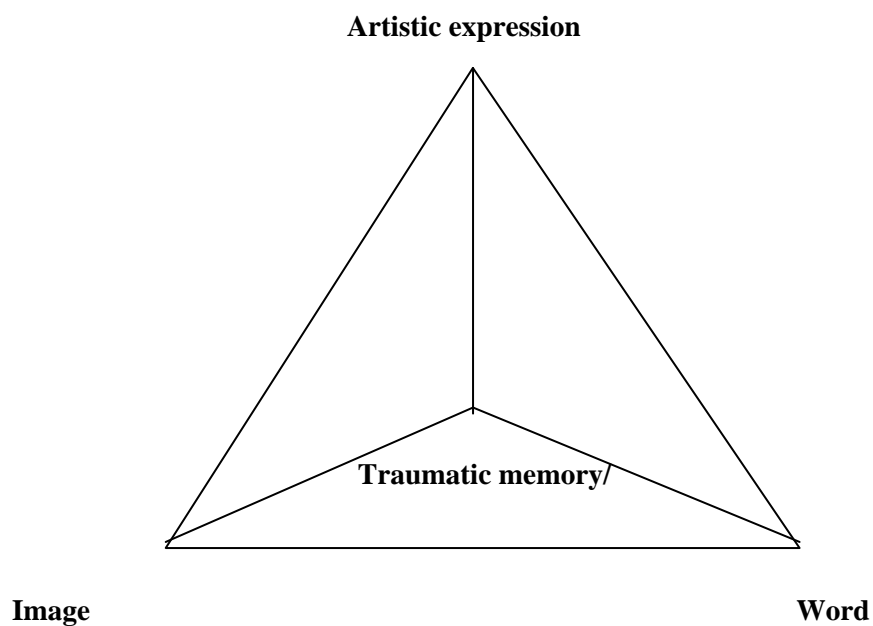


Creative Arts Therapies in Psychiatric Treatment

A Clinical Application of the Bonny Method of Guided Imagery and Music (BMGIM) and Creative Arts Groups

by

Dag Körlin, MD



Stockholm 2005

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To Gun, Anna Ellika and Jenny

Abstract

The Creative Arts Therapies (CATs) are characterized by imagery in altered states of consciousness, artistic expression (art, music, dance, drama) and metaphoric expression (as in poetry). The CATs implemented in this thesis consists of The Bonny Method of Guided Imagery and Music (BMGIM), and the Spektrum Creative arts group program. Spektrum is a four-week treatment program, where group applications of BMGIM and Art therapy are combined with psychodynamic verbal group and occupational therapy. BMGIM and Spektrum both have all the characteristic components of CATs.

In addition to the tools of verbal therapy, CATs techniques also evoke implicit (non-verbal) memories and analogic symbols (sensory images with multiple, parallel meanings). CATs are proposed to provide analogic symbolization for integrating bodily, and affective memories stored outside of verbal recall. They also spontaneously mobilize inner resources that facilitate a therapeutic reexperience of traumatic memories.

The aim of the study was to investigate general and subgroup treatment effects with particular focus on gender and trauma, suggested in the literature. Since control groups were difficult to obtain, outcome differences between subgroups were cues to indications for treatment.

Effects were measured according to statistical significance, effect size and change from pathological to non-pathological status. Outcome measures were the Symptom Checklist-90 (SCL-90), Inventory of Interpersonal Problems (IIP), and the Sense of Coherence (SOC) scale.

The Dissociative Experiences Scale (DES-II) was translated and validated for the purpose of using it as a possible prognostic factor. The Relationship Style Questionnaire (RSQ), was included as a validating measure of the DES. A Trauma Quality Questionnaire (TQQ) was developed, exploring different qualities of trauma. Three populations were studied: 1) general psychiatric patients with a range of diagnoses 2) psychotherapy clients and 3) 650 subjects from a normal population.

Results:

Viability of the Spektrum program was demonstrated by statistically significant changes in the Spektrum sample of 43 patients with a wide range of diagnoses. In the BMGIM study, clinical significance was demonstrated through the change of 6 of 10 patients from pathological (dysfunctional) to non-pathological (functional) status according to the SCL-90 criteria, with large effect sizes. The functional subgroup was improved in measures that are considered hard to change through psychotherapy. Gender differences in IIP and SOC subscales were found following BMGIM treatment. The men were at a disadvantage not only in outcome, but also in greater pre-treatment impairment. Possible ways of improving the fit between BMGIM and gender are discussed.

In the Spektrum sample, a history of trauma was a positive prognostic factor, as a traumatized subgroup had better outcomes, although with a large variation in the treatment results. As DSM diagnoses were not indicative of outcome, a dimensional concept of trauma related disorder was explored. Patients with separative trauma were found to have the best outcomes. A neuropsychological theory of traumatic imagery in BMGIM is presented. The DES was validated and found to have adequate psychometric properties to be used as a prognostic factor. Other dimensions to be explored include attachment, creativity and autobio-graphical memory. Finally, ways of developing CATs for trauma-focused psychotherapy are discussed.

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Papers

This thesis is based on the following papers, which are referred to in the text by their Roman Numerals.

- I Körlin D, Nybäck H, and Goldberg F. (2000). Creative Arts Groups in Psychiatric Care: Development and Evaluation of a Therapeutic Alternative. *Nordic Journal of Psychiatry*; 54:333-340.

- II Körlin D, and Wrangsjö B. (2002) Treatment Effects of Guided Imagery and Music (GIM) Therapy. *Nordic Journal of Music Therapy*; 11(1): 3-15.

- III Körlin D, and Wrangsjö B. (2001). Gender Differences in Outcome of Guided Imagery and Music (GIM) Therapy. *Nordic Journal of Music Therapy*; 10(2): 133-143.

- IV Körlin D, Edman G, and Nybäck, H. (2004). Screening for Trauma - Reliability and validity of a Swedish revision of the Dissociative Experiences Scale-II (DES-II). (Submitted Manuscript)

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Abbreviations

APA	American Psychiatric Association
ASC	Altered States of Consciousness
BDD	Body Dysmorphic Disorder
BMGIM	The Bonny Method of Guided Imagery and Music –
BPD	Borderline Personality Disorder
CATs	Creative Arts Therapies
CBT	Cognitive Behavioural Therapy
CT	Cognitive Therapy
DBT	Dialectic Behaviour Therapy
DES	Dissociative Experiences Scale
DESNOS	Disorders of Extreme Stress Not Otherwise Classified
DID	Dissociative Identity Disorder
DIM	Directive Imagery and Music
DSM	Diagnostic and Statistic Manual
EMDR	Eye Movement Desensitization and Reprocessing
GAD	Generalized Anxiety Disorder
GAF	Global Assessment of Function
GAS	Global Assessment Scale (= GAF)
GIM	Guided Imagery and Music – A comprehensive term for BMGIM and it's various clinical adaptations
ICD-10	International classification of Diseases, tenth revision
IIP	Inventory of Interpersonal Problems Individual form
OCD	Obsessive Compulsive Disorder
PET-scan	Positron Emission Tomography
PTSD	Post-traumatic Stress Disorder
RSQ	Relationship Style Questionnaire
SCL-90	Symptom Checklist -90
SOC	Sense of Coherence

CHAPTER I

Creative Arts Therapies (CATs)

Painting, dance and music have been used for healing, probably since the beginnings of humanity. The first documentation of organized use of Creative Arts Therapies comes from the cathartic tradition in antiquity. Catharsis was the cleansing of emotions through poetry, dance, drama, music and painting. It was continued by Hippocrates (dreams and painting as diagnostic of disease), Asclepius (healing through dreams and imagery), and Synesios (fantasy as a link between thought and soul)(Wide, 2005). Islamic sufi traditions of healing through imagery, music dance, and painting have been documented in the middle ages (Horden, Peregrin (ed.) (2000).

Modern Creative Arts Therapies started developing in the beginning of the twentieth century, and found increased use after the Second World War for the treatment of War trauma including PTSD. The psychotherapies of the day proved inadequate for posttraumatic disorders. The Creative Arts Therapies found immediate use as sources of motivation, connection and mobilization of abilities (Feder and Feder, 1985; Schmais, 1985). Although their efficacy so far has not yet been conclusively established, they remain necessary.

Today, Creative Arts Therapies (CATs) have found continued use through: 1) artistic expression as in art, music, dance and drama therapy, 2) imagery as in receptive music therapies and The Bonny Method of Guided Imagery and Music (BMGIM), 3) metaphoric expression as in poetry, enchantment and narrative and, 4) combinations of the above. For example, painting is in many methods used as a link between internal experiences and verbal integration.

The presence of spontaneous creativity is by the author considered the hallmark of CATs, setting them apart from for example Cognitive Art Therapy or Behavioral Music Therapy, where there is a conscious manipulation, and an intended outcome, of painting and music making.

A common denominator of the various CATs is the intentional use of a trained therapist of art, music, dance/movement, drama, and poetry in psychotherapy. Definitions also include mobilization of potentials, organization (physical, emotional, mental, social and cognitive), and interaction (e.g. Barcello, 1996).

Within psychiatry, CATs have been flexibly adapted to a variety of conditions like affective, anxiety, dissociative and somatization disorders, substance abuse, suicidal behavior, borderline personality disorder and schizophrenia.

The CATs implemented in this thesis consists of BMGIM, and the Spektrum creative arts group program. Spektrum is a treatment program where group applications of BMGIM, Art, and Expressive Arts therapies are combined with psychodynamic verbal group and occupational therapy. A literature review of each of these implementations is provided in Papers I and II.

Theoretical framework

Within CATs it is important to distinguish between the methodology on one hand and on the other the theoretical framework used to understand and manage experiences, treatment processes, and interventions. A given methodology may be informed by different theories. However, theories mostly come from psychodynamic or Jungian psychologies, or integrations of these. Some methods, like BMGIM, where spiritual experiences in a wide sense are frequent, also include aspects of transpersonal psychology.

The theoretical framework presented here integrates knowledge and theories from several fields. These are:

- 1) current neuropsychology of memory, imagery, symbols/representations, modern developmental psychology (Stern, 1996, 2000; Trevarthen, 1996; Trevarthen and Malloch, 2000; Siegel, 1999); affect theory (Tompkins, 1962-63); attachment theory (Ainsworth, Blehar, Waters et al. 1978, Bowlby, 1988; and Mains, 1995).
- 2) imagery and Altered States of Consciousness (ASC) (Crasilneck and Hall, 1985).
- 3) resilience and psychological resources (Antonovsky, 1987; Jung, 1966; Bishop, 1994; Körlin, 2002).
- 4) Psychodynamic, Archetypal/Mythological, Cognitive and Transpersonal theories consistent with current neuropsychology.

At the outset, some basic neuropsychological concepts need to be briefly outlined. They are: information systems/neuronal networks, perceptions and imagery, explicit and implicit memory, discursive and analogic symbolization, affect/emotion, dis-association/dissociation and consciousness.

A more extensive presentation of these concepts is presented as chapter III of this thesis, “A Neuropsychological Theory of Traumatic Imagery in the Bonny Method of Guided Imagery and Music (BMGIM)”. Here, knowledge is combined from the fields of neuropsychology, psychological trauma, trauma therapy, BMGIM and clinical cases into a theory of traumatic re-experience in BMGIM, and their clinical management. This theory is, however, not only applicable to trauma, but also to affects arising in dysfunctional human relationships. Although developed within the context of BMGIM, the theory combines all the components characteristic of CATs: spontaneously creative imagery and artistic expression, bodily interventions, use of metaphors, and verbal integration. Thus, the theoretical framework presented is applicable to CATs generally.

Information systems of the brain

There is an estimated one hundred billion neurons, each with an estimated ten thousand connections, or synapses, with other neurons. In the synapse the signal is propagated to other connected neurons, which in turn may branch to yet another set of neurons, making an estimated sum of one million billion connections (Kandel and Schwartz, 1992; Green et al, 1998). This branching forms *neuronal networks*, capable of firing in a multitude of spatial and temporal patterns. A firing pattern is considered to constitute specific information (Tucker, 1992; Rolls and Treves, 1994). “Neurons that fire together will wire together” (Hebb, 1949) through strengthening of synaptic connections. The firing pattern is a distinct code that cannot be directly understood by another neuronal network. Translation is done by associational linking of neuronal networks into a larger information system, speaking yet another “language”.

