, 2016). Although the legislation has a broad focus on many public health concerns, it includes provisions from the *Anna Westin Act*, which specifically addresses the growing impact of eating disorders in the United States; the act exists to improve healthcare coverage for the treatment of eating disorders and to clarify mental health parity, as well as help provide resources for public and professional education about eating disorders, prevention, and early intervention. (Eating Disorders Coalition, 2016). This is the first legislation in the United States specifically designed to help individuals with eating disorders (Eating Disorders Coalition, 2016).

Individuals with eating disorders often have complex histories and varied symptoms (Brown, Schebendach, & Walsh, 2016). According to the Academy for Eating Disorders (n.d.-b), general consensus among those who treat individuals with eating disorders indicates that effective treatment must be multidisciplinary; treatment teams often include physicians, nurses, dietitians, psychologists, psychotherapists, and other mental health professionals. Treatment typically is determined based on level of care needed; levels of treatment may include outpatient treatment, day-hospital treatment, hospitalization, residential treatment, or any combination thereof (Academy for Eating Disorders, n.d.-b). McFerran and Heiderscheit (2016) noted that, because there is no comprehensive agreement among researchers and clinicians about etiology of eating disorders, treatment varies depending on the orientation of the clinician and their belief about the cause of the eating disorder. Comorbid diagnoses are common for individuals with eating disorders; bipolar disorders, depressive disorders, anxiety disorders, and substance abuse disorders commonly co-occur with eating disorders (American Psychiatric Association, 2013b). Individualized treatment of co-occurring challenges is often necessary for effective treatment;

McFerran and Heiderscheit asserted that because of frequent comorbidity and complex etiology of eating disorders, an eclectic and individualized approach is indicated.

Experiential and creative arts therapies in the treatment of eating disorders. As the demand for effective treatment for individuals faced with the complexity of an eating disorder grows, the role of the creative arts and experiential therapies in treatment is gaining momentum (Heiderscheit, 2016). *Creative arts therapies* refers to the individualized professions of art therapy, music therapy, dance/movement therapy, poetry therapy, and drama therapy. Hornyak and Baker (1989) define *experiential therapy* as the following:

Treatment techniques, based on psychological principles, that are developed and used with the specific intention of increasing clients' present awareness of feelings, perceptions, cognitions, and sensations; that is their in-the-moment experience...[that] usually involves some degree of action on the clients' part, either physical or imagined...[and] typically include expressive or creative arts therapies, which utilize art, dance, music, poetry, and drama...[and] hypnosis, family sculpting, and structured eating activities. (p. 3)

The authors asserted that experiential methods of therapy may be particularly helpful to individuals with eating disorders by assisting individuals to “become aware of, understand, claim, and integrate” somatic, emotional, and cognitive internal experiences, from all of which individuals with eating disorders are commonly disconnected (p. 2). According to Hornyak and Baker, experiential therapies also support relationship development, both within and outside of the therapeutic relationship, as individuals learn that they can explore and reveal challenging aspects of themselves in a healthy way.

Frisch, Franko, and Herzog (2006) conducted a survey of residential eating disorder treatment programs and found that creative arts therapies are consistently employed in some way; all of the programs that responded to the survey (19 of 22) reported at least once weekly inclusion of an arts-based treatment, many with a very high level of client participation. Over a quarter of the programs surveyed (26.32%) offered creative arts therapy daily (Frisch, Franko, & Herzog, 2006). Programs reported effectiveness of arts-based therapies for individuals for whom verbal-focused therapy was challenging, as well as effectiveness of arts-based therapies in providing opportunities for self-exploration, opportunities to work creatively with therapeutic issues, and opportunity for healthy emotional expression. Heiderscheit (2016) asserted that while experimental research about creative arts therapies in the treatment of eating disorders is limited, a wealth of qualitative inquiries and case studies strengthen the case that creative arts therapies can “meet the complex needs of patients [with eating disorders], help to uncover and identify the issues underlying [the eating disorder], provide different ways of expressing difficult and unexpressed feelings, and help patients to discover a sense of empowerment” (p. 21).

Music therapy in the treatment of eating disorders: A brief overview. Tileston (2013) reported that, like many mental health professionals, music therapists frequently create therapeutic partnerships with individuals with eating disorders in the context of multidisciplinary treatment in residential, inpatient, and outpatient settings. Using Bruscia’s (1998) classification of methods of music therapy, Tileston (2013) described receptive, improvisational, re-creative, and compositional music therapy approaches to practice in the treatment of individuals with eating disorders. Receptive methods of music therapy described included the use of song listening and lyric discussion to explore therapeutic themes and issues, live and recorded music to support relaxation responses, live and recorded music combined with scripted imagery to

support relaxation responses, and music to stimulate various artistic responses through the use of various media. Improvisational methods included group and individual instrumental and/or vocal improvisation to encourage self-expression, develop mindfulness and self-awareness, build relationships, and explore therapeutic issues. Re-creative music experiences included therapeutic group singing of pre-composed songs and adapted individualized therapeutic music lessons. Compositional music experiences included group and individual songwriting and instrumental composition. The use of the Bonny Method of Guided Imagery and Music (GIM) is mentioned only briefly in Tileston's (2013) comprehensive chapter on the use of music therapy with individuals with eating disorders. This is perhaps because the book in which the chapter is included is intended for music therapists in general, and not individuals with the specialized training required in order to practice the Bonny Method.

According to Tileston (2013), current music therapy practice in the treatment of eating disorders is derived primarily from clinician experience and clinical descriptions; comparatively little efficacy research is available currently. A review of literature reveals that there is recent robust interest in the clinical application and methodology of music therapy in the treatment of adults and adolescents with eating disorders (Baur, 2010; Frederiksen, 1999; Heiderscheid, 2008, 2013, 2015, 2016b; Hilliard, 2001; Krantz, 2007; Lejonclou & Trondalen, 2009; Loth, 2002; McFerran, 2005; McFerran, Baker, Kildea, Patton, & Sawyer, 2008; McFerran, Baker, Patton, & Sawyer, 2006; McFerran & Heiderscheid, 2016; Punch, 2016; Robarts, 2000; Trondalen, 2003, 2004, 2011, 2016; Trondalen & Skårderud, 2007). Primarily through case illustrations, the literature reveals a variety of music therapy approaches including, among others, a resilience-based approach for adolescents that emphasizes the development and use of individualized music-based coping tools (Punch, 2016); receptive and expressive music approaches to promote

health and empowerment (Trondalen, 2016); songwriting, drumming, singing, and lyric analysis from a cognitive-behavioral music therapy approach to support awareness of and shifting of cognitive distortions and eating disorder behaviors (Hilliard, 2001); music composition, improvisation, singing, music listening, movement to music, and creative writing in order support the creation of a “bridge” between mind and body (Lejonclou & Trondalen, 2009; Trondalen & Skårderud, 2007); and music-assisted relaxation techniques, structured music therapy group techniques, and insight-oriented techniques in inpatient treatment (Justice, 1994).

