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Reflections on selected diagnostic concepts and their relevance for Guided Imagery and Music (GIM)

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Abstract

The indication for Guided Imagery and Music as a psychotherapeutically informed music- centred therapy method is depending on cross-school diagnostic concepts which allow a multi-perspective understanding of the problems and needs of a client. A GIM therapist's assessment of the client's level of psychic structure, the conditions which lead to different relation informed damages and disorders such as trauma, conflicts, deficits and disturbances, and the assessment of the client's ability to mentalize determine the therapist's decisions how to use the music and guide the client in order to support, extend, encourage or catch up on important developmental steps. The article investigates the importance of the adequate verbal and musical stimulation and the meaning of mentalizing the music-imagery experience in and after a GIM session.

Keywords

Guided Imagery and Music (GIM), Guiding, Cross-school diagnostic systems, Schema Therapy, Integrative Therapy, Operationalized Psychodynamic Diagnostic (OPD), Level of the psychic structure, Stimulation and Damages, Mentalization, Mentalization-based Therapy (MBT).

Introduction

The following remarks on diagnostics are not about presenting different diagnostic systems for their own sake. It is assumed that the classical diagnostic systems mentioned below in principle are known. Nevertheless, a short reminder is allowed in order to be able to refer to the aspects relevant for GIM.

Different approaches in diagnostics

Some approaches still concentrate on *Pathology*-centred *classificatory-categorical diagnostic classification* systems which basically serve to assign a disorder to symptoms[1]. This type of *disorder-specific diagnosis* does not take into account information that is

[1] *If, for example, symptoms W, X, Y, ... are present, then the disorder Z is present.*

significant in terms of developmental and social psychology and biography. Therefore, the *structural-categorical classification* was added in order to include the psychodynamic development of the client in his biography as well. However, such a classification was also not sufficient, because a *phenomenological diagnosis* was lacking, where the observable phenomena within the actual therapeutic relationship (e.g., the developing relationship patterns) play an important role to be used to infer underlying structures or schemata (see below).

Nowadays *cross-school diagnostic systems* have been designed because multi-perspective views protect against simplifications and stigmatizing determinations. Cross-school means that phenomena can be viewed from different perspectives without having to abandon one's own conceptualizations and perspectives, be they, for example, psychodynamic, behavioural or systemically oriented. However, one must know how to understand the conceptualizations.

With **Schema Therapy**, an integrative approach was developed in the 1990s that incorporates theories and techniques of psychodynamic, gestalt- and relation centred therapy methods into a unified, neurobiologically based concept (Young et. al, 2006). Typical patterns of feelings, thoughts, and sensations that have emerged over the course of life history and guide behaviour are referred to as schemes which determine one's thinking, feeling and acting. From a diagnostically view a therapist will identify maladaptive schemes (e.g. punitive parent, hurt, angry child) in a client's thinking and feeling. In Guided Imagery and Music the GIM therapist will identify them in the imagery of the client's GIM journey in order to be able to guide[2] the client in his schemes.

The diagnostic perspective of **Integrative Therapy** (Petzold 1993, Petzold, Orth-Petzold 2010) focuses as well on body-related, social-psychological and systemic-oriented perspectives. Main questions are: what is present, what is missing, what can be developed, promoted or compensated for, and what should be preserved and newly consolidated?

The diagnostic investigation in *Integrative Therapy* assesses the interactional and relational experiences that led to damage (deficits, disturbances, conflicts and trauma) and dysfunctional relational patterns due to dysfunctional stimuli in the course of the various maturational and developmental phases and areas in life. Damage due to inadequate stimulation can occur up to old age and also in the therapeutic relationship. Accordingly, the GIM therapist needs permanent alertness for inappropriate stimuli[3]. This has a great impact on how the GIM Therapist guides the client during the music journey.

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[2] 'Guiding' in GIM is a special technique of asking questions, supporting or encouraging the client during the listening phase to develop his/her imagery and music induced feelings.