Associational linking and autobiographical memory

Perceptions, memories, emotions, words and symbols are all constituted by specific spatial and temporal neuronal firing patterns. For example, the experience of an event activates visual, auditory etc sensory codes, which become a whole perception when linked together into a new neuronal network “speaking” a new code. This information is then normally linked with sensory, bodily and emotional memories and social cognition and further translated into images and words. In the process, larger and larger information systems are formed. The constant integration of different qualities of information into a coherent whole creates an autobiographical memory - a sense of continuity of self across time, linking past experiences with present perceptions and anticipations of the future.

The integrative process strives toward narrative coherence, reflected in both the way a life story is told, and the nonverbal manner in which life activities are lived. This associational linking of events has been shown to be disrupted by excessive and/or prolonged release of stress hormones, for example by overwhelming traumatic events in adulthood or trauma and neglect during psychological development. Development of autobiographical memory has on the other hand been shown to be promoted by safety, adequate stimulation and a “narrative climate” during upbringing (Siegel 1999, chapters 1, 2; Tulving et al, 1994). CATs mobilize, through imagery, the analogic symbol or representation (see below), the component of Autobiographical memory that is “hidden” in the verbal dialogue of ordinary consciousness.

Perceptions and imagery

Sensory perceptions are experienced in the visual, auditory, somatosensory and gustatory/olfactory areas of the cerebral cortex. The different sensory codes of for example a tree are linked together by the association cortices into larger networks, creating a coherent perceptual representation. To put the tree-representation into a coherent context, it is associated in even larger networks, thought to be encoded and retrieved by the orbitofrontal cortex (Kapur et al, 1995; Wheeler et al, 1997; Buckner, 1996). Imagery is defined as sensory perceptions originating from within the brain, or secondary perceptions. Images are proposed to be mediated by activity in the same sensory areas as are active in primary perception from the outside world, and considered to start with the evocation of memories (Roland and Gulyas, 1994).

Explicit and implicit memory

Two forms of memory, explicit (verbal and conceptual) and implicit (non-verbal, perceptual, bodily and emotional) are important for understanding CATs, and psychotherapies generally. Explicit memory involves an act of conscious retrieval. It is a tangible experience to search for, and recall, an explicit memory. It can be declared with words and assessed as “true” or “false” (Siegel, 1999). After use, it can be put back into storage until needed again, and ultimately it can be forgotten. In contrast to explicit memory, implicit or non-declarative memory is activated outside of conscious control and without a subjective experience of recall, self, or time. In a sense the memory just “happens” to a person when activated by internal or external cues. Implicit memory includes everyday behaviors and motoric skills, affects/emotions, and perceptual images. They are slow to establish, and hard to “forget” (Siegel, 1999). They also include vitality affects, internal working models, and interactions between caretaker and developing child such as the “pronarrative conversation”. Implicit memories are proposed to form a strong component of transference (Stern, 2000).

Discursive and analogic symbols and metaphors

Discursive and analogic symbols, or representations, are two qualitatively different forms of information processing. Simply put, discursive symbolization processes information through the word and analogic symbolization through the image. The difference between discursive and analogic processing has been summarized as the difference between rational and intuitive, text and context, external and internal attention and action (Ornstein, 1997; Rotenberg, 1994). Discursive (Langer, 1957), lexical (Horowitz, 1983) or digital (Siegel, 1999, page 179) processes are slow, sequential, linear, utilizing monosemantic, strictly defined "packets" of information. The information packets can be manipulated with analytical, logical thought and communicated through words. Analogic processes, on the other hand, are fast acting, parallel and holistic. They contain non-verbal representations of sensations, images and the polysemantic meaning of words. (Siegel, 1999; Langer, 1957). For the purpose of this exploration into CATs, analogic symbolization is here defined as a spontaneously created internal image, that is a condensation of many sensory memories and that carries a multitude of parallel meanings about the past, the present and the future of the person. It may be translated into an external symbolic image by creative expression through for example painting, music making, and dance. It is also proposed in this thesis, based on the findings on the integrative functions of the orbitofrontal cortex (Kapur et al. 1995; Wheeler et al, 1997; Buckner 1996), that this structure mediates symbolic imagery.

When exploring the symbol with language, concepts, and logic we disentangle the possible meanings one by one through discursive symbolization. The metaphor, or word image, is a transitional stage between analogic and discursive symbolization. The potential of metaphor in BMGIM has been explored by Bonde (2005).

Affect and emotion

Vitality affects are bodily profiles of arousal such as surges of energy and strength (Stern, 1985). Categorical affects, for example interest, enjoyment, fear and distress (Tomkins, 1962, 1963) differentiate into emotions by being related to the self, relationships and to discursive concepts (Basch, 1988), enabling one to say "You make me glad". In this thesis "affect" is used according to affect differentiation theory meaning an undifferentiated experience of for example anger, rage and helplessness where the "components" are not possible to recognize and name.

Functional and dysfunctional implicit memories, dis-association and dissociation

Implicit memories of normal development are functional and manifest as imagery, emotions, bodily reactions, motor skills, and healthy working models according to attachment theory. Traumatic memories, which are dissociated from other relevant information about an overwhelming event, also are implicit memories. They are not repressed in the sense of a stable defense mechanism, but dissociated. Repressed memories and affects have lost contact with consciousness in a stable way (Basch, 1988, chapter 5). Traumatic memories have an on-off quality, being either unconscious or intruding into consciousness (van der Kolk, 1996).

Dis-association and dissociation are terms with many meanings (Spiegel, 1996; Waller et al, 1996; Putnam, 1997). Dissociation is defined by the DSM as a "disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (APA, 1994). Here, dis-association is used as a general concept, to describe any disruption of associated information networks, linked together in the psyche's search for meaning (Siegel 1999). However, dis-association in this general sense does not necessarily lead to psychopathology and a psychiatric diagnosis. Re-association will be described as a general mechanism of action for CATs.

Dissociation is used here to denote dis-association that manifests as psychopathology. Dissociation is hypothesized to mainly be a consequence of intrusive trauma (see below). Overwhelming psychological trauma, neglect, and stress are established as major causes of dissociation. Traumatic experiences are thought to be stored as sensory and affective implicit memory fragments, being either unconscious or intruding into consciousness, as in the flashbacks of Posttraumatic Stress Disorder (PTSD) (van der Kolk, McFarlane, and Weisaeth, 1996).

Imagery in Altered States of Consciousness (ASC)

For imagery to become conscious, attention has to be shifted from external to internal perception through an alteration in the state of consciousness. The shift from external to internal perception can be achieved through a number of methods like relaxation, focusing, meditation techniques, breathing exercises etc. Once in the internal world, the client may follow intentional directions from a guide or from own intentions in the form of discursive thoughts (cognitive imagery). Alternatively, a spontaneous chain of imagery may be set in motion by an analogic stimulus (spontaneously creative imagery). Analogic stimuli are by the author classified as receptive or active. Receptive stimuli include listening to music that carries multiple meanings or alternatively contain repetitive elements that stimulate internal perception. Absorption in art, sculpture and dance presupposes an ASC (Altered State of Consciousness) wide enough to hold both external and internal perception in consciousness. The same is true for being absorbed in a creative activity like making music, dancing or painting, although here an alternate opening and closing of the eyes may facilitate the link between internal and external. Once in a creative ASC, the experience may widen spontaneously into a range of experiences, coherently described within GIM (Bonny/Summer 2002; Goldberg, 2002; Grocke 1999; Chapter III).

Imagery has potential for transformation, which in BMGIM means a sudden, often paradoxical creative solution of an impasse, or “stuck” crisis situation, in the imagery. Transformative imagery often takes place in a transpersonal or other strongly altered state of consciousness. Those situations are analogous to meeting ones shadow in Jungian terminology. Spontaneous transformative experiences with music in ASC occur also in dance and music making (Benson, 2002) and spontaneously, in everyday life (Gabrielsson and Lindström, 1995; Gabrielsson 2001).

It is important to distinguish cognitive and spontaneously creative imagery as fundamentally different processes. However, they may interact or intermingle when the metaphoric function is activated as inner speech, and they may fuse in widened states of consciousness. Lately links between imagery and autobiographical memory have begun to be explored (Holmes and Hackman, 2004).

That imagery presupposes an Altered State of Consciousness (ASC) (Crasilneck and Hall, 1985) is an established, but nonetheless overlooked fact within the major psychotherapeutic schools, as well as in psychiatry. Altered states and imagery are common in psychiatric phenomenology. ASC:s are involved in all disorders with a dissociative component, including PTSD, partial PTSD and complex PTSD. Imagery may also be present in anxiety disorders like Generalized Anxiety Disorder (GAD), agoraphobia, social phobia, Obsessional Compulsive Disorder (OCD), Body Dysmorphic Disorder (BDD), depression and psychoses (Holmes and Hackman, 2004). Spiritual emergencies that are spiritual experiences with a frightening, threatening or otherwise disturbing quality can be conceptualized as imagery in ASC. All therapists working in ASC:s should be familiar with these conditions, since such patients often seek their help, most of them in need of stabilization, navigation, containing methods or verbal working through of experiences rather than deeper exploration in ASC. A discussion of imagery in ASC visavi the hallucinations of schizophrenia and other psychoses is important, but will not be attempted here.

Internal resources and resilience

A growing literature addresses psychological resource as opposed to deficiencies due to psychopathology, which is still the dominant aspect in psychiatry and the major psychotherapies. Antonovsky coined the concept of salutogenesis (1987), measured by the Sense of Coherence (SOC) scale. Salutogenesis denotes internal abilities that promote psychological growth and health as a response to potentially pathogenetic stimuli. Other similar concepts include Locus of Control, as measured by the Locus of Control Scale (Rotter, 1966), “adversarial growth” (Linley and Josef, 2004), Monsens Vitality concept (1991) and Positive Abilities (Nordenfelt, 1991 a, b.). Mobilization of resources through music playing/listening has been explored by Aldridge (1996) and Ruud (1998). The SOC scale has been used in the papers of this thesis.

The items of this and similar measurements are all abstractions and the quality behind them are difficult to experience as tangible resources by the individual in the discursive/everyday state of mind. The everyday, discursive mode seems more geared to perceiving, describing and solving problems than experiencing and using resources. They are mobilized and experienced in ASC, as for example in the spontaneous strong music experiences described by Gabrielsson and Lindström (1995) and Gabrielsson (2001). In the psychotherapy context, resource imagery is mobilized either intentionally, through cognitive visualization, or in the spontaneous mobilization of resources, taking place in CATs. In BMGIM, they are seen as functional implicit memories and analogic symbols that make the confrontation with traumatic memories, difficult affects and self images possible (Bishop, 1994; Chapter III).

Summary

CATs access a wider range of psychological domains than therapies based solely on verbal interaction. This wide range of activation takes place through mobilization of the senses, imagery in ASC, and symbolic/metaphorical expression through the different forms of art. The evocation of implicit memories and their processing through internal and/or external analogic representations are central to CATs. Also central is the mobilization of inner resources that allow the patient to hold and own difficult affects, dysfunctional self images and traumatic memories, thus making them available for re-association and symbolization. Cognitive understanding can then be integrated with emotion, social context, and imagery to reestablish a sense of functioning self and autobiographical memory.

The Bonny Method of Guided Imagery and Music (BMGIM)

The Bonny Method of Guided Imagery and Music (BMGIM) is one of four recognized forms of music therapy, developed by the American music therapist Helen Bonny (1978a, b, and c, 1988, 2002). Since it's creation as a psycho spiritual method about 30 years ago, BMGIM has been developed and adapted for various clinical manifestations, and documented in more than 400 articles, book chapters and books (Bonde, 2002). In the recent textbook “Guided Imagery and Music – the Bonny Method and Beyond” (eds. Bruscia and Grocke, 2002), authorities cover definitions, theory, research, developments, and professional issues. Helen Bonny's collected articles and lectures have been published in a volume edited by Lisa Summer, “Music and Consciousness” (2002). For a general literature review the reader is referred to paper II, for a review on gender aspects to paper III, and for GIM in trauma to Chapter III.