The Bonny Method of Guided Imagery and Music and individuals with eating disorders. Within GIM literature, the earliest mention of the use of the Bonny Method with individuals with eating disorders appears in two chapters of a book of case studies about music therapy practices (Clark, 1991; Pickett, 1991). There has been a recent growth in the literature describing the use of GIM with individuals with eating disorders in a variety of settings (Heiderscheit, 2015; Noer, 2015; Papanikolaou, 2015; Trondalen, 2016). The general approach of GIM practitioners seems to be working with underlying issues that are contributing to the eating disorder, versus treatment of acute symptoms of the eating disorder. Heiderscheit (2015) suggested that some of these underlying issues might include latent or repressed emotions, grief or loss, fear, powerlessness, or past trauma. Within GIM lies the possibility to connect to emotions, connect to physical sensations, and explore issues in a symbolic way. Several existing adaptations and considerations used with individuals with eating disorders have been detailed, and are described below.

Existing individual adaptations of the Bonny Method in the treatment of eating disorders. Examples of adaptations of the Bonny Method in the treatment of eating disorders do exist, although in many cases it appears that the adaptations were made primarily to fit the needs of the

setting versus the specific needs of this population. For example, Heiderscheit (2015) described treatment of individuals with eating disorders receiving care in residential, intensive outpatient, and outpatient levels of care. The settings in which these levels of care were delivered necessitated a shortened session, primarily for billing purposes. The author adapted the traditional Bonny Method format to fit within the 45-50 minute therapeutic hour in order to create a structure and time-period that would be covered by the clients' health insurance plans. Sessions were adapted by using shortened musical selections, shortened preludes and postludes, and by the use of mandalas and journaling between sessions so that clients could continue to work with material that arose in session. In a case study Heiderscheit described a progression of therapeutic intervention, beginning with the use of mandalas and verbal counseling, and progressing to shortened GIM sessions when approved by the client's multidisciplinary treatment team. Additionally, during the course of treatment at an intensive outpatient level of care, the client participated in sessions twice a week, with one session for GIM and the other session for processing. In this way, processes that are typically part of a single session were divided across two sessions in order to fit the billable hour.

In her work with adolescents with eating disorders, Papanikolaou (2015) also used a shortened dyad session format. In addition to shortened programs of music, she described multiple structural adaptations including the following: (a) the use of a clear focus image to provide boundaries within which clients can develop a "sense of personal space" (p. 69), (b) the client sitting in chair before lying down to provide grounding and safety, and (c) the use of body-based relaxation techniques, including deep-breathing and stretching to help "recognize and feel the tension in [the] body" (p. 69). Additionally, Papanikolaou described a sequence of treatment beginning with imaging in silence to shorter musical selections, with the client reporting

experiences following the music. If the client tolerated this process, they were introduced to longer pieces of music and used the simultaneous reporting of experience typical of the Bonny Method. Musical complexity, length, and “container” were considered, with the possibility of the client being exposed to musical selections of increasing complexity and length as therapy progressed (up to about 15 minutes of music). Finally, Papanikolaou encouraged the use of past transcripts of sessions as a client coping tool to use when maladaptive behaviors or difficult emotions resurfaced.

Existing group adaptations of the Bonny Method in treatment of eating disorders. Justice (1994) described a group modification of GIM. Clients participated in several sessions per week as part of an outpatient treatment program. Justice used various types of focus images: (a) a word reflecting a perceived or stated need of the group, (b) a story that the therapist begins and then the group members continue to develop in imagery during the music, and also (c) entire stories or poems read during the music, with the group members drawing afterwards (p. 109). Justice discussed the importance of musical selection in a group setting and asserted that it must be “complex enough to allow each person to move into her own imagination, but simple enough to hold one image and not move the person into many images” (p. 109). Group members were also occasionally involved in selecting music.

Noer (2015) described another group adaptation of the Bonny Method she calls *Breathing Space in Music* (BIM) in work with adolescent clients who have eating disorders as well as with their parents. Her process of BIM appears to be influenced by Körlin’s (2007–2008) *Music Breathing*. In this once weekly group method the focus is on fostering “relaxation and resilience,” learning to better recognize one’s body signals, as well as reducing isolation through the sharing of individual experience with others in a group setting (p. 75). Noer provided two

separate groups in the family-focused treatment: one for adolescents with eating disorders and one for parent of the adolescents. The 50-minute group sessions for adolescents included (a) inductions using movement (sometimes with music), (b) improvised music, (c) guided relaxation and breathwork, and (d) mindfulness techniques. Focus images, when used, either arose from group members or were suggested by the therapist. Music used in the shortened programs contained selections from classical music, jazz, electronica, popular, and film music. The sessions often concluded with “drawing” either in silence or while the music used was repeated (p. 76). In the 50-minute sessions for parents, similar flexibility and variety existed in the form of induction, type of focus image, and musical selections, and often included improvised music by the therapist. Noer considered the flexibility and fluidity of this group adaptation to be key in supporting clients in their ability to “move, experience, tolerate and contain whatever is present” and in providing opportunities for “meaningful expressions of inner life” (p. 79). The offering of adapted group GIM sessions for parents or support figures of those with disordered eating is a unique contribution to treatment in this field.

Adaptations and special considerations in related disciplines. Because creative and experiential therapies frequently provide opportunities for depth material to surface, Hornyak and Baker (1989) discussed the therapist’s responsibility in “assessing the client’s readiness to experience and tolerate” emotions, sensations, and inner experiences that may arise in experiential therapies (p. 3). They emphasized the importance of therapist and practitioner scope of practice, training, competence, and supervision when using experiential methods. As with any type of therapy, experiential therapies are most valuable when “incorporated thoughtfully and skillfully into the context of an ongoing treatment plan and therapeutic relationship” (Hornyak & Baker, 1989, p. 7).

While not referring specifically to GIM, Tileston (2013) noted the importance of therapist mindfulness of language when guiding individuals through relaxation exercises, as language commonly used (e.g., “bring your awareness to your stomach”) may be “triggering” for individuals with eating disorders (p. 408). When referring to the body in relaxation exercises, she recommended using general rather than specific language (“the middle of the body” versus “the belly;” p. 408), and suggested that some body parts, such as “hands, arms, feet, legs, neck, shoulders, face, and jaw,” may be “safer” than other parts of the body (p. 408). When using relaxation exercises with clients, Tileston (2013) emphasized the importance of fostering a safe environment and ensuring that clients feel a sense of autonomy and choice throughout the experience, as well as the importance of the therapist’s assessment of client readiness to participate in such experiences.

In the inpatient treatment of adolescents with eating disorders, Cameron and Kipnis (2016) reported that clients often present with rigid and perfectionist behaviors and thoughts, and suggest that having access to a number of artistic modalities may be helpful when they cannot easily access verbal accounts of their inner experiences. Dean (2013) asserted that cultural factors must be explored in the effective treatment of eating disorders. She suggested that individuals who have experienced cultural clashes or cultural instability may have less stable cultural identities, which could be a contributing factor to their experience of disordered eating; participation in a visual or symbolic process can be helpful in revealing cultural factors at play.

