The Bonny Method of Guided Imagery and Music (BMGIM) and its Adaptations in Psychotherapy for Patients with Complex Posttraumatic Stress Disorder

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Complex Posttraumatic Stress Disorder

Many people who were traumatized over a prolonged time starting in childhood do not just develop simple posttraumatic stress disorder (PTSD), but a more complicated syndrome due to interruption of normal brain development in childhood and to adaptation to a constantly threatening environment (Herman 1998, Siegel 1999). Herman (1998) first describes this syndrome as complex PTSD; other authors call it disorder of extreme stress not otherwise specified (DESNOS) (see for example van der Kolk et al. 2005). Both terms are interchangeable. Herman (1998, p. 121) describes complex PTSD as follows:

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples include also those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.
2. Alterations in affect regulation, including
   - persistent dysphoria (state of confusion, agitation, emptiness, and utter aloneness)
   - chronic suicidal preoccupation
   - self-injury
   - explosive or extremely inhibited anger (may alternate)
   - compulsive or extremely inhibited sexuality (may alternate)
3. Alterations in consciousness, including
   - amnesia or hypermnesia for traumatic events
   - transient dissociative episodes
   - depersonalization / derealization
   - reliving experiences, either in form of intrusive post-traumatic stress disorder symptoms or in form of ruminative preoccupation
4. Alterations in self-perception, including
   - sense of helplessness or paralysis of initiative
   - shame, guilt, and self-blame
   - sense of defilement or stigma
   - sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alteration in perception of perpetrator, including
    - preoccupation with relationship with perpetrator (includes preoccupation with revenge)
    - unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
    - idealization or paradoxical gratitude
    - sense of special or supernatural relationship
    - acceptance of belief system or rationalization of perpetrator
6. Alterations in relation with others, including
    - isolation and withdrawal
    - disruption in intimate relationships
    - repeated search for rescuer (may alternate with isolation and withdrawal)
    - persistent distrust
    - repeated failures of self-protection
7. Alterations in systems of meaning
    - loss of sustaining faith
    - sense of hopelessness and despair

In addition to that, Siegel (1999) describes possible adaptations in attachment style to the prolonged period of totalitarian control and abuse marked by

1. chaotic, frightened, frightening, dissociated, and/or disoriented behaviour;
2. paradoxical injunctions (for example "come here and go away")
3. lack of internal coherence;
4. intrusive emotional memories;
5. rapid shifts in state of mind;
6. overt trance states in response to stress;
7. difficulties with affect regulation.

Not everybody exposed to trauma develops any disorders as results of it. Risk factors for developing complex PTSD are not researched yet, however, Brewin (2003) found risk factors for developing any posttraumatic stress syndrome. The following risk factors are given in order of importance:

1. Lack of social support after the trauma
2. Posttrauma life stress
3. Trauma severity
4. Other adverse childhood experiences
5. Low IQ
6. Low socioeconomic status
7. Female gender

8. Lack of education
9. Psychiatric history

Kluft, Bloom & Kinzie (2000) describe three groups of PTSD patients according to their ego-strength, and what that means for their therapy:

1. Patients with good ego-strength and little comorbidity. These patients usually have difficulties being with traumatic material and integrating it. For them uncovering therapy is useful. Exposure therapy should alternate with supportive therapy.
2. Patients with little ego-strength, substantial comorbidity, and strong and persistent symptoms of PTSD. They show highs and lows in therapy, and their therapy has a longer duration. The emphasis in therapy should be on coping-strategies and on working in the here and now. Therapy should alternate between uncovering work when the patient feels better and supportive work when the patient feels worse.
3. Patients with very strong and/or chronic PTSD-symptoms, severe ego-weakness and/or severe comorbidity. For these patients exposure therapy usually is destabilizing. Therapy should be resource-oriented and it should help the patient with managing everyday life.