BMGIM refers to the individual form where the client/patient spontaneously images while listening to music, and at the same time engages in a dialogue with the therapist. GIM refers to individual and group adaptations for clinical and other populations. A BMGIM session may vary between 90 and 120 minutes, and has the following components

- 1) A verbal pre-session, or “prelude” (15-30 minutes), where current issues are explored, including the impact of the previous session on the psyche and daily life. During this phase, the therapist tries to evaluate the client on both explicit and implicit levels in order to choose a suitable relaxation and music programme attuned (Stern, 2000) to the patient’s issues and current state.
- 2) To facilitate the entry into the music experience, a short relaxation is performed, followed by an “induction”, or starting image (5-10 minutes). The starting image may be very open, or contain a metaphor attuned to the clients needs, for example a meadow, a path, or an image from the previous session.
- 3) Listening to the music in an ASC (30-50 minutes), induces a flow of emotions, thoughts, memories and images for all senses. The imagery organizes into a metaphorical narrative, that the patient, or “traveller”, reports to the therapist or “guide”. The guide engages in a dialogue with the traveller, by open-ended questions and suggestions. The guide’s role is to be present, supportive and encouraging, without directing the experience, and giving as much room as possible for the travellers spontaneous imaging. The traveller may encounter difficult relationships and traumatic experiences as well as inner strengths and potentials. As the music session deepens, a wide range of altered states of consciousness may be evoked, making healing, transformative and spiritual experiences possible.
- 4) As the music ends, the guide explores the travellers situation, and more directly guides him back to the external reality. If needed, the guide here has the option to continue with more music.
- 5) In the post session or “postlude” (20-30 minutes), imagery is worked through with creative expressions such as art, clay, music improvisation, and movement, followed by an open-ended verbal integration.
- 6) The guide continuously records the unfolding imagery, along with notes on music and interventions. After the session, the traveller gets the original of this record, while the guide keeps a copy. The traveller is encouraged to work with the session material until the next session in the form of journaling, further paintings etc.

Classical music mainly from the baroque, romantic, and impressionistic periods, is used for the BMGIM session. The music is organized into “programs” of 30-50 minutes length, following principles developed by Bonny, who created twenty-three programs. Subsequently, other BMGIM therapists, or “facilitators” have contributed more, bringing the total number to almost ninety (Bruscia and Brocke, 2002). With experience, the facilitator learns to improvise music choice during the session

Classical music that has endured into the present is used, since it has shown the ability to transcend the composer’s intentions and can be invested with new meanings generation after generation. Such music carries many potential meanings, thus having the properties of a moving analogic symbol, and the ability to evoke analogic imagery. Music is not chosen for an intended effect, but to provide the traveller with potentials to work with issues on the analogical and metaphorical level.

The images can be seen not only as symbols of formative events, relationships and conflicts according to psychodynamic theory but also as archetypes, according to Jungian psychology. Imagery may also reflect unsymbolized bodily and sensory preverbal interaction of the so-called protonarrative conversation between infant and early caregivers. The preverbal communication between the baby, using "baby talk", and the mother, talking "motherese", linked to specific states of consciousness of the child has been shown to encompass musical qualities (e.g. Stern, 1996; Trevarthen and Malloch; 2000). Traumatic experiences and interactions are also often stored in implicit form, for example as flashbacks that may be evoked by alarm qualities of the music, as proposed in Chapter III.

The BMGIM process is characterized by a cyclical evolution of positive and problematic aspects of the psyche. The experience of positive or resource imagery encourages the patient to confront difficult experiences, for example the reexperiencing of trauma (Bishop, 1994). In BMGIM, the transference work is done not only in relation to the therapist, but also to a large extent internally vis-à-vis music and imagery. The verbal interaction during the BMGIM session also fosters integration of implicit memories and analogic symbols with language and logical understanding (discursive symbolization) (Chapter III).

The term GIM is used when the components of the session are adapted to address the needs of different populations. Psychiatric patients often have difficulties of tolerating affects, memories and images evoked in the full BMGIM session, where psychologically demanding music is used. To adapt, all phases of the session may be shortened. The patient may sit up instead of lying down on a couch, and maintain eye-contact with the guide. The theme of the session may be focused, the relaxation may be brief, and the starting image directive. Music of little evocative potential ("small containers") may replace the more demanding music ("large containers") of the regular BMGIM session. Guiding may be directive, leaving little room for spontaneous imagery.

In group work, patients listen together in silence to the music. For obvious reasons, guiding takes place in the post-session. Patients describe their experience, often with the help of a painting created after the music has ended. This form of guiding presupposes a trained BMGIM guide, that afterwards can recognize and explore non-verbal experiences that has taken place during the music, and employ adequate BMGIM interventions. For an overview of clinical adaptations, the reader is referred to Summer (1988), Goldberg (1994) and Körlin (2003). In Körlin (2003) the development of the Group GIM Therapy used in the Spektrum program is described.

The Spektrum Creative Arts Group Program

Spektrum is a Swedish adaptation of multimodal Creative Arts programs within acute psychiatric care and inpatient PTSD programs. (Goldberg, 1994; Foa, Keane and Friedman, 2000). The Spektrum program has two essential features: 1) Group cohesion, which is fostered by the special continuity person, the encouragement of group interaction, and the security of the framework. 2) There is a high emotional temperature due to the evocative power of CATs, and a four week time limit.

The group, is the basic ingredient of the program. In Creative Arts groups in psychiatry, there is a need for structured, individual-in-group processing. This type of group is able to channel and absorb difficult group processes.

As the result of a reorganisation, a traditional general psychiatric ward was stripped of most of its staff, and turned into a group ward with an emphasis on creative methods. A group started every second week, which meant that there were two overlapping groups of 8-10 patients at the ward simultaneously. Each group was followed through a weekly schedule of sessions by one of three psychiatric nurses, who monitored the group and acted as co-therapist to the specialized group leaders. The third nurse thus had a two week interval in which to discharge the previous group, and prepare the next. The patients had the option to stay overnight during the week, but not on weekends. There was a fixed weekly schedule of GIM, Art, Body Awareness, Psychodynamic- and Occupational therapy groups. These were lead by therapists from the various outpatient units of the clinic.

Since the inpatient population was diagnostically wide, exclusion and inclusion criteria were based on psychiatric and psychotherapeutic dimensions like phase of psychiatric illness, physical acting out, suicidality, strength and nature of defenses, reflective capacity, and motivation. Diagnoses were used for exclusion more than inclusion, mainly of sociopathic disorders and active substance abuse. Patients with a history of schizophrenic psychosis or schizotypal disorder were generally excluded, but could be accepted if considerable motivation and sufficient ego strength were present. They still needed higher levels of safety, continuity, and framework, and required lower psychotherapeutic intensity than patients from other diagnostic groups. Those with paranoid disorders or strong projective mechanisms were generally not interested in the program.

Other inclusion criteria were that patients had to be through the acute phase of their condition or crisis, symptoms stabilized, and on a steady medication. Patients had to be willing and able to explore the personal history of symptoms, affects, interpersonal conflicts and self-concepts. Attitudes participating in groups and motivation for following the schedule were also evaluated. Every patient who met the above criteria, and declared an interest in participating, was accepted. In fact, patients tended to be either interested or disinterested when offered to participate, and this reaction had the greatest prognostic value for participation or non-participation in the program.

Applicability of CATs

General

There are some basic questions when evaluating whether Creative Arts therapies are feasible in heterogeneous psychiatric/psychotherapeutic populations. Any new form of therapy first needs a phase of stabilization and exploration of effects and possible indications. Measures need to be found that can quantify the psychological changes of the therapy in the chosen population with low enough standard deviation. The ultimate questions are those of validity and reproducibility, which requires a stable influx of patients large enough for statistical power and randomization.

The term “effect” refers to changes before and after treatment without comparison of changes in a matched and randomized control group. Effect can be measured, with increasing certainty as pure statistical significance, as “effect size” and as change from dysfunctional to functional status, or change of “case-ness”.

In the first stages of exploration, positive effects, clinical usefulness, and practicality is the first basis for continuation. When specific control groups are difficult to obtain, outcome differences between subgroups are cues to indications. Subgroups are included according to common criteria, receive the same treatment, and pretreatment similarities or differences can be measured. The main caveat for using subgroups as mutual controls is that they may improve or deteriorate differently with time.

Gender

Although overlooked, gender is a basic subgroup factor in treatment, considering the many epidemiological and clinical differences between men and women in psychiatry and psychotherapy. In contrast to other health fields, psychotherapy is an area in which men may be the disadvantaged gender. In national US surveys, men and women consistently are mirror opposites in prevalence of depressive disorders and alcohol abuse (e.g. Hanna and Grant, 1997; Pajer, 1995). In Swedish general psychiatry, women are more common than men, who seem to be more dysfunctional, less prone to psychotherapeutic treatment and more likely to be found have substance abuse. As of today 17% men have attended the Spektrum program, and in the study of individual BMGIM the men accounted for 33% (Paper III). There is, however, unpublished data of gender differences in 350 Spektrum patients, some of which will be summarized after the BMGIM study.

From the point of view of male disadvantage, it has been argued that there is a bias toward the female in the phenomenology of anxiety and depression, and consequently also in psychotherapy methods developed to deal with these conditions (Heifner, 1997). Women dominate the borderline personality disorder diagnosis (Simmons, 1992), and a special psychotherapy, Dialectic Behaviour Therapy (DBT), has been specifically devised for young self-destructive women.

In BMGIM there is a female bias in the sense that it can be said to have been developed by women mainly for women. In BMGIM theory, mother-child bonding, nurturing experiences and "music as mother" are essential elements (Ventre, 1994; Summer, 1995; Wärja, 1999). Meadows (2001) explored eight BMGIM therapists' constructs of their clients, each rating about ten clients. Each therapist was found to have gender constructs; a concept of what it meant when clients were male-like and female-like. When compared, male-like and female-like qualities were generally seen as very different. Interestingly, the male-like constructs were typically perceived as not conducive to effective BMGIM, whereas the female-like constructs were seen as effective. Meadow's results imply that an awareness of the gender perspective is essential for the therapist in evaluating male-female responsiveness to BMGIM. This would seem important especially in "engendered" dimensions in BMGIM as mothering, "father hunger" (Bush, 1995) and integration of anima or animus (Brooks, 1994).

In a response to the female perspectives, Bruscia (1995) in a phenomenological study identified, in BMGIM therapy with both men and women, a "penetrating" mode of consciousness in BMGIM, distinct from a "containing" mode. He has also developed music programs addressing male needs (Bruscia, 2002 a,b,c). These still developing male augmentations of the BMGIM method were not available for the clients of the present study, raising the question if their BMGIM treatment favoured the female clients compared to the male.

However, although it is generally assumed that women are more empathic, relational, and psychologically minded than men, the majority of studies have failed to confirm the assumption that females benefit more from psychotherapy than males, and that women therapists are more effective than their male counterparts, for that matter. Any study attempting to explore gender differences must address this enigma.

A literature review revealed that this lack of empirical confirmation probably is due to a multitude of uncontrolled factors that probably average out in total outcome scores. These include therapist-patient gender combinations, therapist's experience and gender attitudes, diagnoses, issues, and developmental level, gender differences in therapy process and gender sensitivity of outcome measures. Here, these issues were addressed by studying gender differences in outcome of Inventory of Interpersonal Problems (IIP) and Sense of Coherence (SOC) subscales reflecting gender attitudes (Paper III).

Trauma

In the literature, several possible indications for Creative Arts treatment were found, among them psychological trauma, alexithymia and psychosomatic disorders, existential issues concerning cancer survival, rehabilitation of chronic psychiatric disorders and habilitation of neuropsychiatric and other handicaps.

Of these, psychological trauma seemed the most promising line of research, given the composition of the population. Patients were primarily seeking treatment for a mix of psychiatric and psychological complaints, not psychosomatic or any of the other problems implied in the list of indications. Patients with primary alexithymia in all likelihood selected themselves out of both Spektrum and BMGIM treatment due to their limited affinity for reflective inner exploration.