Purpose and Research Questions

The purpose of this study is to explore GIM in the treatment of individuals with eating disorders in order to widen the body of research related to GIM and eating disorders and to help

practitioners gain awareness, skill, and sensitivity in working with this population. The research questions are as follows:

1. How is GIM currently being used to treat individuals with eating disorders?
2. What, if any, adaptations or special considerations are GIM practitioners making in working with individuals who have eating disorders?
3. Are primary trainers teaching any adaptations related to work with individuals with eating disorders?
4. What can be learned from clients who have eating disorders regarding what is helpful and what is a hindrance in therapy using GIM?

CHAPTER 3

Method

This chapter describes the methodology of the study. It includes criteria for the inclusion of respondents, description of the survey instruments, design of the study, procedure, and data collection and analysis.

Respondents

The respondents included three groups of individuals: GIM practitioners, GIM primary trainers, and travelers. All respondents are described below.

GIM practitioners. For the purposes of this study, a GIM practitioner was defined as either (a) a Fellow of the Association for Music and Imagery (AMI) who has completed the AMI-endorsed training requirements and has expertise in The Bonny Method of Guided Imagery and Music (GIM) or (b) an advanced GIM trainee of an AMI-endorsed training program. This inquiry sought participants who have had past experiences working with individuals who have been diagnosed with an eating disorder. GIM practitioners may have used either the individual form of the Bonny Method of GIM, a group form of GIM, a modification or adaptation of the method, or any combination thereof. Respondents in this group were recruited by use of the online directory of AMI-endorsed GIM practitioners, which included Fellows of the Association for Music and Imagery in the United States and in 22 other countries worldwide (Association for Music and Imagery (n.d.-b)).

Of the 249 emails sent to potential respondents to the GIM Practitioner Survey, 3 emails were undeliverable and 17 respondents replied indicating they did not have relevant experience to complete the survey. Out of 229 potential respondents, 11 questionnaires were submitted, resulting in a response rate of 4.8%.

Primary trainers. A primary trainer is an individual who is an AMI Fellow and an experienced GIM therapist who has also met the standards for primary trainer as established by the Association for Music and Imagery (Association for Music and Imagery, 2015b). Primary trainers who offer advanced training in GIM were sought for this survey. Primary trainers were also recruited by use of the online directory of GIM Practitioners (Association for Music and Imagery (n.d. -b)). Of the 11 GIM practitioners who responded to the survey, 27.3% ($n=3$) of respondents additionally identified themselves as primary trainers.

The respondents to the GIM Practitioner Survey (which also included primary trainers) reported an education level of at least a master's degree, with most of the respondents (45.5%) reporting a master's degree in music therapy (see Table 1). All respondents identified as Fellows of the Association for Music and Imagery. Respondents completed their training at 8 distinct GIM training programs including Appalachian State University, Atlantis Institute for Consciousness and Music, the Mid-Atlantic Training Institute, The Danish Bonny Method GIM Institute, The Bonny Foundation, the Therapeutic Arts Institute, and trainings through Kenneth Bruscia and Temple University (see Table 2). Practitioners indicated a range of 2.5–23 years of experience using GIM, with a median of 11 years of experience as a GIM practitioner. All respondents completed their GIM training between the years of 1994 and 2016, with the median completion year of 2006. The majority of practitioners (72.7%) indicated that the primary work setting in which they use GIM is within a private practice, while the remaining respondents

indicated using GIM in an agency or hospital, university or academic setting, or state institution.

(See Table 3).

Table 1

Highest Educational Level Obtained by GIM Practitioners

Current Study (<i>n</i> = 11)		
Degree Type	Frequency	Percentage
Master's Degree in Music Therapy	5	45.4%
Doctoral Degree in Music Therapy	3	27.3%
Master's Degree in Other Discipline	2	18.2%
Doctoral Degree in Other Discipline	1	9.1%
Bachelor's Degree	0	0.0%
Other	0	0.0%
Total	11	100%

Table 2

GIM Training Programs in which Respondents Trained

Current Study (<i>n</i> = 11)		
GIM Training Program	Frequency	Percentage
Appalachian State University	2	18.2%
Atlantis Institute for Consciousness & Music	2	18.2%
The Bonny Foundation	2	18.2%
Other*	2	18.2%
Mid-Atlantic Training Institute	1	9.1%
The Danish Bonny Method GIM Institute	1	9.1%
Therapeutic Arts Institute	1	9.1%
Total	11	100%

*“Other” responses included “Bruscia Training” and “Temple University”

Table 3

Primary Work Setting in which GIM is Used

Current Study (<i>n</i> = 11)		
Setting Type	Frequency	Percentage
Private Practice	8	72.7%
Agency/Hospital	1	9.1%
University/Academic Setting	1	9.1%
Other*	1	9.1%
Total	11	100%

* “state institution”

Travelers/clients. The term ‘traveler’ is a term from GIM literature used to refer to the other member in the GIM dyad. For this study, the traveler refers to an individual with a currently or previously diagnosed eating disorder who has participated in multiple GIM sessions with either a Fellow of the Association for Music and Imagery or an advanced GIM trainee of an AMI-endorsed training program. Travelers may have participated in GIM sessions in a variety of settings, and may have participated in a range of number of GIM sessions. They may have participated in the individual form of the Bonny Method of GIM, a group form of GIM, a modification or adaptation of the method, or any combination thereof. Clients were accessed only with expressed and informed consent and only through the GIM practitioner with whom they had previously worked. All travelers remained anonymous to the researcher to maintain confidentiality. The inclusion of travelers/clients an important part of the inquiry process; the participation of travelers reflects the process-oriented and depth-oriented method of GIM, which emphasizes the experience and meaning of imagery as perceived by the traveler. Travelers are not “subjects,” but rather active participants in their own exploratory and healing process.

A total of 8 individuals responded to the client survey, all of whom identified themselves as female. Because GIM practitioners forwarded the invitation to participate to former clients in order to protect confidentiality, it is not known how many potential respondents received the email, and so a response rate could not be calculated. The range in ages was 32–65, with a median age of 51. Of these 8 individuals, 4 individuals completed the survey beyond providing the demographic information of gender and age; of these 4 individuals, half participated in GIM while studying music therapy, 1 individual was referred to GIM by a mental health practitioner, and 1 individual learned about GIM through an individual-led search (see Table 4).

Table 4

How Clients Learned about GIM

	Current Study (<i>n</i> = 4)	
Setting Type	Frequency	Percentage
Other*	2	50.0%
Individual search	1	25.0%
Referred to GIM by a mental health professional	1	25.0%
Total	11	100%

*Other respondents: “while studying music therapy”

Instruments

All potential respondents were sent an email invitation to participate in an online survey. Three different surveys were originally created, one for each of the respondent groups (GIM practitioner, GIM primary trainer, and traveler/client). The surveys for the GIM practitioners and the GIM trainers were eventually combined into one survey, The GIM Practitioner Survey (Appendix A), which included questions about education level, training, possible adaptations or considerations specific to their work using GIM with individuals with eating disorders, and

training considerations. The GIM Traveler/Client Survey (Appendix B) included questions about the respondents' experiences in GIM in the treatment of their eating disorder.