Patients usually alternate between these categories. When therapy proceeds patients build more ego-strength and more uncovering therapy would be possible. On the other hand, if patients during the course of therapy get into a crisis their ego-strength might weaken and supportive therapy could be indicated.

Methods of Music and Imagery Therapy for Trauma Survivors

BMGIM will not be explained here. For readers unfamiliar with the method, I suggest reading Bonny (2002) or Bruscia & Grocke (2002). In this paper I will concentrate on individual therapy for trauma survivors. For group therapy with trauma survivors see Körlin (2004) and Summer (2002).

People with less ego-strength often have difficulties developing defensive manoeuvres defined as “adaptive means of coping with deeply emotional and potentially stressful or threatening experiences … they are essential to avoid fragmentation or disintegration of the ego” (Goldberg 2002, 364). This may lead to flooding with overwhelming material from the psyche, resulting in decompensation and re-traumatizing. To prevent this, there are different possibilities:

1. Reducing the frequency of using BMGIM or music and imagery therapy and using more verbal therapy. In the verbal parts of the therapy, the dynamic material from the music and imagery work can be integrated.

2. Less music can be used in a session (5 – 15 minutes might be enough), so that less dynamic material appears. One can also use music that is very structured and does not change much (no big changes in dynamics, no sudden changes of instrumentation or key, clear rhythms, etc.). Examples of music for supportive music and imagery therapy or supportive GIM are: A. Pärt, Spiegel im Spiegel; Pachelbel, Canon in D; Bach, Sheep May Safely Graze (orchestral version); Saint-Saens, The Swan; etc.
3. The guiding should be more directive for people with less ego-strength. This would be necessary for developing defensive manoeuvres or for stopping flashbacks. (Maack 2004a).

Summer (2001) describes the different levels of therapy with music and imagery and the roles of music, imagery, and the therapist in the different methods:

Method (level of therapy) / **Elements**	***GIM (reconstructive)***	***Music and Imagery Therapy (re-educative)***	***Music and Imagery Therapy (supportive)***
Music	Client's relationship with music is prime mover of therapy.	Holds client in current state or topic to work with an image.	Provides a common aesthetic experience – feeling of unity.
Imagery	Client's relationship is expressed through imagery. Internal experiences are divided into manageable pieces.	Provides constant internal objects with which to work and to relate to the therapist.	Connects client with internal world. Provides a positive internal experience.
Therapist	Supports client's responsiveness to the music by working with his/her imagery experience.	Primary mover of the therapy; helps divide the internal world into manageable pieces.	Primary mover of the therapy; helps client connect with positive resources.

Trauma Therapy with BMGIM and Music and Imagery Therapy

Today the 3-phase-model (Herman 1998) is state-of-the-art in all psychotherapies for patients with complex PTSD. The three phases are stabilization, trauma exposure, and integration. Stabilization includes: stress-reduction; acknowledging coping-strategies; psycho-education about trauma; connecting with healing imagery and cognitions; learning affect regulation and affect differentiation; building inner and outer safety; finding and using resources; naming distorted transferences; learning to sense the body and care for the body; learning to control traumatic material. Trauma exposure include: revisiting the traumatic situation(s) in a very structured setting with the goal of trauma-synthesis; use of distancing techniques. Integration includes: accepting one's limits; recognizing, naming, and working through the results from the traumatizations; trying out changes in relationships; this phase is not much different from regular psychotherapy. (Reddemann 2001) The phases usually do not proceed in a linear way but alternate. Phases of trauma exposure usually are rather short. They are always followed by phases of stabilization.

In BMGIM and music and imagery therapy, trauma therapy can include the following parts[1]:

Stabilization: healing imagery

- Developing positive inner imagery to counteract traumatic imagery
- Help the client to relax and get stronger
- Functions of the music: including all senses so that the imagery becomes more vivid, offering safety and support.

Case example:

(Secret Garden, Cantoluna)

Th.: What are you with?