[3] For example, even before the start of a GIM therapy, it must be determined through careful music anamnesis and listening biography whether there are signs of traumatic previous experiences with music, in order to prevent re-traumatization through inadequate music offerings. Furthermore, it must be asked whether the person in question has the ability to imagine to music at all, i.e. to be able to develop and identify inner images including the emerging emotions, affects, body reactions, memories and associations to and through music.

The *Operationalized Psychodynamic Diagnostic* (OPD 2004/2007) **work group** also follows a multi-perspective view, but remains committed to psychoanalytic thinking. The concept includes the evaluation of a client's sufferings on the basis of four interrelated and always interdependent axes, the results of which can be assigned to the disorder patterns of the ICD 10[4] and the DSM IV[5] in a fifth axis. No observed phenomenon stands alone, but must always be understood from the perspective of all axes[6].

The **OPD** has provided useful work by categorizing different levels of psychological structure (Axis IV) into "**good integration," "moderate integration," "low integration," and "disintegration"** (OPD, 2007, 432-440) so that the guide can assess how to proceed in GIM.

In the case of a ***client with a well-integrated level of structure***, GIM can be well maintained even with existing deficits, disruptions, and conflicts. The traveler knows that his imagery expresses inner realities and can distinguish them from the outer reality. His imagery is vivid and emotionally multifaceted and includes somatic as well as spiritual dimensions. He can engage in emotionally challenging music and threatening imaginings without becoming fundamentally unstable. At the very least, he is able to catch himself at critical moments and protect himself (e.g. from travel experiences that could traumatize). He is able to stay in verbal contact with the guide during music imagining. He recognizes conflictual situations and can search for possible solutions with the help of the guide and the music, which itself lives from opposites and tensions and processes them musically.

In case of a ***moderately integrated structure*** and further in case of a ***low*** or ***even disintegrated structure,*** the damages could possibly not be clearly distinguished. Presumably, missing, contradictory and ambiguous or even traumatizing stimuli could impair or block the ability of perception and mentalization. Music that stimulates the desire to merge may be violently rejected ("I can't do anything with that" or "such kitsch"), or threatening images may appear or scenes may stand next to each other incoherently. It is difficult to become emotionally involved with music or to protect oneself from emotional flooding.

With a ***moderately integrated structural level***, GIM work (BMGIM and MI) with and in imagery is only possible if the guide can stimulate by mentalizing in such a way that affect awareness and regulation become possible and if music enables positive experiences of being nourished and of secure attachment.

A low integrated level of structure impedes the ability to transform mental states. Patients with this psychic structure have difficulties to mentalize their own feelings and what

[4] ICD 11 does not come into force until 2022

[5] Axis I of the OPD stands for the illness experience, the severity of the illness, suffering pressure, resources, existing protective factors, psychosocial and social background, motivation, therapy expectation, etc. Axis II examines dysfunctional relationship patterns (in terms of transference and countertransference). Axis III concerns conflicts, with special attention to intrapsychic and averted conflicts, and Axis IV concerns the level of psychological structure achieved. Axis V represents the ICD 10.

[6] Those who have a low-integrated psychic structure will also have conflicts in relationships. In turn, intrapsychic conflicts shape the client's experience of illness, his ability to relate, and his psychic structure.

others feel and think about them. Conflicts (Axis III) are also met in the GIM imagery either in the active mode in form of defensiveness and reaction formation or in the passive mode by regressive defensiveness.

The guide will feel very clearly in his counter-transference the impulse to give positive support or rather provide nurturing stimulations and emotional resonance experiences. The guide must pay special attention to mirroring the affects in a marked way so that the traveler learns to regulate them.

Here **MI** can be applied at a low-threshold depth level, i.e., with no more than one piece of music in a sitting position with eyes open, as the long music programs and the setting with eyes closed in a lying position in the BMGIM method would be too challenging for patients with low-integrated structure. The music offered in MI in the face to face setting, on the other hand, is a positive medium for those who have problems opening up to a direct counterpart, because it can be shared as a common interest in something third, thus allowing a more anxiety-free access to themselves and to the therapist.