Design

This was a survey-based quantitative study designed to investigate how GIM is being used in the treatment of individuals who have an eating disorder. Quantitative data were the descriptive statistics that emerged from the responses to the surveys.

Procedure

Upon approval from the university institutional review board, two surveys were created: a GIM Practitioner Survey and a GIM Client Survey. The GIM Practitioner Survey was completed by two advanced GIM trainees, and adjustments were made based on those participants' feedback. Potential respondents were contacted by email, and data from both surveys were collected in the spring of 2017. Specific procedures for each category of respondents are described below.

Survey of GIM practitioners and primary trainers. GIM practitioners and primary trainers were contacted directly through email. All contact information was gathered through the directory of AMI-endorsed GIM practitioners (Association for Music and Imagery, n.d.-b). The informed consent form, which included a description of the purpose of the study, was sent via email to potential respondents, along with a link to the GIM Practitioner Survey, which was created using the survey platform Qualtrics. The researcher sent reminders to potential respondents to this survey two weeks after the initial email and again one week before the closing of the survey.

Survey of travelers/clients. Travelers/clients were accessed through GIM practitioners. GIM practitioners who participated in the research were sent an initial email with information

about the study. An additional email was sent to practitioners that they could forward to former clients who have eating disorders with whom they had used GIM; this email included the client consent form and a link to the online survey for clients. In order to protect the confidentiality of the clients, practitioners were asked not to indicate to whom they had forwarded the email. This survey was also created using an online survey platform (Qualtrics) so that the anonymity of travelers was maintained. Special considerations were taken in the language and wording of survey questions for the travelers in order to invite responses that accurately reflected their experiences.

Data Analysis

Descriptive data from both surveys were analyzed by the researcher, including counts and frequencies. Because of the small sample sizes, median values were calculated. Open-ended questions were examined and themes were determined based on those responses.

CHAPTER 4

Results

This chapter describes responses from each of the three respondent groups who participated in the study: GIM practitioners, GIM primary trainers, and GIM clients. Descriptive statistics are reported for each of the three respondent groups.

Responses from GIM Practitioners

Of the 11 respondents to the GIM Practitioner Survey, 45.5% (5 practitioners) indicated that they had experience using GIM with individuals who have an eating disorder. Respondents reported having between 2 and 12 years of experience using GIM with individuals who have an eating disorder, with a median value of 2 years of experience. Clients who have eating disorders represented a range of 0-30% of respondents' total GIM client load, with a median value of 5%.

Factors in assessing readiness for or appropriateness of GIM. Respondents reported a number of factors to consider prior to beginning GIM sessions with an individual who has an eating disorder. Sample responses indicated the following have been taken into account by GIM practitioners in assessing readiness or appropriateness for the GIM process:

- “Eating disorder (ED) behaviors must be monitored. Good supports specific to ED must be in place before doing any altered states work. Careful assessment needs to explore possible traumas, relationships, body image and dysmorphia, depression, anxiety, etc.”
- “Level of treatment, symptom management, ego strength, available coping skills, issues underlying the eating disorder (anxiety, depression, trauma, etc.), medical stability.”

- "The initial interview with the patient, performing the Circles of the Self (mandala) assessment."

Adaptations, special considerations, or alterations made in the process of GIM. GIM practitioners reported a number of adaptations or considerations made to various components of the GIM process including guiding language, induction, physical environment, and others. Respondents provided information by checking any applicable adaptations that they have incorporated in their use of GIM with individuals who have an eating disorder. Respondents were also able to indicate any alterations or adaptations that were not listed. For an overview of these adaptations, see Table 5.

Alterations to inductions. In GIM, the induction refers to the process in which the therapist assists the client in shifting to an internally focused state. Inductions vary in structure and form and are selected by the practitioner in way that is individualized to the needs of each client. Inductions may include a focus on the body such as progressive muscle relaxation, an autogenic induction in which a quality is carried through the body, focus on the breath, a systematic incorporation of or engagement with a specific image, or other methods. In this study, 40% of respondents indicated that in work with individuals who have an eating disorder, they used concrete, body-based inductions more frequently, and used general rather than specific language when referring to the body ("the middle of the body" versus the specific body part "the stomach"). One respondent reported that they did not make changes to inductions. Several practitioners (60%) reported additional considerations, which included, "grounding, [and] connecting with breath." One respondent reflected on the importance of tailoring the inductions not just to the individual but also to the stage of therapy:

"In the first sessions, it is important to build a safe place with a visual induction. After that, more or less in the fifth session, I use different inductions, depending on the

Table 5

Adaptations Reported by GIM Practitioners for Clients with Eating Disorders

Current Study (<i>n</i> = 5)		
Alterations to Inductions	Frequency	Percentage
Other	3	60.0%
Use concrete, body-based inductions more frequently	2	40.0%
Use general rather than specific language	2	40.0%
No alterations made to induction	1	20.0%
Alterations to Guiding Language	Frequency	Percentage
Encouraging engagement with somatic imagery	3	60.0%
Use of clear focus image prior to music	3	60.0%
Continuing with induction as music begins	2	40.0%
Other	2	40.0%
Clients image in silence	1	20.0%
No alterations made to guiding language	1	20.0%
Alterations to Physical Environment	Frequency	Percentage
No alterations made to physical environment	3	60.0%
Other	2	40.0%
Clients sit upright in chair	1	20.0%
Other Adaptations	Frequency	Percentage
More focused preliminary conversation	4	80.0%
Homework between sessions	3	60.0%
Shortened music	3	60.0%
Shortened session overall	3	60.0%
Forgo use of mandala	1	20.0%
Introduction of increasingly longer pieces of music over time	1	20.0%
Other	1	20.0%
None	1	20.0%
Use of mandala in every session	0	0.0%

intention of the traveler. However, body-based inductions work very well when the client feels comfortable and safe with the process.”

Another respondent acknowledged the importance of assessing individual needs and steering clear of generalizations, and also acknowledged that in her experience she had found “that people diagnosed with anorexia had extremely limited tolerance for any direct reference to the body, at least in acute phases.” Further, “those with bulimia seemed to be less heavily defended, but you must be ready to deal with underlying heavy issues.”

Alterations to guiding language. The term guiding language refers to the therapist’s (guide’s) choice of words and focus when communicating with the client during the GIM session. Results indicated that the use of a clear focus image prior to music and encouraging engagement with somatic imagery were the most commonly used alterations to guiding language (60%). Respondents also reported continuing with the induction as the music beings (40%). Participants (40%) reported additional alterations of guiding language, including “avoid[ance] of language in the induction that focuses on the body relaxing by feeling heavy, as this pulls the focus into the left brain and out of the imagery experience”, as well as “starting with supportive level interventions; Music [and] Imagery [MI] method developed by Fran Goldberg may be a good option.” Additionally, one respondent indicated that clients image in silence rather than report images to the GIM practitioner. One respondent indicated that they made no alterations to their guiding language.