Furthermore, presence or absence of trauma, as well as conditions known to be associated with trauma were possible to extract from the records, and could be used as independent variables in the search for subgroups with better outcome.

The patients were diagnostically heterogeneous, and not defined for inclusion into the program through a posttraumatic disorder. At the outset, early trauma was conceived as a disturbance of development leading to a wide range of possible manifestations, and as such an impediment for treatment. At the same time, traumatic events seemed to be an indication for CATs. This bivalence was reflected also in the difficulties encountered with dissociative patients. Any attempt at therapy in an ASC with a dissociative patient also evoked states that were hard to navigate both for patients and therapists. At the same time, many case reports were published claiming positive results in Dissociative Identity Disorder (DID) with CATs (Cohen and Cox, 1995; Pickett and Sonnen, 1993).

The Positron Emission Tomography (PET) scan of ongoing flashbacks (Rauch, van der Kolk, Fisler, et al, 1996), seemed to provide further rationale for CATs in dissociative conditions (described in Chapter III).

Separation and intrusion

Furthermore, the difficulties experienced in therapy of dissociative states resulting from abuse or other infringements of integrity did not arise to the same extent in affective/depressive reactions to loss. This was consistent with theories of developmental consequences of abuse respective loss. In poetic language, separation causes the flower to wither through loss of water and nutrients, but intrusion causes withering and damage through breaking the stem. Thus was born the hypothesis of a difference in treatability between intrusive trauma and loss.

Separation trauma implies loss of persons or faculties for example through death, divorce, or illness. Separation threatens the nourishment, security and sources of love/intimacy of the individual, and has been linked to anaclitic reactions, separation anxiety, attachment disorder and adult depression (Bowlby, 1980; Perris, 1966). From a developmental point of view, excessive early separation is thought to lead to affects of loss and despair. When these affects are reevoked by separative experiences later in life, established emotional equilibrium and autonomy might be overwhelmed, leading to affective states like anxiety/depression.

Intrusive trauma, on the other hand, implies an invasion of physical and/or psychological integrity through for example physical, sexual or psychological abuse, combat experiences, accidents, and somatic illness, with sudden overwhelming symptoms. The excessive stress response may lead to over-conditioning of the amygdala's alarm reaction, dysregulation of the fight/flight and "freeze" reactions of the autonomous nervous system, and dissociation of perception, memory, consciousness and identity.

In the author's opinion, it is traumata with these qualities that are a precondition for a diagnosis of PTSD and are thought to be a major cause of the dissociative disorders. Intrusive trauma in childhood leads to "child PTSD" with age specific symptoms such as nightmares, acting out and metaphoric play but also attachment and other developmental disorders.

In most trauma, intrusion and separation are combined. This is common in somatic illness, for example the helplessness when overwhelming shortness of breath and chest pain combines with fear of death and loss. Other examples of combined intrusion and loss are accidents, disasters, and witnessing of death. Intrusive trauma perpetrated by a close relative in addition also implies loss, and intrusive trauma by a non-related person loss of faith in humanity. The coexistence of intrusion and separation for the children of dysfunctional families combine into neglect.

Dissociation is here hypothesized to mainly be a consequence of intrusive trauma.

Dissociation and attachment in trauma-related disorders

A relationship has been observed between early psychological trauma, dissociation and attachment disorders, particularly fearful and disorganized attachment (Carlson, 1998). Psychological trauma causes not only PTSD and the Dissociative Disorders, but also anxiety, depressive and personality disorders where dissociative mechanisms may be prominent (Foa et al, 2000; Moreau, and Zisook, 2002). For example, Borderline Personality Disorder (BPD) contains a trauma-related subgroup characterized by dissociation and disorganized attachment. This subgroup has been alternately classified as a Disorders of Extreme Stress Not Otherwise Classified (DESNOS) or Complex PTSD (Jongedijk, Carlier, and Schreuder, et al 1996; Rorty and Yager, 1996; Zlotnick, Zakriski, Shea et al 1996; Roth, Newman, Pelcovitz et al, 1997).

These must be met with a more accepting and trauma-focused strategy than the traditional strategy of frustration (Carlson, 1998).

It has consistently been found that approximately one quarter of patients with psychiatric disorders have significant dissociative symptoms (Mulder, Beautrais, Joyce and Fergusson, 1988). Moreover, several studies show that trauma and dissociation, also PTSD (Ekblad and Roth, 1997; Al-Saffar, Borgå, Hällström, 2002), are underdiagnosed in clinical practice (Saxe, van der Kolk, Berkowitz et al, 1993).

Studies also find that subgroups of patients with anxiety, depressive, psychotic, and personality disorders and unrecognized trauma are more impaired and have worse treatment outcomes than the non-traumatized. The situation is unfortunate, since rather than offering trauma focused treatments, patients are evaluated and treated for secondary symptoms. In populations with complex post-traumatic disorders, evidence based treatments like CBT, CT and EMDR also tend to be less effective than in for example single trauma PTSD (Bradley, Green, Russ, et. al. 2005). Here, complex and flexible treatments like CATs present an alternative together with integrated Cognitive-Psychodynamic approaches.

CHAPTER II

Aims of the study

- to explore the clinical viability of treating psychiatric patients with the Spektrum program (Paper I).
- to evaluate the effects of individual BMGIM in psychotherapy clients (Paper II).
- to study possible gender differences in outcome of BMGIM (Paper III).
- to investigate the reliability and validity of a Swedish revision of the DES-II in a community sample, and its ability to detect dissociative features in Spektrum patients (Paper IV).

Measures

The SCL-90 (Symptom Checklist-90), IIP (Inventory of Interpersonal Problems) and SOC (Sense of Coherence) scale were used as outcome measures in Paper I, II and III, and in addition with the RSQ (Relationship Style Questionnaire) as validating measures of the DES (Dissociative Experiences Scale) in Paper IV.

Psychiatric symptoms were measured by a Swedish translation of the SCL-90 (Derogatis & Cleary, 1977). Ninety questions are scored on a five point Likert scale from 0 – 4. The items are organized into nine subscales that measure Somatization, Obsessive-compulsiveness, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism, and Additional Items. The average item score, (GSI), indicates the general level of distress. In a Swedish standardization (Andersen and Johansson, 1997), of the SCL-90 (M = 5D, SD = 10) T-scores have been calculated based on gender and age.

Interpersonal problems were measured by the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer et al, 1988), which consists of 64 items, summarized into eight subscales (Domineering, Vindictive, Cold, Socially avoidant, Nonassertive, Exploitable, Overly nurturant, and Intrusive). Test-retest reliability for the whole test was reported to be 0.98 (Horowitz et al, 1988). A measure of inner resources and growth was included to study the propensity of BMGIM and Creative Arts Therapies to mobilize inner competencies not easily studied by rating scales constructed within a framework of disorder and pathology.

The Sense of Coherence Scale (SOC) (Antonovsky, 1987) was developed within a salutogenetic framework, trying to measure factors that promote improvement or health in the presence of pathogenetic influences. It consists of 29 items with three subscales: Meaningfulness, Comprehensibility, and Manageability. Cronbachs alpha is reported to be 0,84 to 0.93.

A Global 4-step rating of change was developed for the Spektrum patients (see Paper I).

A global rating of improvement on a five point Lickert scale was made by clients as well as by the therapists in the outcome study of individual BMGIM (see Paper II).

The DES-II consists of 28 items, covering different aspects of dissociation (Carlson and Putnam, 1993). The subjects' task is to indicate, by ticking a box, the amount of time (0%, 10%, 20% etc to 100%) they have had dissociative experiences. The items of the DES were developed from interviews with persons with dissociative disorders, and with experts on their diagnosis and treatment. Items included experiences of amnesia, depersonalization/ derealization, and absorption/imaginative involvement. Items of dissociation of moods or impulses, overlapping with affective disorders, were excluded.

Early factor analyses from clinical and non-clinical populations yielded three factors with varying correlation to these dimensions (Carlson, Putnam, Ross et al, 1993). A priori, all dissociative phenomena were assumed to be on a continuum from normal to pathological. Later, a distinction has been made between 1) continuous N-items of absorption/imagination and 2) categorical (pathological or non-pathological) T-items of amnesia and depersonalization/ derealization (Waller and Ross, 1997).

The Relationship Style Questionnaire (RSQ); (Griffin and Bartholomew, 1994) was included 1) as a validating measure to the DES-II, and 2) as a possible prognostic factor for outcome. Bartholomew (Bartholomew and Horowitz, 1991), constructed the RSQ as a four-category model of adult attachment combining two dimensions – positive and negative models of self and of others. Fearful attachment results from a sense of unworthiness combined with a negative expectation of others. The RSQ consists of 30 items, which are summarized to four subscales: Secure, Fearful, Preoccupied, and Dismissing, as well as a total score. The Fearful attachment pattern, thought to be caused by childhood trauma and neglect, is associated with later dissociative manifestations both in prospective and retrospective studies.

Ethics

The studies underlying Papers I and IV were approved by the Research ethics committee of Karolinska Hospital We applied for authorization of the studies behind Papers II and III, which were deemed as quality control by the Research ethics committee, hence not requiring authorization.

Summary of Papers

Paper I

The aim was to explore outcome from a creative arts group program for a heterogeneous population of psychiatric patients, with the primary aim of finding subgroups of patients that benefit from creative treatment modalities.

Subjects

After referral from the clinic's outpatient and inpatient facilities, patients were invited to the creative group unit where they were thoroughly informed about the program. Of the 58 patients who were willing to participate, 40 came from the outpatient units and 18 from the nearby hospital ward.

Due to the needs of the clinic, the inclusion criteria had to be broad in terms of diagnoses.

Measurements

Anamnestic trauma, substance abuse, eating disorder, suicidal ideation and attempts were rated as present or not present. Global Assessment of Function (GAF), reflecting the functional state at the time of entering the program, was rated as defined in DSM-III-R. Psychiatric diagnoses were made according to the DSM-III-R criteria. Outcome measures were the SCL-90, IIP, and SOC at start, at termination of the four weeks, and after six months. A Global rating of change was made six weeks after discharge.

Statistics

The size of the patient material and the distribution of self-rated scores allowed employment of parametric statistics. Student's t-test of dependent variables was used for computation of treatment effects and the t-test of independent variables for correlations between effects and clinical subgroups.

Results

With the wide intake criteria employed, the patient population became heterogeneous in many respects. Fifty-eight patients started the program during the one-year period of investigation. Seven patients dropped out of the program prematurely, due to difficulties of tolerating the group processes. Another eight were excluded from the evaluation for different reasons.

The demographic data, symptom and SOC scores show that the patient population had a wide range and a high level of psychopathology, as well as marked impairments of psychosocial function.

In the 43 patients that remained for the study, the SCL-90 profile showed a significant improvement in total score and in 7 of the 10 subscales. The total IIP-scores improved significantly, as well as the subscales "Exploitable" and "Overly Expressive". Also the total SOC scores were significantly improved as well as the subscales Comprehensibility and Meaningfulness. There was a good correlation between the global rating and the self-rated outcome in SCL-90, IIP and SOC.

There was great variation in the treatment results in most diagnostic groups. Both substantial improvements and deterioration were found among dysthymic, affective and anxiety patients according to the SCL-90. However, patients with a history of trauma did significantly better than patients without trauma in all self-rated total scores, and most subscales.

Patients with an eating disorder had significantly better treatment results in SCL-90 than patients without and strong tendencies in the same direction are in the IIP and SOC. Patients with abuse or suicidality also tend to do better than those without these conditions in total scores and most subscales.

Discussion

The patients of the present study had a high level and a great variety of psychopathology as well as marked impairments of psychosocial function. Despite the unconventional treatment modalities and often emotionally demanding group sessions, 88 % of the patients completed the program. The treatment evaluations indicated significant improvements in most outcome measures. These results encourage further applications of dedicated creative therapy programs within general psychiatry.

Since no control group was used it is not possible to ascertain if the results were specifically due to the creative treatment methods.