According to Bruscia (2002, p. 273) the Bonny Method (BMGIM) with the long music programs is contraindicated in case of a ***disintegrated structural level*** because the verbal skills necessary to dialogue with the guide during and after the music journey are lacking; There is a lack of sufficient reality orientation to distinguish between the imaginary and real worlds; and the ego boundaries that prevent merging of the self with the other (or the environment) are missing. Thus, looking at these statements from the perspective of Axis IV (structure), it is clear that challenging GIM journeys in the classical form are contraindicated for clients with low and disintegrated levels of psychological structure.

Against this background, some concepts relevant to the assessing and processing in GIM will now be discussed in more detail. The significance of a well-integrated level of the psychic structure (OPD, 2007) relates to the concept of **Stimulation** and the possible **damages** caused by inadequate stimulation (Petzold (1993), as well as to the concept of **mentalization** (Allan & Fonagy 2009; Fonagy, 2012; Petzold, 2008, Frohne-Hagemann, 2012, 2015, 2017, 2019; Herold, 2014)

Stimulation

The concept of stimulation plays an important role in procedural diagnostics and theragnostics, because it can provide clues to the damage that has occurred in the developmental stages and levels of mental structure and to the development of the ability to mentalize (Frohne-Hagemann, Pleß-Adamczyk, 2005). Ultimately, this knowledge informs the intervention practice of the GIM guide.

As infant research (e.g., Stern, 1992; Papoušek, 1994; Petzold, 1993) has shown, a child's development is based on reciprocal stimuli between caregiver and child. A baby is stimulated by its caregiver to become curious about something, and in turn also sets signals

itself to bring the caregiver into action[7]. Reciprocal stimulations take place throughout life and into old age and determine our state of mind and behaviour. We are dependent on stimulating stimuli, whether individually by another person or by collectively mediated traditions, values, and circumstances.

Stimulation can be positive or negative. One can be stimulated to feel secure by a comforting atmosphere or supportive music, but one can also be unsettled or even traumatized by threatening stimuli (too strong stimulation e.g. by assaults, violence, sexual abuse, war, natural disasters or threatening unemployment). Thus, relational and world experiences can be damaged by dysfunctional stimuli.

Consequences of inadequate stimulation: Deficits, Disturbances, Trauma, and Conflicts.

Petzold (1993) identified four forms of possible **damages** as consequences of inadequate stimulations:

If stimuli were absent or too weak during development, this can lead to developmental ***deficits***, e.g., deficient perceptual and affect regulation abilities or shallow fantasies. If someone has been neglected, this can lead to developmental delays and - especially in old age- even loss of cognitive abilities and interests.

Disturbances are caused by unpredictable or ambiguous stimulation. One becomes insecure because the behaviour (the stimulation offers) of the other person is not predictable and one does not know where one stands.

In contrast, overly strong stimuli, e.g., authoritarian parental actions, violence, death of a parent, unprepared move, unemployment, illness, natural disasters, etc., can lead to ***traumata***.

Contradicting stimuli that are mutually exclusive will result in ***conflicts***: One is encouraged to perform, but at the same time devalued to the effect that one cannot do it after all. Or one gives signals of wanting to be cared for, but at the same time rejects help: Wash me, but don't get me wet.

Stimulation in GIM (Frohne-Hagemann & Pleß-Adamczyk, 2005; Frohne-Hagemann 2015; 2017; 2019).

Damage/disorders caused by dysfunctional stimuli have to be diagnosed and classified against the background of the client's *achieved psychic structural level*. The level of the client's psychic structure essentially determines how the guide's intonation, the imagery and the music should be used for therapeutic mental stimulation.

[7] In response to the baby's hunger cries, smells and stimuli, the mother involuntarily activates hormones such as prolactin, which stimulates the flow of milk, and the hormone oxytocin, so that she turns towards the baby.