Alterations to physical environment. The majority (60%) of respondents indicated that they made no changes in the physical environment when facilitating GIM sessions with individuals who have an eating disorder. Some respondents (20%) indicated that clients sit upright in a chair, versus reclining or lying down as is common in GIM sessions. Respondents

(40%) indicated that other adaptations to the physical environment were made; they specified only that changes were made based on individualized preferences and needs.

Other adaptations. Respondents indicated that a number of other adaptations were used, including a more focused preliminary conversation (80%), shortened music (60%), shortened session overall (60%), and assigning homework to clients between sessions (60%). One respondent in the ‘other’ category echoed the assignment of homework:

I find due to the complexity of eating disorders and comorbid diagnoses that I need to provide opportunities in between GIM sessions to process the GIM experiences. GIM sessions are often emotional laden and additional time is needed to process the complexity of what is uncovered.

One respondent reported introducing increasingly longer pieces of music over time; one respondent also reported that they did not include the use of a mandala, which is commonly used in GIM sessions. One respondent reported making no other adaptations.

Client commonalities. GIM practitioners indicated that a number of challenges, experiences, or conditions appeared to be common among the individuals who have eating disorders with whom they have worked (Table 6). A majority of respondents (80%) indicated that anxiety, major depressive disorder or dysthymia, and a history of sexual abuse were commonly present in the individuals with whom they have worked. Many respondents (60%) also reported that the health conditions of obsessive-compulsive disorder, substance use disorder, and a history of trauma were found to be common. GIM practitioners also reported on what appeared to be commonalities in imagery experiences of individuals with whom they have worked (Table 7). A majority (60%) reported common experiences of avoidance of somatic imagery or bodily experiences, avoidance of emotional imagery, and distancing from imagery.

Table 6

Common Client Challenges, Experiences, or Conditions

Current Study (<i>n</i> = 5)		
Challenge, experience, or Condition	Frequency	Percentage
Anxiety	4	80.0%
Major depressive disorder or dysthymia	4	80.0%
Sexual abuse	4	80.0%
Deliberate self-harm	3	60.0%
History of trauma	3	60.0%
Obsessive-compulsive disorder	3	60.0%
Substance use disorder	3	60.0%
Bipolar disorder	0	0.0%
Other	0	0.0%
None	0	0.0%

Table 7

Commonalities in Client Imagery

Current Study (<i>n</i> = 5)		
Imagery characteristic	Frequency	Percentage
Avoidance of emotional imagery	3	60.0%
Avoidance of somatic imagery	3	60.0%
Distancing from imagery	3	60.0%
Other	3	60.0%
Food-related imagery	2	40.0%
None	0	0.0%

Comments from respondents expanded upon these observations:

- “Symptomology [of one’s experience of the eating disorder] is expressed in imagery. [Images of] emotions being stuck in the body and feeling unable to move those emotions.”
- “Fear of facing emotions or painful memories/experiences.”
- “Describing imagery as an observer rather than actively being a part of it.”

A number of respondents (40%) also reported the presence of food-related imagery; others (60%) additionally indicated the following commonalities in imagery or qualities of imagery:

- “Mother and father”
- “Avoidance and flooding”
- “Feelings as colors”

Why GIM? GIM practitioners were asked to describe how they decide to use GIM with an individual with an eating disorder versus another method or approach that they use in their work as helping professionals. The responses reflected a variety of perspectives:

- “GIM works better than active music therapy because it goes to the core of the problem. GIM gives a lot of answers to the client and to the therapist and allows one to go within and heal wounds. The music is powerful and does the 70% of the work.”
- “I combine active music therapy and voice-breathing work with GIM. GIM gives more focus and active music therapy helps bodily expression, connection with breathing, etc.”
- “I utilize all methods with clients. If there are issues underlying their eating disorder that they are having difficulty addressing then I discuss how GIM can be helpful in addressing these issues.”
- “I no longer work in an environment where I could use other music therapy methods.”
- “[I use GIM] if they appear to fit the criteria, have a positive response to or investment in creative expression (whether art or music or both), appear to have developed enough trust to close their eyes and look more deeply within, and are motivated to improve.”

Responses from GIM Primary Trainers

A total of 3 respondents to the GIM Practitioner Survey identified themselves as primary trainers who offer advanced training to GIM trainees. These respondents reported a range of 2 to 7 years of experience offering advanced GIM training, with a median of 5 years of experience. Respondents were asked to describe any special considerations or adaptations specific to working with individuals who have an eating disorder that they teach in their training of GIM practitioners. One respondent reported teaching no special considerations for individuals with eating disorders. The other respondents indicated the following:

- “I teach modified methods appropriate also for eating disorders and give examples based on clinical experience.”
- “Yes, I certainly emphasize that in my module on clinical training. In many cases, eating disorders result from a previous trauma in childhood. I teach [the use of] certain GIM programs (working programs) [for] when the traveler is ready to work, and teach other programs to help comfort and heal the inner child.”

Responses from GIM Clients

A total of 8 individuals responded to the client survey, all of whom identified themselves as female. Of these 8 individuals, 3 individuals completed the entire survey. Two individuals reported that their experience of disordered eating was binge eating disorder; one respondent reported that their experience of disordered eating was bulimia nervosa. When asked about the frequency and duration of GIM sessions in which they participated, two respondents reported that they participated in 12 GIM sessions that took place over the course of one year. The other respondent participated in twice weekly sessions for an undisclosed period of time. When asked to rate their level of agreement to the statement that GIM was “helpful in the treatment of my experience of disordered eating”, one respondent indicated they “strongly agreed”, one respondent “agreed”, and one respondent “somewhat agreed.”

Clients were also asked to describe images and experiences in GIM, as well as actions of the guide/GIM practitioner, that were helpful to them. The respondents described several different personal experiences:

- “The process of developing self esteem and exploring relationships with family of origin.”
- “Images of loss - like connecting with a beloved pet; of a family member who is becoming terminally ill. Chances to grieve, to move on and to interact with them during the imagery experience.”
- “Understanding kinesthetic responses- having a guide [who is] very knowledgeable about the body.”

One respondent also described factors that they felt were not helpful in their experiences in GIM:

- “Sometimes I would arrive to the session after having traveled a long distance. Once in an altered state, fatigue would hit.”

Summary

Results of survey responses from each of the three groups revealed information about the current use of GIM in the treatment of individuals who have eating disorders. Responses from GIM Practitioners indicated adaptations or alterations made to inductions, guiding language, physical environment, special considerations in assessment and use of GIM, as well as common characteristics that practitioners have found among individuals with whom they have worked. While responses from primary trainers were limited, respondents indicated special considerations for individuals with eating disorders that they teach in their advanced trainings. Responses from clients were also limited, but revealed information about the individuals’ courses of GIM treatment and perceptions about helpfulness of participating in the GIM process.

CHAPTER 5

Discussion

This chapter includes a discussion of the research findings as they apply to the original research questions. This will be followed by implications for clinical practice, limitations, and areas for further study.

Research Questions

Results from the surveys were synthesized and viewed through the lens of the original research questions. Data from both of the surveys were used.