Cl.: I am in nature. I have my own house. There is nobody except me. There are forests and a river.

Th.: What does the house look like?

Cl.: … It has a veranda where one can sit in the evening. The upper story is white. On the left, there is a white wooden fence. There is nobody, no neighbours. Deer comes to the fence in the evening…

(Secret Garden, Chaconne)

Th.: Could you be there now?

Cl.: Yes. I am sad and I also feel joy in my whole body. [Tears]

(Secret Garden, Song from the Secret Garden)

Th.: Bring the music into this feeling.

[1] Case examples are from a GIM-therapy with a 31-year-old male with complex PTSD. He had good ego-strength and supportive surroundings, but suffered especially from difficulties with affect regulation and severe outbursts of anger. The case examples are originally published in German (Maack 2004b) and are translated into English.

Cl.: Everything is so wonderful! [Tears]

Th.: What are you with now?

Cl.: I am walking through the fields with my wife. Our child runs towards us. It is so beautiful…

Stabilization: affect regulation

- Conscious use of positive imagery to prevent dissociation, freezing, numbness, inhibition, speechlessness, acting out and/or somatization.
- Functions of the music: carefully experimenting with tension in the music.

Stabilization: the inner child

- Contacting the inner child.
- Reassuring the child that s/he is important.
- Contacting the child's pain.
- Taking the child out of the painful and/or traumatic scene.
- Bringing the child to a safe place.
- Functions of the music: Providing safety and support.

Case example:

(Haydn, Concerto for cello in C major, Adagio)

Th.: What are you with now?

Cl.: I am squatting in a corner of the room.

Th.: What does the room look like?

Cl.: It is big and has a wooden floor. I do not dare to get up. I am afraid.

Th.: Where do you feel the fear?

Cl.: Everywhere.

Th.: What makes you afraid?

Cl.: I wait for the door to open, my father coming in and beating me.

Th.: How old are you?

C.: Eight or nine. I am wearing a red polo-neck sweater like back then. It was a terrible time.

Th.: What do you need?

Cl.: I want him to enter without a stick in his hand and I want him to take me in his arms.

Th.: Is that possible?

Cl.: No. I feel despair. I do not have the courage to go to him and hug him.

Th.: Where do you feel the despair?

Cl.: Everywhere.

Th.: Does it have a form?

Cl.: I do not know. It is red, round, and it moves in circles. There is no solution.

Th.: What does the red and round one need to do?
Cl.: Break. I am caught in it. It can only be destroyed from the outside. He would have to hug me just once. I feel hate against my father; it is struggling up. I want to beat him.
(Sibelius, The Swan of Tuonela)
Cl.: The father should feel my feelings. He is circling around me. It is awful. He is unpredictable.
Th.: What is the father feeling?
Cl.: I do not know. I do not want to feel it.
Th.: What do you want?
Cl.: Get up and not be afraid anymore. The child needs nurturance.
Th.: Can you give that to the child?
Cl.: Yes. (To the inner child). I love you. You can always come to me. He looks at me. He is confused. Now he looks away. I am patting the child's head. He looks up again. He starts getting up. I hug him very firmly. I feel warmth and contentment like at the safe place.
(Boccherini, Concerto for Cello in B flat major, Adagio)
Th.: What happens now?
Cl.: I have the child in my arms and we look into each other's eyes. I put him down and together we walk through the door. He holds my hand firmly. He trusts me. We are going into a different life. The child is pulling me away from this place. I turn around. I see the empty room. I am happy and proud for having freed the child.
Th.: Can you feel the freedom?
Cl.: Yes in my whole body.
Th.: Where are you?
Cl.: At no definite place. I feel expectancy and joy for taking part in the life of the child.
Th.: Does the child want that?
Cl.: Yes, it is encouraging for him. He seems self-confident.