There was a large variation in the treatment results in the diagnostic subgroups. Perhaps the most interesting finding was that traumatized patients did better than non-traumatized in most outcome measures. This finding supports clinical hypotheses that creative therapies are especially suited for conditions where a history of trauma is part of the clinical picture (i.e. Johnson, 1987).

Paper II

The aim of this study was to further evaluate previously found effects of individual BMGIM in fourteen clients (Wrangsjö and Körlin, 1995). The present population includes thirty clients with self-actualization needs, interpersonal difficulties, or psychiatric symptoms. The application with normative Swedish data of the SCL-90 for age and gender is used to study the clinical significance of change as well as effect size of outcomes.

Therapists and Subjects

Thirty clients were recruited as consecutive cases during trainee therapists' advanced training in BMGIM. Two of the male therapists completed their training during the end phase of the study, affecting the latter part of treatment for two clients. All therapists had previous formal psychodynamic training, considerable clinical experience, and were supervised by certified BMGIM trainers.

Measurements

The SCL-90, IIP and SOC, described in the previous chapter, were used as outcome measures, complemented by a global four-point rating.

Statistics

The size and distribution of self-rated scores together with Shapiro-Wilkes W-test of the normality assumption allowed the employment of parametric statistics for all computations except for the SCL-90 of the total population. Due to the bimodal distribution of this population, the Sign test was employed for assessing total significance of changes.

Student's t-test for dependent variables was used for significance testing of pre-post differences. Effect sizes were computed by dividing the difference between pre-post mean scores with the pre-score standard deviation. In the absence of normative values for Swedish dysfunctional populations, the cutoff was set at two standard deviations from the mean of the normal population (Jacobsson and Truax, 1991), giving a SCL-90 value of 70. Clinical effectiveness was calculated as the number of clients that moved from dysfunctional to functional scores after treatment as measured by the SCL-90 GSI T-score.

Results

Looking at primary presenting issues and complaints, seven clients sought increased self-knowledge or actualization, seven wanted to work on interpersonal problems, three needed help for crisis reactions with affective symptoms, seven had depressive symptoms ranging from dysthymia to major depression; four had severe anxiety and phobic symptoms and two presented with somatization complaints. Nine clients reported present or previous contact within public psychiatry and ten heredity for mental disorders.

A cut-off GSI T-score of 70, derived from normative Swedish data, produced two distinct pretreatment subpopulations, a dysfunctional (n=10) and a functional (n=20) group. Apart from high symptom scores, the dysfunctional group had a high proportion of psychiatric complaints, whereas the functional group mostly consisted of clients coming for self-actualization, interpersonal problems and crisis reactions. After treatment, six of the ten dysfunctional persons had moved to functional status according to SCL-90 scores. Both groups fulfilled statistical criteria for normality in contrast to the total population. Effect sizes were in the high range above 2 for the global indices and depression. The functional group had effect sizes mainly in a low to moderate range.

In the IIP, the dysfunctional patients had significant improvements only in Exploitable and Overly nurturant, whereas the functional population has significant improvements in all subscales except Intrusive, and the strongest in Vindictive, Cold and Socially avoidant. In the SOC, both functional and dysfunctional groups showed moderate beneficial effects in the Manageability subscale.

In the global rating, two patients reported themselves as Fully recovered, 21 as Much improved, four as Somewhat improved and two as Unchanged. The functional group reported a slightly higher mean change (3,9) than the dysfunctional (3,5). The therapists in general rated the level of improvement slightly lower than the patients.

Discussion

In the absence of patient norms, the cut-off score between a functional and a dysfunctional population was set at 70, which was consistent with Swedish general population data. This line demarcated two distinct subpopulations in the T-score histogram. Presenting complaints were more symptomatic in nature in the dysfunctional population where eight of the ten persons had anxiety and depressive symptoms in contrast to the functional group where 16 of the 20 persons sought help for self-actualization, crisis reactions and interpersonal problems.

At the conclusion of therapy, clinical effectiveness was indicated by the fact that six of ten persons moved from dysfunctional to functional status in the SCL-90 GSI T-scores. This was consistent with effect sizes in the high range above 2 for the global indices as well as for depression. No one in the dysfunctional range deteriorated. The dysfunctional group, being more symptomatic, should be harder to improve with psychotherapy.

The functional group, although modestly improved in terms of effect size, showed improvements in subscales of the IIP (Vindictive, Cold and Socially avoidant) that are generally reported to be hard to change through psychotherapy (e.g. Horowitz et al., 1993).

The heterogeneity of the patient group, the uneven gender distribution, and the absence of a randomized control population precludes conclusions about the efficacy of BMGIM. However, the fact that the subscales did not improve uniformly in the two groups speaks against regression to the mean as an explanation for the greater effects of the dysfunctional group.

Paper III

The purpose of this study was to investigate gender differences in outcome of BMGIM in the same sample of 30 patients as in Paper II and with the same outcome measures. The subscales of the IIP and the SOC have potential for gender sensitivity. According to underlying interpersonal theory, men should have problems relative to their gender role expectations in the Autocratic, Vindictive and Overly expressive subscales, while women should have difficulties relative to the Nonassertive, Exploitable and Overly nurturant subscales (e.g. Alden et al, 1990). In the SOC, men should have expectations of Manageability and Comprehensibility and the women of Meaningfulness. Therapy is gender sensitive if it effects changes in these proposed gender specific areas.

The total IIP scores also provide a tool to measure the generally assumed, but empirically unconfirmed, gender differences in relational capacity.

Subjects and Therapists

Of the 30 patients 21 were women and 9 were men with a mean age of 44 (19-62 years), and with no marked demographic differences between the sexes. Four therapists were women and 3 were men. Patients spontaneously sought out their therapists, thus were not randomized to male or female therapists.

Measurements

No gender differences in IIP scores are reported in normative American and Swedish samples, or in the few clinical populations where gender is reported as an independent variable (Horowitz, Rosenberg, Saul, et al., 1988, Weinryb, Gustafsson, Hellström, et al., 1995, Osterkamp, Strauss and Schmitz, 1996). In the SOC, no gender differences are reported in several normal Scandinavian samples (Langius and Björvel, 1993; Due and Holstein, 1998; Nilsson, Holmgren and Westman, 2000).

In the SCL-90, men in normal samples consistently have lower raw scores than women (see methods). The T-scores employed in this study are gender and age corrected in a Swedish standardization (Andersen and Johansson, 1997). Derogatis reports factorial invariance between men and women of clinical populations (Derogatis and Cleary, 1977) while no corresponding data are available from Swedish samples.

Statistics

The statistical methods were the same as for paper II.

In view of the bimodal distribution of the male population of most SCL-90 subscales and total scores, a number of non-parametric statistical methods were employed to compare pre-post effects between the male and female groups. The significance of outcome differences between men and women were investigated with the Mann-Whitney U-test with gender as the

independent variable. Significance of outcome within the male and female groups were also computed with the Wilcoxon and Sign tests for dependent variables, and the significances were then compared between men and women for each subscale. In addition, the histogram for each pretreatment subscale score was inspected. Difference in effect between men and women was accepted only in the case of agreement between the different statistical procedures.

Results

The males presented with more psychiatric complaints and higher pretreatment SCL-90 scores, where they showed a bimodal distribution, and a greater proportion of “cases” according to SCL-90 criteria (6/9 males, against 3/21 females). The pretreatment IIP scores were normally distributed and without significant gender differences, although six women against one male presented with interpersonal problems. The pretreatment SOC scores were also normally distributed, but showed significantly higher (=better) values for the women in all aspects except Manageability.

In the SCL-90, the proportion of men (4/6) and women (2/3) who moved from a dysfunctional rating before to a functional after were equal. The men had significantly better results in the Somatization subscale in all three non-parametric tests. In addition, the pretreatment Somatization score was equal. In all other subscales and global indices, gender differences were inconsistent although the men had numerically better effects in most variables.

In the IIP, the women had significant improvements in total scores and all subscales except Autocratic, while the men showed no significant changes. The effect sizes suggest distinctly different results in the sexes, the women having higher values and a more even profile of improvement while the men deteriorated sharply in Autocratic, Vindictive and Intrusive, although not significantly.

In the SOC, there was a marked difference in gender outcome profiles, the men having significant results in Comprehensibility and Manageability, while the women improved significantly in Total score and Meaningfulness.

There were no significant differences between the patients of male and female therapists in terms of SCL-90, IIP or SOC pretreatment scores. Both male and female patients treated by female therapists tended to have the same profile of improvement as the total female patient group and those treated by male therapists tended to have the same profile of improvement as the male patient group.

Discussion

Men and women were comparable in demographic data, numbers of sessions and duration of the treatment.

The SCL-90 outcome scores were consistent with previous research that finds no gender differences. In Somatization, however, men had a significantly better outcome. The results are hard to interpret due to the male’s bimodal distribution and higher average pretreatment T scores. Results are also consistent with previous data indicating that men have a higher threshold for seeking treatment.

In the IIP, results confirmed the hypothesis that women have greater interest in and ability for relational change. Although pretreatment IIP scores were equal between the sexes, some caution is warranted by the fact that more women than men reported interpersonal problems as reasons for seeking psychotherapy.

In the SOC, pretreatment scores and subscale effects are consistent with gender role expectations.

Paper IV

Although there are several Swedish translations of the DES, most use a cumbersome language, hard to understand for many patients. Moreover, psychometric qualities, such as reliability and validity had not been investigated in a non-clinical Swedish sample. Also, the factor structure provided with the English version, was debatable, and did not show any predictive value in a pilot study of 43 Spektrum patients. A further aim was to find a factor solution that was statistically correct, ie handled the problem of skewness of responses when calculating factors.

Subjects

The nonclinical population consisted of 342 out of 600 randomly sampled subjects who completed the inventories. i.e. a response rate of 57 %. The population was between 18 and 59 years of age and consisted of 155 men (mean age= 44.0, range 18-69 yrs) and 187 women (mean age= 43.5, range 18-70 yrs). The clinical sample, consisted of 181 Spektrum patients, 35 males (mean age= 39.1, range 18-67 yrs) and 146 females (mean age= 38.1, range 19-64 yrs) with multiple clinically significant traumas and a wide range of post-traumatic disorders. There was a significantly higher proportion of women among the patients who also were about two years younger.

Measurements

A culturally sensitive, idiomatic translation of the DES-II was done.

There were several problems with previous three and two factor solutions and the assumption of continuity of dissociative experiences from normal to pathological. A non-addressed problem with the factor analytic method is that the distributions of responses to DES items in non-clinical and also in many clinical samples are severely positively skewed, i.e. a majority of the respondents do not endorse dissociative experiences. Thus, parametric statistics cannot be used, which invalidates a principal component analysis, which is based on a matrix with Pearson's product-moment correlation coefficients. Waller (1994) controlling for skewness, could only find one general factor in the DES.

Also, no conceptual analysis of Absorption, Depersonalization/derealization, Amnestic, N- or T-items was found in the DES literature. Thus, before the factor analyses of this study were performed, these dimensions were conceptually categorized according to our a priori understanding.

The RSQ was used as a validating measure to the DES as well as the SCL-90, IIP and SOC.

Statistics

The problem of skewness for parametric statistics was solved by dichotomizing the scores before the factor analysis. Thus, 0 percent agreement was assigned a score of zero, and 10-100 percent agreement a score of 1. A score of 1 thus denotes at least some degree of agreement (10-100%). By this procedure, scores on a dichotomized interval scale were attained.

The seven components extracted by a principal component analysis were equal to the number of eigen values exceeding 1.0. Subsequently, a second-order principal component analysis of the 7 subscales was performed, which resulted in 2 factors.

The internal consistencies of the two subscales, based on the second order analysis, and the total scale were expressed as a Cronbach (1951) alfa. Since there were significant differences in gender distribution between normal controls and Spectrum patients, differences in the DES components and the total scale was analyzed in an analysis of variance with two factors (group and gender).

Results

The internal consistency was high (Cronbach's alfa= 0.87).

In the non-clinical group, women tended to score higher than men in all components as well as in the total scale. Significant differences were obtained for the three of the First order factors. The total scale correlated -0.19 ($P \leq 0.001$) with age.