How is GIM currently being used to treat individuals with eating disorders? The responses to the GIM Practitioner Survey suggest that the use of GIM with individuals who have eating disorders is a specialized area of practice. While the number of practitioners who responded may not accurately reflect the number of practitioners currently using GIM with individuals who have eating disorders, it suggests that the number is currently relatively low. The growing but limited body of research in this topic area supports this notion.

Responses to the survey reflect the notion in the literature that in using GIM with individuals who have an eating disorder, focus is generally on treating underlying issues that are contributing to the eating disorder, versus treatment of acute symptoms associated with a particular eating disorder. Practitioners choose to use GIM with individuals who have an eating disorder for a number of reasons, including the belief that through the GIM process “underlying issues” can be identified and addressed and that GIM processes can assist the client to “go

within”, reach the “core of the problem”, and allow for experiential knowing and new patterns of health to emerge. Assessing readiness for participation in GIM sessions appears to be key; several practitioners described the necessity of being at an appropriate level or stage of treatment in which eating disorder behaviors are being monitored and coping skills are available as prerequisites to entering into the depth work that is central to the process of GIM. The concept of assessing readiness for depth work is also reflected in the literature (Hornyak & Baker, 1989).

GIM practitioners who work with individuals who have eating disorders appear to be encountering a number of commonalities in client experiences, including co-occurring client experiences of anxiety disorders, major depressive disorder or dysthymia, history of sexual abuse or other trauma, obsessive-compulsive disorder, and substance use disorder. Some clients may have common experiences in GIM, including avoidance of somatic imagery or bodily experiences, as well as avoidance of or challenges with emotional experiences in imagery.

What, if any, adaptations or special considerations are GIM practitioners making in working with individuals who have eating disorders? Many of the responses to the survey confirmed previous descriptions in clinical research regarding adaptations or special considerations made by GIM practitioners. Responses to the GIM Practitioner Survey indicated that practitioners are making adaptations in inductions, guiding language, physical environment, session structure, and other factors. Tileston’s (2013) clinical recommendation to music therapists to use general rather than specific language when referring to the body in relaxation exercises appeared to be incorporated by GIM practitioners. Inductions that are concrete and body-based, as well as inductions that support feelings of being “grounded,” safe, and connected to one’s breath have been commonly implemented. Conversely, one practitioner reported that focus on or direct reference to the body may not be tolerated by some individuals who are in

acute phases of anorexia nervosa. As is common with all individuals with whom GIM is used, practitioners emphasized throughout the survey the importance of individualizing elements of each session to fit the needs of each specific individual.

Several other adaptations described in the literature (Heiderscheit, 2015; Noer, 2015; Papanikolaou, 2015) also appeared in survey results, including the use of a clear focus image, inviting clients to sit or recline instead of lying down, the use of shortened programs of music, and a shortened session overall. Practitioners also commonly intentionally increased focus in the preliminary conversation, as well as commonly incorporated “homework” between sessions to continue processes begun in GIM sessions.

Are primary trainers teaching any adaptations related to work with individuals with eating disorders? Based on the limited responses from GIM primary trainers to the survey, it appears that modifications or adaptations specific to working with individuals who have an eating disorder are being taught but are uncommon. Modified methods that are generally appropriate for other individuals are being taught.

What can be learned from clients who have eating disorders regarding what is helpful and what is a hindrance in therapy using GIM? The limited responses to the client survey revealed that individuals with eating disorders who have participated in GIM sessions generally viewed them as helpful in the treatment of their disordered eating. Respondents highlighted experiences in GIM that were helpful or meaningful to them; these responses included experiences of exploring relationships with family members, connecting to images and experiences of loss and grief, and working with a practitioner who helped them to understand bodily responses in the GIM process. Interestingly, respondents did not mention experiences specific to individuals who have an eating disorder, which seems to reflect the intention of GIM

practitioners as reported in the literature and in this survey that the process of GIM allows for opportunities to work with issues that are underlying or contributing to one's experience of disordered eating.

Implications for Clinical Practice

Results from the survey suggest that potential GIM clients who have an eating disorder need to be carefully assessed before beginning GIM work. Factors such as medical stability, availability of coping skills, ability to manage symptoms of disordered eating, and sufficient ego strength should be present; these factors are similar to factors considered for GIM clients who do not have eating disorders. Results also suggest that an in-depth assessment of personal history be completed and that clients be assessed for "issues underlying the eating disorder", including substance use, history of trauma, relationships, and other possible co-occurring mental health conditions. As with any specialized area of practice, training and clinical experience in comprehensive assessment is recommended.

It may be helpful for GIM practitioners to consider specific adaptations that will be supportive of each individual's needs and challenges. In order to create an atmosphere of safety, one might consider language used, session structure and length, and musical choices. Assisting clients to find ways to work in between sessions with material that arises in sessions may also be helpful. Practitioners may also consider the degree to which they focus on bodily experiences and encourage engagement with somatic imagery. Client experiences of avoidance of somatic or emotional imagery may be considered in the context of literature that describes challenges in both interoceptive awareness (Boswell, Anderson, & Anderson, 2015; Merwin, Zucker, Lacy, & Elliot, 2010) and alexithymia (Nowakowski, McFarlane, & Cassin, 2013) in individuals who have experiences of disordered eating. In this regard, it may be helpful for GIM practitioners to

be aware that individuals who have an eating disorder commonly experience lack of clarity about internal experiences or non-acceptance of internal experiences, or both. Practitioners may need to consider how this common difficulty in connecting with internal experiences may present challenges in the GIM process and consider the use of adaptations to support various levels of client engagement and connection.

Limitations

There were a number of limitations to this study. One limitation is that the surveys were written only in English; this may have affected the responses from international GIM practitioners who do not speak English. The number of respondents in each of the three groups – GIM practitioners, GIM primary trainers, and clients – was very small in number. In the distribution of the client survey, GIM practitioners may have been prohibited from contacting former clients because of workplace policies; at least one respondent indicated that this was true for them.

Areas for Further Study

While this study provided some information about the current use of GIM in the treatment of individuals who have an eating disorder, there are many opportunities for future research. While there are examples in the literature of the use of group modifications and adaptations of GIM in the treatment of individuals with eating disorders (Justice, 1994; Noer, 2015), this survey did not investigate current group uses or adaptations. Additionally, further clarity could be sought about whether the adaptations were made primarily because of what GIM practitioners saw as specialized needs of individuals, or if adaptations were made because of limitations or needs of the setting (e.g., for a billable hour covered by insurance, because of space limitations, or expectations or structure imposed by the place of work).

A question that arose in the process of this study was whether it is at all helpful or important to consider general adaptations for individuals with eating disorders when using GIM. Does the GIM process naturally lend itself to individualized client considerations, making recommendations about using GIM with individuals with eating disorders irrelevant? Additionally, as this study and literature revealed that GIM practitioners generally consider themselves to be working with clients' "underlying issues," should practitioners look to the literature and follow recommendations for practice for those issues instead? Conducting interviews with practitioners and primary trainers may yield helpful information and help to clarify rationale and intentions behind adaptations that are being made. What, if any, personal or clinical experiences influence primary trainers to teach adaptations or considerations specific to individuals who have an eating disorder? Interviews with clients may yield helpful information about client experiences and how practitioners might provide better support. Future research may also investigate the effect that participation in GIM sessions has on areas of challenge common to individuals who have eating disorders, such as interoceptive awareness, body image disturbance, and emotional regulation.