Stabilization: work with perpetrator-introjects

- Naming perpetrator-introjects.
- Giving them a form.
- Find helpers for fighting the evil.
- Render the evil creature harmless.
- Finding the treasure of the evil creature and make it one's own.
- Becoming conscious of how this protection influences one's life.
- Functions of the music: Providing support and safety, mirroring the introject's energy or power, and offering help fighting the evil creature.

Case example:

(Bach, Adagio in C major)

Cl.: I took the child in my arms. We are looking at each other.

Th.: What do you see?

Cl.: Hope, strength and energy.

Th.: What happens now?

Cl.: We looked at each other and the child nodded at me as if he knew exactly what we would do now. I put him down and we are walking.

(Bach, Mein Jesu)

Cl.: I can see something. In the far distance is a dark spot. We are walking through the light passage towards the spot but we cannot get any nearer. It is as if the spot is moving, too. I am impatient. The child pulls me back as if he wanted to say: “Be patient!”

Th.: Is that okay?

Cl.: Yes.

Th.: What is happening now?

Cl.: The light fog around us is disappearing slowly. It becomes darker. Everything is changing.

Th.: What are you aware of?

Cl.: Coldness. It is getting cold. … It is dark. The only light here is radiating from us.

(Bach, Easter Cantata, Chorale)

Th.: What happens now?

Cl.: I have the feeling that we are inside the fear. We did not even see it.

Th.: How is that?

Cl.: I am not afraid. We are just in it. It is cold. It is as if the child had seen that before. I look around in wonder.

Th.: How is it for the child?

Cl.: I have the feeling that he is happy that I am with him. He has so much hope.

(Bach, Orchestral Suite #3, Aria)

Cl.: We are walking on. Caves and passages are opening … it is as if the fear is leading us, as if it wants to show us how it looks inside it. There are many rooms. They are all different. … it starts getting lighter. … it is calm.

Th.: Is that good?

Cl.: Yes, I feel very safe. It is as if the child wants to lead me somewhere. We stand in front of a wall. The child nods at me as if to say: “Do not be afraid. Just come with me.” The wall is opening.

Th.: What is behind it?

Cl.: I see a very big room, a hall. It is round. There are columns at the sides. One can walk around on the top. There are many openings. Staircases are leading downwards. We walk down. It is like being in a hemisphere and walking down to the bottom of it.
Th.: What are you feeling?
Cl.: I am excited.
Th.: And the child?
Cl.: He is very calm… No, that is impossible! In the middle there is a black ball. It is turning. The father sits on the ball. [Tears]
(Mozart, Ave verum corpus)
Th.: What is happening now?
Cl.: We are watching him. … He is just sitting there with his head hanging down. The ball is turning. He is looking up. He is looking at us. [Tears] No movement, he is just looking. He is bending his head again as if he did not recognize us. In his eyes there is desperate fear. His face is without any movement.
Th.: How is that for you?
Cl.: I am irritated. I do not understand that. The child pulls me down towards him. He wants to tell me something.
Th.: What?
Cl.: He almost yells at me: “Can you see now? Do you understand now?” I start to understand why he is at this place. It is as if he is damned to be here. I had expected anything but not to find the father in the centre of the fear. I am still watching but I do not see any movement.
(Warlock, Capriole Suite, Pieds en l’air)
Th.: What is there now?
Cl.: We want to leave this place.
Th.: Is that possible?
Cl.: Yes, because I know that I can come back any time. Both of us can enter. He is caught. I turn around once more.

Trauma exposure

- Visiting the traumatic situation in a very structured setting.
- Encouraging inner comforting.
- Functions of the music: Providing support and safety; reminds of the present situation (the music was not present during the original trauma); a walking rhythm helps to keep going through the trauma memories and prevents unwanted dissociation; evokes dissociated affect and body memories which can be linked to the rest of the memories.

Integration

- Similar to regular psychotherapy for non-traumatized patients.
- Functions of the music: same as in BMGIM

(Körlin 2002, Reddemann 2001)

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