The Second-order analysis revealed two components, which reflected normal and pathological dissociation, and could readily be summed into one scale. The results of the factor solutions were compared to an a priori conceptual categorization of items into the dimensions of Absorption/imaginative involvement, Depersonalization/derealization, and Amnesia. In sum, when comparing factor solutions across this and previous studies, only ten items show complete agreement.

High DES scorers in the clinical population had more interpersonal problems, more severe symptoms, lower attachment, and lower sense of coherence. Correlation coefficients above 0.35 ($P \leq 0.001$) were found for several subscales, showing that high scorers in the DES tended to be more fearful; more vindictive, cold, and overly nurturant; and higher in somatization, obsessiveness, sensitivity, anxiousness, anger, and more paranoid; and, finally, lower in comprehensibility.

The distribution of endorsement in the normal group showed that a small number of the non-clinical (1.2%) endorsed 90-100 percent of the items to some extent and a positively skewed distribution could be observed. The patient group, however, tended to be bimodally distributed with one peak corresponding to the controls, and one with a peak in the higher end. 40 percent of the patients scored above 60 percent endorsement, which should be compared with 13 percent of the control group.

Discussion

Internal consistency was shown to be above (0.87) the lower limit of sufficient reliability (0.80). The gender and age differences were modest and without practical significance, i.e. there is no firm reason for a standardization of the DES taking gender and age into consideration.

Factor structure

The Second-order analysis revealed two components, which reflected normal and pathological dissociation, and could readily be summed into one scale. Only 10 items were consistently ascribed to the same factors/dimensions of dissociation across this and previous studies. The most likely explanation for the discrepancies of items and factors is that these items have a different meaning in clinical as compared to non-clinical populations.

Comparisons between controls and patients

The higher scores of the Spektrum patients was in accordance with many studies showing dissociative disorders in post-traumatic patients (Carlson, Putnam, and Ross et al, 1993). However, dissociation does not seem to be a characteristic of all traumatized patients. A bimodal distribution of the scores in the total scale identified two subgroups of Spectrum patients. Thus, a subgroup of patients with significant dissociation was identified.

Relationship with other scales

In line with the hypothesis, dissociation had wide ranging effects for interpersonal problems, attachment difficulties, a broader range and more severe psychiatric symptoms, and less sense of coherence. The correlation between a high score in the DES and fearful attachment constitutes the strongest validation of the dissociation scale. However, the correlation coefficients were generally moderate (common variance not exceeding 30%) indicating that the DES scale has a significant proportion of unique variance, and measure a phenomenon not captured by the other scales.

Conclusion

The comparison of factors between controls and patients validates the dissociation scale. The DES-II is best regarded as a one factor scale for three reasons: 1) there is a strong interrelationship between second order components I and II; 2) patients and controls score differently on these two components and 3) components I and II do not differ regarding correlations with other validating scales.

CHAPTER III
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CHAPTER IV

General Discussion

Effects and clinical viability

Spektrum

It was not to be expected that the Spektrum program, with its high emotional temperature, should be effective over the whole range of diagnoses. That 88 % of the patients completed the program with significant improvements in most subscales and total scales showed that the program was clinically viable. However, efficacy could not be determined due to the absence of randomized controls.

An indication for this implementation of Creative Arts groups was suggested in the better results for the traumatized. The better outcomes of patients with eating disorder, abuse or suicidality, factors that are associated with DESNOS or Complex PTSD, points to a role of dissociation and attachment for treatment effects.

Possible explanations for the traumatized patients compared to the non-traumatized will be discussed below under "Trauma subgroups".

BMGIM

There were several important features of the statistical methods of Paper II compared to paper I. First, reliability and validity data of the SCL-90 from several Swedish normal populations had been published, with gender and age corrected T-scores. This made it possible to determine a tentative cut-off score between clinical and non-clinical populations, which coincided with a bimodal distribution of the SCL-90 histogram. Second, effect sizes were computed in addition to statistical significance of effects, which was possible since the sub-groups were normally distributed in contrast with the total population.

The differences in diagnostic composition, magnitude of effects, and effect profiles support the validity of dividing the patients into functional and dysfunctional populations according to the SCL-90 T-scores. This made it possible to determine changes of "caseness". Additional support for caseness of the dysfunctional population was that they presented more symptoms compared to the functional.

Concerning the general effectiveness of GIM the most tangible result is the movement of six of ten persons from dysfunctional to functional status in the SCL-90 GSI T-scores. This is reflected by effect sizes in the high range above 2 for the global indices as well as depression. A T-score above 70, in combination with a high score on symptom breadth and intensity, as well as a high proportion of psychiatric complaints reflects a significant psychiatric disturbance. The fact that the subscales did not improve uniformly in the two groups speaks against regression to the mean as an explanation for the greater effects of the dysfunctional group.

The heterogeneity of the patient group, the uneven gender distribution, and the absence of a randomized control population precludes conclusions about the efficacy of GIM.

Effects in subgroups

Gender differences

To our knowledge, this is the first attempt to investigate gender differences in outcome of a creative arts therapy, in this case GIM. This is also one of very few studies to investigate gender differences with a measure having potential for gender sensitivity, the IIP. In these conditions, we found support for the so far unconfirmed hypothesis that women have a greater capacity than men for improving interpersonal problems through psychotherapy. The results of the SCL -90 and SOC, although less statistically substantive, support the notion that men and women may have different profiles in utilizing psychotherapy. In these measures, they are different also in somatization, and the subscales of the SOC.

Despite a majority of negative findings concerning gender differences (Garfield, 1994), it is thus possible that men and women constitute qualitatively different populations, which can be disclosed if gender sensitive therapies and measurements are used.

The small number of men, and bimodal distribution of symptoms, limit the findings and also illustrates the inherent difficulty in finding comparable populations of men and women in naturalistic settings. On the other hand, the results do suggest that men are harder to recruit, have a higher threshold for seeking psychotherapy and present different challenges than the women.

This is supported also by the data on gender differences in Paper I, where female patients had a strong tendency to do better than males in all outcome measures. These differences become significant in a later, so far unpublished, wait-list control outcome study of 52 Spektrum patients (see below), with a later development of the Spektrum program. Here (the SOC was dropped as a measure), the males are proportionally even fewer (9/52) and more symptomatic than the females. They do worse than the females in all SCL-90 and IIP subscales and total scores with an interesting exception: the genders have equal outcomes in somatization.

In both settings, the BMGIM study and the Spektrum unit, men are thus harder to recruit and harder to treat, and more so as the “caseness” of the population increases. In a wider perspective, they are further disadvantaged to the extent that they “choose” substance abuse as a solution more often than the women.

Creative Arts treatments like Spektrum, and to an even greater extent GIM, offer opportunities for future studies into these issues. They both mobilize different domains of the psyche (the implicit and analogic) than the verbal methods investigated so far, one possible explanation for their gender sensitivity. In BMGIM there is a methodology developed by Meadows (2001) for investigating therapist’s male-like and female-like constructs of gender, independent of biological sex. Interestingly, the male-like constructs were typically perceived as not conducive to effective GIM, whereas the female-like constructs were seen as effective. These results suggest a female bias in the theory and practice of BMGIM. Additionally, Bruscia (2002) has developed music programs for male needs and identified differences in male and female states of consciousness in the BMGIM session.

The importance of therapist factors was illustrated by the fact that patients treated by female therapists tended to have the same profile of improvement as the total female patient group and patients treated by male therapists tended to have the same profile of improvement as the male patient group.

Trauma subgroups

Outcome differences between the traumatized and the non-traumatized

There are methodological reasons for thinking that improvements in subgroups have a greater relevance than improvements in the total group, in the absence of controls. In this case, the traumatized and non-traumatized receive the same treatment and they are comparable in many, although not all measured aspects. However, although adjustment disorder and crisis reactions were excluded, it is still possible that the traumatized improve faster with time.

Additional support is found in long tradition since World War II of multimodal creative arts programs as intensive treatments in PTSD units (Foa, Keane and Freedman, 1999). How then to explain the beneficial result for the traumatized patients compared to the non-traumatized with a Creative Arts program? One explanation would be in line with the notion of special characteristics of CATs presented in the introduction. These can be summarized as 1) the greater ability of CATs to evoke implicit traumatic memories and dysfunctional working models, and at the same time 2) provide analogic symbolization as an additional means of integration. Although not CT or CBT, Spektrum also provided means of discursive integration in the psychodynamic verbal group, which had psychoeducational elements. This finds support in a chapter on Creative Arts therapies in a comprehensive summary of established and emerging approaches for treating PTSD (Foa, Keane and Friedman, 1999, chapter 26): “creative therapies are considered to involve the invocation of kinaesthetic cues to memories and images, as well as the benefits and creativity in ameliorating feelings of hopelessness and worthlessness.”

One other issue to consider is the ability to perceive, remember and report traumatic events, in other words autobiographic memory and narrative capacity. The linking of present experiences with past trauma presupposes two things. The first is that there are distinct traumatic child- or adulthood events as opposed to a constant state of neglect, loss and invasion. In trauma of this type, there are no distinct events to remember and such continuous trauma, or dysfunctional upbringing, has been prospectively found to result in disorganized attachment, dissociation and acting out in adolescence (Carlsson 1998). In adulthood, this is thought to result in the overlapping BPD, DESNOS, complex PTSD, and dissociative disorders. Impaired autobiographical memory may be an ultimate outcome of any combination of the above. This touches on the debate around “false memories”, and the ethicality of searching for “repressed” memories with CATs and hypnotic techniques (Foa et. al. 1999).

Impairment of autobiographic memory is not exclusive to PTSD, but have also been found in depressed patients with a history of physical abuse (Hermans, Van den Broeck, Belis, et.al. (2004). Trauma and autobiographical memory specificity in depressed inpatients, and in patients with functional psychoses and negative symptoms (Shaw, McFarlane, and Bookless, 1997). Both these categories are found in the non-traumatized population of this study.

A negative outcome may depend on other negative prognostic factors like diagnosis. Patients with schizophrenic spectrum disorders are thought to be too fragile for a “pressure cooker” therapeutic climate like Spektrum. The aggregated diagnostic groups were too heterogenic, and small, however, for statistical comparisons (Table 1).

Outcome differences between separation and intrusion trauma

The results of Paper I were reanalyzed with respect to intrusion and separation trauma, with the aim to investigate differences in outcome between the two qualities.

TABLE 1. Subgroups of trauma

Gender	Age	Diagnosis (DSM-III-R)	GAF	All trauma	Separative trauma	Intrusive trauma
Male	24	Aff. syndr.	60	No	No	No
Male	26	Schiz. spectr.	40	No	No	No
Female	30	Borderline	50	No	No	No
Female	34	Aff. syndr.	50	No	No	No
Male	46	Aff. syndr.	40	No	No	No
Male	28	Anx. dis.	45	No	No	No
Female	36	Schiz. spectr.	55	No	No	No
Female	36	Aff. syndr.	65	No	No	No
Female	26	Borderline	60	No	No	No
Male	34	Schiz. spectr.	40	No	No	No
Female	39	Borderline	50	No	No	No
Male	22	Anx. dis.	55	No	No	No
Male	22	Schiz.sp	40	No	No	No
Female	44	Dysthymia	65	Yes	Yes	Yes
Female	40	Anx. dis.	45	Yes	Yes	Yes
Male	40	Diss. syndr.	45	Yes	Yes	Yes
Female	43	Aff. Syndr.	30	Yes	Yes	Yes
Female	22	Diss. syndr.	45	Yes	Yes	Yes
Male	40	Pers.dis	50	Yes	Yes	Yes
Female	32	Pers.dis	45	Yes	Yes	Yes
Male	49	Diss. syndr.	45	Yes	Yes	Yes
Male	32	Diss. syndr.	45	Yes	Yes	Yes
Female	58	Borderline	55	Yes	Yes	Yes
Male	33	Diss. syndr.	50	Yes	Yes	Yes
Female	50	Aff. syndr.	50	Yes	Yes	Yes
Female	43	Dysthymia	60	Yes	Yes	Yes
Female	39	Dysthymia	55	Yes	Yes	Yes
Female	34	Dysthymia	50	Yes	Yes	Yes
Male	33	Schiz. spectr.	35	Yes	Yes	No
Male	29	Anx. dis.	55	Yes	Yes	No
Female	23	Borderline	50	Yes	Yes	No
Male	61	Aff. syndr.	50	Yes	Yes	No
Female	47	Pers.dis	30	Yes	Yes	No
Female	57	Anx. dis.	55	Yes	Yes	No
Male	48	Dysthymia	50	Yes	Yes	No
Female	64	Dysthymia	55	Yes	Yes	No
Female	37	Anx. dis.	50	Yes	Yes	No
Female	54	Dysthymia	55	Yes	Yes	No
Female	51	Som. form.	55	Yes	Yes	No
Male	33	Dysthymia	65	Yes	Yes	No
Female	39	Anx. dis.	65	Yes	No	Yes
Female	43	Som. form.	65	Yes	No	Yes
Female	49	Diss. syndr.	55	Yes	No	Yes

There are obvious differences not only in clinical manifestations but also in impact on development, outlined in the introduction. Subjects, measurements and statistics were the same as in Paper I. Intrusive trauma was defined as distinctive events of torture, sexual or physical abuse, serious accidents, mobbing or other grave infringements of personal integrity. Separation trauma was defined as loss of important persons, in the case of parents if occurring before age 15.