Conclusion

This study sought to investigate the current use of GIM in the treatment of individuals with eating disorders and to determine adaptations and considerations made by GIM practitioners and primary trainers to meet the therapeutic needs of individuals with eating disorders. Additionally, client experiences were sought in order to better understand helpful and detrimental experiences in GIM. While the number of respondents in each of the three groups was limited, helpful information emerged regarding the current use of specific adaptations in inductions, guiding language, physical environment, and others. Factors in assessing readiness

for entering into therapy using GIM were highlighted. The use of GIM with individuals who have an eating disorder is a small area of specialized practice with a recently growing interest that is reflected in the literature. The topic invites many opportunities for further investigation in order to better understand therapeutic choices, improve clinical training of GIM practitioners, and above all to better serve individuals who seek support for this particular life experience.

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Appendix A: GIM Practitioner Consent Form and Survey

Information to Consider about this Research

The Bonny Method of Guided Imagery and Music (GIM) and Eating Disorders: Learning from Therapist, Trainer, and Client Experiences

Principal Investigator: Lizzy Barmore, MT-BC

Department: Music Therapy

Contact Information: barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444

Dear GIM Practitioner,

As a practitioner who uses the Bonny Method of Guided Imagery and Music (GIM), you are invited to participate in a survey that concerns your practices and experiences as a GIM practitioner, specifically, your experiences using GIM in the treatment of individuals with eating disorders. This survey is part of my master's thesis research on the use of GIM in therapeutic partnership with individuals with eating disorders, which I am conducting at Appalachian State University. This was reviewed and declared exempt from further review on March 1, 2017 by the University's Institutional Review Board.

If you agree to be part of the research study, you will be asked to respond to several questions regarding the use of GIM in treatment of individuals with eating disorders; this process should not take more than 20–30 minutes. If you are willing to participate, please continue to access the online survey.

Your participation in completing this survey is voluntary, and there are no consequences if you decline to participate or decide to discontinue participation at any time. No risks are associated with completing this survey, and you will receive no compensation.

Your contact information is being used with permission from the Association for Music and Imagery (AMI). The website (Qualtrics) where the survey is located is a secure site. At the end of the survey, you have the option of submitting your contact information if you are willing to be contacted for a follow-up interview. You are not required to enter your contact information, and your agreement to participate in this survey does not require your participation in an interview. Data collected both through the survey and potential interview will remain anonymous. The data collected in this survey will be included in the researcher's master's thesis, and the study may be submitted for publication and presentation at the conferences of the American Music Therapy Association and/or the Association for Music and Imagery.

If you are willing to participate, please continue to access the online survey. By submitting responses to the survey you are consenting to participate. Please complete the survey by April 11, 2017

Questions may be directed to:

Lizzy Barmore; barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444

Or the Institutional Review Board at Appalachian State University at irb@appstate.edu

By continuing to the survey, I acknowledge that I am at least 18 years old, have read the above information, and provide my consent to participate under the terms above.

Thank you for your participation.

Sincerely,

Lizzy Barmore, MT-BC

Principal Investigator, Candidate for Master of Music Therapy degree

Advanced Trainee in the Bonny Method of GIM

GIM in the Treatment of Eating Disorders Survey (GIM Practitioner Version)

What is your highest educational level obtained?

- Bachelor's degree (please specify discipline: _____)
- Master's degree (please specify discipline: _____)
- Doctoral degree (please specify discipline: _____)
- Other: _____

Please indicate your GIM credentials/training level:

- FAMI (Fellow of the Association for Music and Imagery)
- Advanced Trainee (Level III)

From what GIM training did you or will you graduate?

- Archedigm (Keiser Mardis)
- Appalachian State University
- Atlantis Institute for Consciousness & Music
- The Bonny Foundation
- Institute for Consciousness and Music (Bonny, then Clark & Keiser)
- Institute for Music and Consciousness (Summer)
- Creative Therapies Institute (Ventre)
- Therapeutic Arts Institute
- Association for Music Therapy, Singapore
- GIM Training South Africa
- Training with Leslie Bunt
- The Danish Bonny Method GIM Institute
- European Guided Imagery and Music Training Program
- Inner Journey with GIM: Canada or Capilano University (Moffitt)
- Institut für Musik, Imagination und Therapy (IMIT)
- Institut für Musikgeleitete Psychotherapie
- Institute Imago
- Integrative GIM Training Programme

- Mid-Atlantic Training Institute (Bush & Stokes/Sterns)
- Southern California Center for Music & Imagery (Merritt)
- Southeastern Institute for Music & Imagery (Skaggs)
- University of Melbourne or Avalon Guided Imagery & Music Training (Grocke)
- Other: _____

What year did you complete or when do you anticipate completing GIM training?

Including advanced training, how long have you facilitated GIM sessions?

Please indicate the primary work setting in which you practice GIM:

- Private practice
- Agency/Hospital
- University/Academic setting
- Other:

Do you now work, or have you ever used GIM with individuals who have an eating disorder?

- Yes
- No

If they answer 'No' here, then the next question would be:

In your GIM training, were you taught any special considerations or adaptations to consider specific to working with individuals with eating disorders? If so, please describe.

Thank you very much for your time and energy in completing this survey.

[This would be the end of the survey if they answered 'No']

[If they answered 'Yes' to currently working on working in the past with individuals with eating disorders, then the survey would continue as follows:]

How many years of experience do you have using GIM with individuals who have an eating disorder? _____

Of the GIM clients with whom you currently work, approximately what percent of those clients have an eating disorder?

In your GIM training, were you taught any special considerations or adaptations specifically for working with individuals with eating disorders?

No

Yes

If so, please describe: _____

Beyond factors that you would consider for every GIM client, what do you consider in assessing readiness or appropriateness of GIM specific to individuals with an eating disorder? Please describe.

In what ways, if any, do you alter your guiding language in your work with individuals with eating disorders? (Check all that apply)

Encouraging engagement with somatic imagery

Clients image in silence

Use of clear focus image prior to the music

Continuing with the induction as the music begins

Other, please specify:

I do not alter my guiding language

Please describe any special considerations or adaptations you make in selecting and using inductions with individuals with eating disorders. (Check all that apply)

Use concrete, body-based inductions more frequently

Use general rather than specific language (“the middle of the body” versus “the

stomach”)

- Other, please specify:
- I do not make adaptations in selecting and using inductions

In what ways, if any, do you alter or adapt the physical environment or room set up in your work with individuals with eating disorders? (Check all that apply)

- Clients sit upright in chair
- Other, please specify:
- I do not alter the physical environment

What other adaptations do you make specifically for people with eating disorders? (Check all that apply)

- Shortened music
- Shortened session overall
- More focused preliminary conversation
- Forgo the use of mandala
- Use of mandala in every session
- Homework between sessions
- Introduction of increasingly longer pieces of music over time
- Other, please specify:
- None

What comorbid issues are commonly present in individuals with eating disorders with whom you work/have worked in GIM?