For this purpose, it is important to ask: What kind of *deficient resonance experiences*, what kind of *disturbed or traumatic relationship patterns* and what kind of *conscious and defended conflicts* had an effect on the psychological development and level of the psychic structure and in what way do such relationship experiences phenomenological show up in the here and now.

Reciprocal stimulations take place not only between guide and traveler, but - specifically for GIM - in the triad of music, guide and traveler. Questions arise like: How are music-induced imaginations stimulated, how does the traveler perceive the guide's stimulations and how do these influence his attention, feelings and his imagery? How does the traveler stimulate the guide's suggestions? On what assumptions is the imagery potential of the music selected by the therapist based in regard to the client's needs and conflicts? So, how are behaviours, how are stories, how are affects and emotional processes stimulated?

Such questions concern the very complex relationships and are difficult to answer. However, taking into account the developmental phases and structural levels, it is possible to hypothesize certain types of damage due to earlier inadequate stimuli, and to draw conclusions for appropriate stimulation offers (mentalization aids).

Deficits, Disturbances, Trauma, and Conflicts can arise in all developmental phases. I will give here a few examples:

Deficits

Missing stimulations, if occurring f. ex. in the early development of the phase of "*bodily self-perception*" (Petzold) or as Stern says the "*world of feelings*" lead to feelings of isolation and deprivation or cosmic loneliness. In his countertransference the guide could feel an impulse to give verbal interventions in a reliably warm and facing voice quality. The guide might experience that his voice presence can be more important than the content of the interventions.

A *lack of stimulation* can certainly lead to speechlessness and perception deficits. Here, too, the guide will select music that is emotionally sustaining and reliable and, like the hormone Oxytoxin, can trigger feelings of security and relatedness. The therapist will encourage the traveler to experience the music in a sensory, pre-linguistic way. Thus, the function of the music will be nurturing and sustaining, not challenging.

However, the guide must be prepared for the fact that such a trailing music can also trigger anger, sadness or mistrust and defensiveness, because early deficits can, after all, affect and activate all later negative attachment experiences that could not yet be mentalized and then flood the traveler's psyche.

Disturbances

If, for example, in the early developmental phase of the *world of stories* (Petzold, 1993), damage has been caused by ambiguous stimulation experiences, it could become manifest in the client's GIM journey by incoherent imagery, interrupted perceptions and communications. The result may be an incongruent narrative. The traveler may confuse the guide by acting "sometimes this way sometimes that way," engaging briefly with an image, and then digressing elsewhere so that the guide loses the thread.

The guide would be adequately stimulating by the choice of clearly structured music, which invites to imagine a story with a comprehensible development. The traveler could stick to a solo instrument with which he can identify and which reliably accompanies him in the musical experience. The guide will notice that his verbal interventions must help the traveler to mentalize, to connect and form the parts of the imaginings, i.e. to perform networking services himself.

If it is the guide himself who stimulates or guides in an ambiguous way, either by conveying comfort and protection through music or by unsettling the traveler with music and leaving him to his fate, the traveler will become suspicious of getting involved in anything.

Trauma

If overstimulating experiences during the developmental stages of the *verbal and narrative selves* (the world of symbolic experience and the world of stories) have led to trauma, the traveler may become silenced and unable to communicate his inner images and feelings. Overstimulation easily leads to *mentalization blocks* and the development of a *low level of structure*. The guide should pay special attention to a marked mirroring of the traveler's emotional world in order to overcome mentalization blocks.

In case the guide pushes the traveler into an experience the client does not want, or, if he overstimulates the client by selecting music that is far too challenging and anxiety-provoking without assisting to overcome the anxiety, the guide would be triggering old structural patterns/schemes. But sometimes it can also be the traveler who over-stimulate the guide and trigger old trauma of his own, f.ex., by confronting the guide with the scariest details of a bad experience.