Of the 43 patients, 13 had no anamnestic trauma. Of the remaining 30, 12 had only separation, 15 separation and intrusive trauma and 3 only intrusive trauma. Gender, age and diagnoses of these subgroups are shown in Table 1. When comparing outcome between the subgroups, it was found that separation-only patients had the best outcomes, showing significant improvement in total scores and most subscales of all employed instruments. In the subgroup with combined separation and intrusion trauma, significant improvements were noted only in the IIP total score and the subscale Intrusive. The subgroup with only intrusive trauma was too small (n=3) to allow statistical comparison.

The presence or absence of intrusion, with its more deleterious effects on attachment, defenses, capacity to symbolize and dysregulation of bodily functions thus seems to explain the different outcomes between the trauma subgroups. In addition, manageable separation may be a driving force for individuation, as illustrated by Winnicott's concepts of transitional objects and transitional space (Winnicott, 1981). From neuropsychological perspective, implicit memories of faces, voices, touch, behavioral interactions, and pleasant or unpleasant internal states begin to synthesize into so-called mental models of being with caregivers. By eighteen months, it is postulated that children can bring an image of an attachment figure forward in their minds (Freyd, 1987), and link images with mental models. Conceivably this process is facilitated by manageable separation.

Dissociation and Attachment

The aim was to investigate the reliability and validity of the DES-II for possible use as 1) a screening instrument for trauma and dissociation and 2) as a prognostic factor for outcome of the Spektrum program. The psychometric properties were found to be sufficient for use in Swedish clinical and non-clinical populations. Dichotomizing of scores was used to address the problem of skewness of responses for determining factor structure. Two components were calculated that correspond to the previously found N (normal-continuous) and T (categorical-pathological) factors. However, since they were strongly interrelated and did not differ in correlations with the validating scales, the DES-II was found to be a one-factor scale. This is in accordance with Waller (1994), who, controlling for skewness, could only find one general factor in the DES and concluded that previously found factors reflected the frequency of endorsement of the items. The absorption factor might be a high, the derealization/depersonalization a moderate, and the amnesia a low endorsement factor.

The strongest validation of the DES was the association of high scores with fearful attachment disorder. There is prospective support that children subjected to neglect, loss, or abuse later develop behavioral disorders, difficulties in school, and susceptibility to dissociative disorders and PTSD following re-traumatization (Carlsson, 1998). The polysymptomatic profile in the SCL-90 was consistent with the pervasive effects of dissociation. In its present form, the DES-II is a method of choice for recognizing features of dissociation in psychiatric inpatients, where the categorical-pathological items are more common. The importance, of the DES in screening for DID and the dissociative disorders, is already established.

For use as a prognostic factor for outcome of CATs, the sensitivity of the scale probably needs to be increased with items identifying less obvious dissociative phenomena in mid-functioning patients, like "partial" PTSD symptoms, and dissociated affect. Such items could replace the ambiguous items that have performed inconsistently over time.

The groundwork is now done for investigating correlations between DES items and outcome, for example if high scores in absorption/imagination are associated with better outcomes, and high scores in other items with worse results. Ability to absorb/image is obviously a precondition for integration and creative transformation of dissociated imagery with a Creative Arts therapy.

A concept of trauma-related disorders

Table 1 illustrates how different outcomes in different qualities of trauma are associated with a wide range of diagnoses. This demonstrates the clinical validity of a concept of trauma-related disorders. Although patients were not selected according to presence or absence of trauma during the first year of the program, yet 30 of 43 patients reported trauma. 15 had a mixture of intrusion and separation trauma, 12 had separation trauma and three intrusive trauma. These three patients had three different diagnoses: PTSD, an anxiety disorder, and a somatoform syndrome. Of the 15 patients with both intrusion and separation trauma, two had dissociative syndromes and two PTSD, six had some form of depressive disorder, one an anxiety disorder, and four a personality disorder.

It is clear that trauma is associated not only with PTSD, but also with depressive disorders, anxiety disorders, substance abuse and personality disorders without concomitant PTSD (Brady, Killeen, Brewerton, et. al., 2001). The association of trauma to a range of psychiatric disorders may be due to two things. First there is underdiagnosis both of “full” PTSD and “partial” or “subthreshold” PTSD, leading to diagnosis of only co-morbid disorders (Marshall, Olofson, M., Hellman, F., et. al. 2001). Second, even if this is allowed for, there remains a significant number of independent anxiety and depressive disorders following trauma. One explanation for this could be that trauma during psychological development may elicit different disturbances of development and symptoms in different maturational phases (Maercker, Michael, Fehm, et.al. 2004). This may be part of the explanation for the co-morbidity of PTSD and anxiety, depressive and personality disorders. Surveys also indicate a positive association between co-morbidity and abuse/neglect during childhood (Foa, et. al. 1997).

As mentioned in the introduction on dissociation, traumatized patients have more impairment and worse treatment outcomes than the non-traumatized. Table 1 illustrates a heterogenic trauma-related group of patients that were actually helped by the Spektrum program compared to the non-traumatized.

Diagnostic and clinical aspects

The trauma-related treatment strategy centers on the clinical goal to find trauma that can be a focus for treatment. It is clear from the above that every patient needs to be screened for trauma irrespective of DSM-diagnosis. Consequently, a systematic checklist for different qualities of traumatic events (the TQQ, appendix 2) was developed and used in the diagnosis and evaluation of patients. Asking specific questions is often necessary, since passively waiting for the patient to disclose trauma often fails. However, the TQQ can not be used as an instrumental diagnostic tool. Structured questions depend on a quick building of rapport, where the interviewer signals his/her preparedness to listen to, recognize, and follow up on flashbacks and autonomic dysregulation. Ideally, a knowledge of stabilization techniques should also be present. The use of trauma checklists and rating formats should not be implemented without these abilities. It may, however, be unproductive not to ask for trauma, as has been shown in a recent Swedish study of psychiatric outpatients where better health was reported in those who had their trauma somehow addressed, compared with those who had not (Al Suffar et al, 2002).

It is also important to have a range of treatments to meet the varying needs of patients with complex trauma. In these populations, who constitute the majority of trauma patients, evidence based therapies developed for single trauma, frequently fail (Bradley, Green, Russ, et al. 2005). As argued, CATs provide an alternative, but need to be developed and further validated as suggested below.

A future strategy for research of trauma-related disorders

When investigating prognostic factors for Creative Arts Treatments in a heterogeneous psychiatric population containing post-traumatic patients, several dimensions need to be considered. In a dimensional view of trauma there is an interplay between quality of trauma and age at traumatization. There are poorly investigated age specific consequences for attachment, dissociation, symbolization and narrative capacity. Categorical DSM or ICD diagnoses, although essential, leave insufficient guidance for treatment decisions. In the case of CATs, resilience and internal resources should also be part of the equation.

A wait-list control study of 52 recent Spektrum patients illustrates that although the group as a whole moves from dysfunctional to functional values according to SCL.90 criteria, there is a large variation of treatment results. A study of trauma dimensions as prognostic factors for outcome may help reduce this variation, and sharpen the indications.

These considerations have governed the choice of measurements as the Spektrum program has developed. A Trauma Quality Questionnaire (TQQ, appendix 2) was developed, that also included age and duration of traumatization as well as demographic factors. The SOC was included as a measure of resilience. However, SOC turned out not to be a resource-related predictor of outcome, but rather an insensitive outcome instrument. Thus it was phased out to give room for a measure of dissociation, DES, and later a measure of attachment, the RSQ. The resilience dimension awaits a more adequate measure. Also measures of autobiographic memory and imaginal creativity are needed.

Further developments of CATs in trauma therapy

The potential of BMGIM for the treatment of trauma was explored in Chapter III. The cases described used, in various combinations, spontaneous analogic symbolization to trace traumatic presymbolic implicit memories and subsequently to integrate these memories into more complex analogic symbols. When thinking/talking about these more complex symbols, dysfunctional self images were reappraised and found to be irrational. When, for example, the fragmented image of a perpetrator was transformed into a mediterranean windmill, it became obvious for the patient that her assailant was indeed in a far away country, not outside her door, and that she had been able to protect herself by fleeing. Spontaneous resource images of quickly moving animals and birds, combined with positive vitality affects, served as emotional confirmation.

However, the danger with spontaneous imagery is that it may degrade into traumatic imagery from which the patient can not recover by resymbolization. Cognitive and cognitive/behavioral visualization are evidence based methods in these situations. Trauma therapists of all schools need to have adequate skills in cognitive imagery that are the first methods of choice in single trauma PTSD. In cognitive visualization, the image is intentionally evoked and manipulated for a specific outcome. For example, a safe place, a dependable nurturing person, or a successful moment from the past may be evoked from explicit memory, embellished and consolidated in the mind. It may then be used as protection from, or even replacing, traumatic imagery. The therapist or patient may also assume the role of movie director, and change the outcome of a traumatic memory into a better ending.

Intentional imagery also may directly influence bodily autonomic reactions and the immune system (Acterberg, 1985). In CBT and CT therapies, there is also an intentional dialogue between traumatic imagery and logical thought, (discursive symbolization), with the aim of cognitive reframing, leaving the analogic representations aside.

As has been pointed out, evidence based therapies like, CTs and CBTs are less effective in cases of complex traumatization, and direct confrontation with traumatic memories may lead to deterioration (Foa, Rothbaum, Riggs et al, 1991; Paunovic and Öst, 19xx, Foa et. al. (2000). To keep these patients in treatment, a host of stabilization and resource mobilization methods using cognitive visualization have been developed in integrative approaches like EMDR (Korn and Leeds, 2002).

However, in the author's experience, even these are sometimes ineffective, and may even lead to deterioration. Attempts at cognitive visualization have been observed to set off overwhelming chains of imagery, or the cognitive approach is perceived as an attempt at manipulation. These patients, in individual and group GIM, have reacted positively to spontaneous analogic imagery during music listening, where they spontaneously experience safe places and other resources, which subsequently allow them to confront also traumatic imagery. This is the cyclical process referred to in Chapter III, first described by Bishop (1994). Alternatively, every successive GIM experience contains an adequate balance between resource and traumatic imagery.

The author has by now experience of 350+ group and individual GIM sessions, were 1500 paintings made after the music experience, has been documented in photographs. In these paintings, spontaneous resource imagery may be ordered into the following categories, appearing singly or in different combinations: Movement, Protection, Helpers, Nurturing, Energy and Transpersonal. Some, but not all, of these may be suggested cognitively, before the session. Movement is the easiest to access, through the movement of music itself. Protection, in the form of finding a safe place in the music, Helpers and also Nurturing require timing to the therapeutic process. Energy and above all Transpersonal experiences are impossible to evoke intentionally.