- Anxiety
- Major depressive disorder or dysthymia
- Substance use disorder
- Obsessive-compulsive disorder
- Bipolar disorder
- Sexual abuse

- History of trauma
- None
- Other: _____

In your work with individuals with eating disorders, what commonalities in imagery or types of imagery have you noticed? Please describe.

- Avoidance of somatic imagery
- Avoidance of emotional imagery
- Distancing from imagery (e.g. watching from the outside)
- Food-related imagery
- None
- Other: _____

If, as a professional, you use methods *other than* GIM in your work, how do you decide to use GIM with an individual with an eating disorder versus another method or approach? Please describe.

Are you a primary trainer who offers advanced training in GIM?

- Yes
- No

How many years have you worked as primary trainer of GIM? _____

In the training program in which you teach, do you teach any special considerations or adaptations specific to working with individuals with eating disorders? If so, please describe.

Would you be willing to be interviewed about the topic of this survey?

If so, please include your name and email address below:

Thank you very much for your time and energy in completing this survey.

Lizzy Barmore; barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-644

**Appendix B: Email to GIM Practitioners about Client Message; Traveler/Client Consent
Form and Survey**

Email to GIM Practitioners about Client Message

Dear GIM Practitioner,

You should have received a separate email regarding a survey for practitioners; this email is regarding a survey for clients with eating disorders with whom you have used GIM. As a practitioner who uses the Bonny Method of Guided Imagery and Music (GIM), you are invited to participate in a survey that is part of my master's thesis research on the use of GIM in therapeutic partnership with individuals with eating disorders, which I am conducting at Appalachian State University. This was reviewed and declared exempt from further review on March 1, 2017 by the University's Institutional Review Board.

I will be sending an additional email that you may forward to any former clients who have eating disorders with whom you have used GIM. This will include the Client Consent Form, which will contain a link to the online survey for clients. In order to protect the confidentiality of your clients, please do not inform me to whom you have forwarded the email.

Please feel free to contact me with any questions.

Lizzy Barmore; barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444

Email for Practitioners to Forward to Clients/Client Consent Form

Information to Consider about this Research

The Bonny Method of Guided Imagery and Music (GIM) and Eating Disorders: Learning from Therapist, Trainer, and Client Experiences

Principal Investigator: Lizzy Barmore, MT-BC

Department: Music Therapy

Contact Information: barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444

Dear Participant,

As an individual who has participated in sessions using the Bonny Method of Guided Imagery and Music (GIM), you are invited to participate in a survey that concerns your experiences in therapy, specifically, your thoughts and impressions of GIM as a tool in the treatment of your experience of disordered eating. This survey is part of my thesis research on the use of GIM in therapeutic partnership with individuals with eating disorders, which I am conducting at Appalachian State University. This was reviewed and declared exempt from further review on March 1, 2017 by the University's Institutional Review Board.

If you agree to be part of the research study, you will be asked to respond to several questions regarding the use GIM in treatment of individuals with eating disorders; this process should not take more than 20–30 minutes.

Your participation in completing this survey is voluntary, and there are no consequences if you decline to participate or decide to discontinue participation at any time. No risks are associated with completing this survey, and you will receive no compensation.

You should be receiving this email from the GIM therapist with whom you have worked. The information you provide in the survey will remain completely anonymous, and you will not be asked for personally identifying information. You will be asked to provide basic demographic information. The website (Qualtrics) where the survey is located is a secure site, and it neither stores nor tracks your email address, nor does it attach your email address to your responses. The researcher will have no access to names or emails of those who do or not participate in the study, and the researcher will not have the ability to link e-mail addresses to responses. The anonymous data will be included in the researcher's master's thesis, and the study may be submitted for publication and presentation at AMTA conferences.

If you are willing to participate, please continue to access the online survey. By submitting responses to the survey you are consenting to participate. You can choose to respond to all, some, or none of the items. Please complete the survey by April 11, 2017.

The Appalachian State University Institutional Review Board (IRB) has determined that this study is exempt from IRB oversight. Questions may be directed to:

Lizzy Barmore; barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444

Or the Institutional Review Board at Appalachian State University at irb@appstate.edu

By continuing to the survey, I acknowledge that I am at least 18 years old, have read the above information, and provide my consent to participate under the terms above.

Thank you for your participation.

Sincerely,

Lizzy Barmore, MT-BC

Principal Investigator, Candidate for Master of Music Therapy degree

Advanced Trainee in the Bonny Method of GIM

GIM in the Treatment of Eating Disorders Survey (GIM Traveler/Client Version)

Gender:

Age:

How did you learn about The Bonny Method of Guided Imagery and Music (GIM)?

- Individual search
- Referred to GIM by a mental health professional (ex: counselor, psychologist)
- Other (please specify):

Which of the following best describes your past or current experiences of disordered eating?

Please check all that apply.

- Anorexia nervosa
- Bulimia nervosa
- Binge eating disorder
- Eating disorder not otherwise specified (EDNOS)
- Other: _____

Please describe the approximate frequency and duration of GIM sessions in which you have participated (ex: 12 sessions over one year):

Please rate the following statement:

GIM is/was helpful to me in the treatment of my experience of disordered eating:

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

In GIM, what images, experiences, or actions of your guide are/were helpful to you in your recovery?

In GIM, what was *not* helpful to you? Please feel free to describe any aspect of your experiences, including music, actions of your guide, physical surroundings, or any other aspect that is relevant to you.

Thank you very much for your time and energy in completing this survey.

Lizzy Barmore; barmoreea@appstate.edu; 828-338-9959

Dr. Cathy McKinney, Faculty Advisor, mckinnych@appstate.edu, 828-262-6444

Vita

Lizzy Barmore was born in Pasadena, TX. She attended Sam Houston State University in Huntsville, TX for her undergraduate studies, for which she earned a Bachelor of Music Degree in Music Therapy. She completed her music therapy internship at CarePartners Hospice and Palliative Care in Asheville, NC in which she worked with individuals receiving end-of-life care and adults in bereavement care. After earning her music therapy certification (MT-BC), she worked for several years in Houston, TX, where she gained professional experience in therapeutic partnership with adults seeking mental health care, individuals who have experienced trauma, and individuals who have neurological and developmental differences. Her experiences led to a desire to deepen and expand her clinical skills and knowledge, which led her to pursue training in the Bonny Method of Guided Imagery and Music (GIM) and later, graduate studies. Through Appalachian State University in Boone, NC, she is pursuing both a Master of Arts degree in Clinical Mental Health Counseling with an emphasis in Expressive Arts Therapy and a Master of Music Therapy degree, as well as a graduate certificate in Expressive Arts Therapy. She is an advanced trainee in the Bonny Method of Guided Imagery and Music.

Following graduation from Appalachian State University, Lizzy plans to pursue a career as a licensed professional counselor and music therapist in western North Carolina. She hopes to integrate the two disciplines with individuals who are seeking support for mental health challenges.