However, the resource concept is not straightforward. Emotions, resources and defenses perceived to be positive may be problematic in themselves. Each of them has a problematic, or in Jungian terms, even a "shadow" side. These opposite sides of the coin may be sketched as: protection – isolation; nurturing – overfeeding; movement and energy – different qualities of flight; and transpersonal – spiritual by-pass¹. Nevertheless, the positive quality has priority in interpretation, because of the strong tendency among psychiatric patients to regard themselves as powerless, worthless, guilty, and destructive (Chapter III).

Integrating the creative and the cognitive elements of therapy

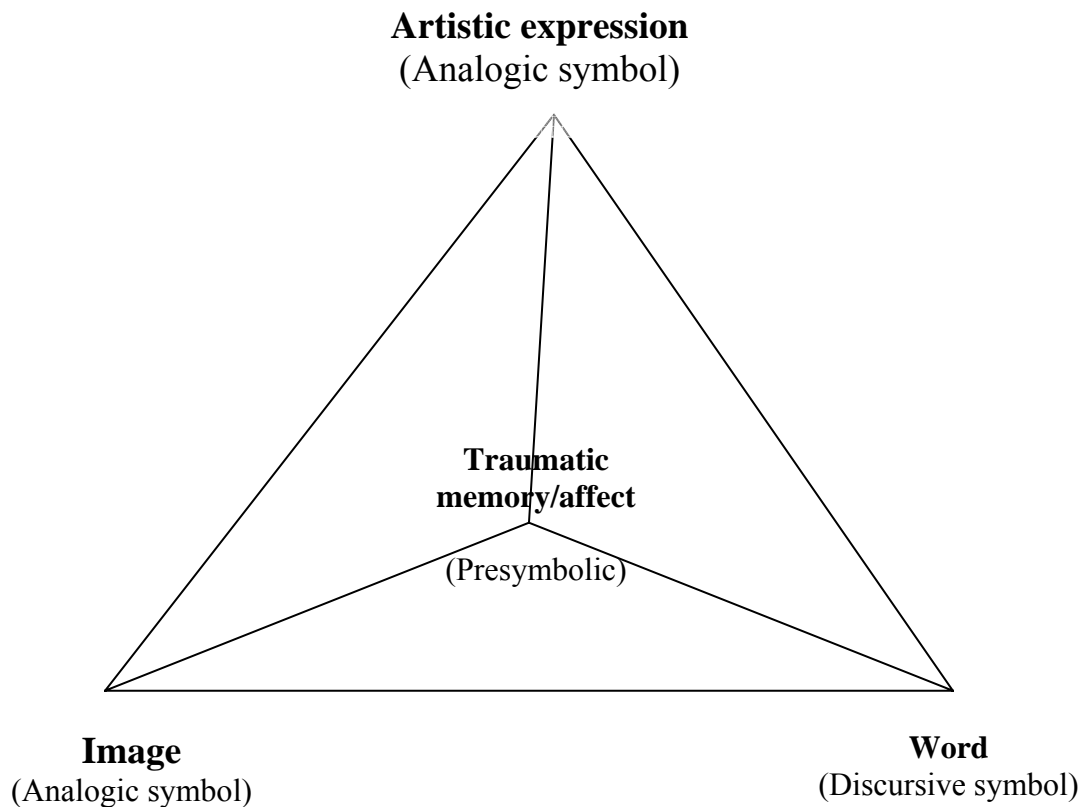
There are two alternatives for CATs, in working with trauma patients. One is to integrate cognitive techniques, while keeping the advantage of analogic symbolization. The other is to keep within the analogic domain, but limit imagery to manageable proportions. In GIM, this may be done through shortening the time of the music experience or limiting the evocative potential of the music. Evocative qualities include sudden dynamic shifts (for example drumbeats), dissonances, complex thematic and harmonic development and other features of the music that is high in information content. These options have been explored in GIM by Blake (1994), Goldberg (1994), Summer (2002), and in Chapter III.

Both cognitive and analogic imagery have a common ground in the metaphor (Horowitz, 1983; Bonde, 2000, 2005) has explored different ways of working with the metaphor in GIM. Bonde's work is a starting point for development of CATs generally.

¹ Spiritual by-pass, originally a Buddhist concept ascribed to the master Chogyuan Trungpa, is a term within transpersonal psychology. It refers to people using spiritual experiences to try to step over negative intrapsychic content or painful biographical events.

The Tetraeder Model

The different aspects of CATs discussed in this thesis can be summarized in a “Tetraeder Model” (Figure 1), developed from the “Symbolization Triangle” of Chapter III. The place of the metaphor, or “word-image” is the link between the discursive apex to the right and the other corners of the tetraeder. The metaphor is a way for the discursive mind to attempt a first description of the image, be it traumatic, symbolic, or in the form of Art.



Conversely, a suggestive sentence in a conversation may evoke a traumatic image, or flashback. The side connecting the traumatic image and the symbolic image illustrates a continuum of representations, between the protosymbolic traumatic sensory image and the complex analogic representation. And finally, the side connecting the traumatic image and the Creative Art expression may represent direct bodily symbolizations as in metaphoric play, dance and movement.

In CATs, the different domains are allowed to come into play and stimulate each other in spontaneous sequences. In BMGIM, for example, the music may evoke a symbolic image that is subsequently expressed in a painting. When talking about the painting, some form or colour may be described in a metaphor. The metaphor may stay in the mind, and in the next session evoke an affect, or a traumatic memory, as in two of the cases of chapter III. In spontaneous imagery, these sequences of evocation can seldom be predicted. It is assumed that the wisdom of the inner process will determine the way in which experiences unfold (James, 1910). In cognitive structuring of CATs, the sequence of events is manipulated, metaphors are presented by the therapist as instructions for the experience, and discursive reframing in writing or speech has priority. Both strategies are needed, as Chapter III illustrates.

In conclusion, the tetraeder model is not only a metaphor for the therapeutic process, it is also a model for development and future qualitative research of CATs.

CONCLUSION

The application of Creative Arts Therapies in clinical psychiatry was investigated in the form of the Bonny Method of Guided Imagery and Music (BMGIM) and the Spektrum group program.

The symptoms and complaints of the Spektrum patients and the psychotherapy clients were significantly reduced following treatment, particularly in patients with a history of trauma. Gender differences were found following BMGIM treatment, as men were at a disadvantage both in terms of pre-treatment impairment and outcome, as compared to women. The results suggest that trauma-related disorders in a wide sense may be an indication for CATs. The therapeutic action of CATs is thought to be mediated through neuropsychological mechanisms involving non-verbal memory and analogic representations. There is a potential for further adaptation of CATs to achieve better outcomes as well as for further knowledge of indications and contraindications of the method.

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Eva Barkman, research assistant at the Spektrum unit, and clinical psychologist, helped me with administrating the DES study, and the scoring of it's data. Anna-Karin Johansson, and before her Anna Bång, both deserve special credit for administering the rating scales and photographing patient's artwork. In the beginning, Anna-Greta Rudklint did the computer registration of the data behind Paper I.

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DISSOCIATIONSSKALAN (DES)

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Instruktion: Detta formulär innehåller frågor om vissa upplevelser som man kan ha i det dagliga livet. Vi är intresserade av hur ofta Du eventuellt har dessa upplevelser. Det är viktigt att Du inte tar med tillfällena då Du är påverkad av alkohol eller droger. Försök att avgöra hur ofta de beskrivna upplevelsena gäller Dig, genom att kryssa för i en av rutorna där ”aldrig”= 0% och ”alltid”= 100%, som i exemplet nedan.

Exempel:

 Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

1. Under bilkörning kan man upptäcka att man helt eller delvis glömt vad som hänt under resan. Kryssa för i en av rutorna hur ofta detta händer Dig.

 Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

2. När man lyssnar på någon som talar, kan man plötsligt uppleva att man inte hört något alls eller bara delar av vad som sagts. Kryssa för i en av rutorna hur ofta detta händer Dig.

 Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

3. Man kan upptäcka att man hamnat på en plats utan att ha en aning om hur man kom dit. Kryssa för i en av rutorna hur ofta detta händer Dig.

 Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

4. Man kan upptäcka att man bär kläder som man inte kommer ihåg att man har satt på sig. Kryssa för i en av rutorna hur ofta detta händer Dig.

 Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

5. Man kan, bland sina tillhörigheter, upptäcka nya saker som man inte kommer ihåg att man har köpt. Kryssa för i en av rutorna hur ofta detta händer Dig.

 Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

6. Man kan uppleva att okända personer kommer fram och kallar en vid fel namn, eller påstår att man träffats förut. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

15. Man kan uppleva att man är osäker på om händelser man minns verkligen har hänt eller bara är en dröm. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

DES – SKALAN

16. Man kan uppleva att man är på en välkänd plats som ter sig främmande eller obekant. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

17. Man kan uppleva en film så fångslande att man är omedveten om händelser runt omkring en. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

18. Man kan bli så absorberad av en dagdröm att den känns verklig. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

19. Man kan ibland uppleva att man inte känner att det gör ont i kroppen. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

20. Man kan komma på sig själv med att titta tomt framför sig utan att tänka eller vara medveten om tiden. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

21. Man kan upptäcka att man pratar högt för sig själv när man är ensam. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

22. Man kan ibland bete sig så annorlunda i en situation jämfört med en annan situation, att man nästan känner sig som om man vore två olika människor. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

23. Man kan upptäcka att man ibland förvånansvärt lätt gör saker som annars skulle kännas svåra att göra, i t ex sport, arbete och sällskapsliv.
Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

DES - SKALAN

24. Man kan glömma att man verkligen gjort något som man tänkt göra. (T ex att man inte vet om man verkligen postat ett brev eller bara tänkt göra det.) Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

25. Man kan hitta bevis för att man gjort saker som man inte kommer ihåg att man har gjort.
Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

26. Man kan bland sina tillhörigheter upptäcka anteckningar eller bilder man själv måste ha gjort utan att man kommer ihåg det. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

27. Man kan uppleva att man hör röster inne i huvudet som säger att man ska göra något eller som kommenterar vad man gör. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

28. Man kan uppleva att man betraktar världen som genom en dimma, så att människor och föremål tycks avlägsna eller otydliga. Kryssa för i en av rutorna hur ofta detta händer Dig.

Aldrig = 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% = Alltid

Appendix 2: The Spektrum Trauma Quality Questionnaire

TRAUMA- & DEMOGRAFIBLANKETT

VEM REGISTRERAR DATUM

PATIENTUPPGIFTER

PATIENTENS NAMN PERS.NR.

PATIENTKOD SPEKTRUM-PERIOD ÅLDER (vid gruppstart) KÖN

ANTAL ÖPPENVÅRDSBESÖK
 ANTAL SLUTENVÅRDSTILLFÄLLEN

	<input style="width: 100%; height: 20px;" type="text"/>		<input style="width: 50px; height: 20px;" type="text"/>
Axel I (DSM IV)	<input style="width: 100%; height: 20px;" type="text"/>	GAF (vid gruppstart)	<input style="width: 50px; height: 20px;" type="text"/>
Axel II	<input style="width: 100%; height: 20px;" type="text"/>	Relationskapacitet	<input style="width: 50px; height: 20px;" type="text"/>
Annan axel	<input style="width: 100%; height: 20px;" type="text"/>	Arbetskapacitet	<input style="width: 50px; height: 20px;" type="text"/>

Fullständig PTSD?
 Partiell PTSD?

Trauma? ja nej Grad av negativ påverkan:
 Återupplevanden? Mardrömmar?
 Grubbel? Kroppsförnimmelser? Undvikande av platser?
 Undvikande av situationer? av relationer? av tankar?

MEDICINERING

	ja	nej
Neuroleptika	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressiva	<input type="checkbox"/>	<input type="checkbox"/>
Litium	<input type="checkbox"/>	<input type="checkbox"/>

BAKGRUNDSFAKTA - ALLMÄNNA

	Nej	Ja	Inom senaste året	Uppfyller kriterierna för anorexi (A)	Har symtom för anorexi (A) eller bulimi (B)	Uppfyller kriterier för missbruk	Uppfyller kriterier för beroende
Suicidtankar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidhandlingar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ätandestörningar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missbruk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Kommentarer: _____