Conflicts

Contradictory stimulation experiences are reflected in the music and imagery experience as impulses that exclude each other. In case the client was previously forbidden to take pleasure in her own body there could be a conflict when stimulating self-esteem in the layer of *bodily self-perception*. The guide then could select music that stimulates her to experience the bodily states of tension through mindful guiding, in order to make the conflict conscious and workable.

In other cases the guide would stimulate contradictorily if the traveler was to direct his attention simultaneously, for example, to very different phenomena, such as following what the violin is currently saying to the orchestra, and at the same time looking around the cave to see what secrets there might be to explore. Conversely, the traveler can stimulate

contradictorily if he offers the guide superficial or particularly beautiful imagery experiences, but at the same time conceals the actual subject.

In Integrative Therapy conflicts are regarded as a result of inappropriate *mutual stimulations.* A diagnosis made in GIM will always be a *procedural diagnosis*, or rather, a "*theragnostic"* [8] one , because "every therapeutic happening implies a diagnostic grasping from moment to moment" (Orth, Petzold, 2010, 26) and during a GIM journey correspondingly appropriate stimulations.

The concept of Conflicts seen from the *Operationalized Psychodynamic Diagnostic*

The **OPD** considers conflicts[9] (Axis III) primarily in terms of unconscious (and/or averted) intrapsychic conflictual material that persists over time[10] (OPD, 2007, 212).

The conflict field "*individuation versus dependency*" becomes apparent when the traveler in his music imagination either experiences himself as completely helpless and abandoned and seeks protection from stronger persons (passive mode) or seems to need no one (active mode). E.g., romantic music, which stimulates the repressed longing for symbiotic closeness, is warded off out of fear of merging by emphasizing independence. The music is experienced as sentimental or corny, indicating an experience of overstimulating closeness (e.g., the caregiver needed closeness to the child more than vice versa) or unpredictable stimulation (today I love you, tomorrow I hate you). Conflict polarities are also manifested in the imaginations, e.g. the traveler imagines a situation where he meets someone who has wonderful abilities and knows everything. He does everything to please him and not to be abandoned. Here, stimulation stimuli for the own exploration of the world and self-efficacy were obviously missing. The conflict as a result of inadequate stimuli can thus be consciously and emotionally processed by the guide, taking into account the existing structural level of the traveler, through mentalization aids. The goal would be to reach a level of sovereign individuation that also allows a satisfying closeness to others.

The field of conflict "*subjugation vs. control*" becomes apparent when power and powerlessness, self-control and control by others are involved. Scenes are imagined which can also give information about the sensitive phase of emergence, e.g. when the traveler imagines himself small and has to fight with strong powers. The music itself can also be experienced as threateningly overstimulation when it comes to conflicts of authority and the active processing mode of dealing with the "power" of music and the fear of subjugation. Can the traveler transform the threat by integrating the power of music (or the power of powerful figures)?

[8] Thera(py) and (dia) gnosis (the term was created by H. Petzold)

[9] for example, the conflict polarities of individuation versus dependency; subjugation versus control; provisioning versus self-sufficiency, as well as self-esteem, guilt, Oedipal, and identity conflicts, and, as an extra category, 'averted conflict perception...'.

[10] In the active mode, conflicts are processed dysfunctionally as counterphobic defenses and reaction formation, and in the passive mode as regressive defensiveness.

The conflict field of *supply vs. self-sufficiency* is revealed when the need for self-sufficiency and supply demands become diagnosable in the imaginings. The guide can perceive the conflict as the need of the traveler to want to experience music in its function of a caring mother (supportive music), and thereby (in passive processing mode) avoid the development towards self-sufficiency of the traveler. He feels that he must stimulate the traveler through music (in the vehicle function) that leads into action in the imaginations.

Self-esteem conflicts or *narcissistic* conflicts and the regulation of self-esteem are about the need to be loved and to receive recognition, but also to make oneself present for this. In musical imaginations - especially in music with solo instruments and tutti - the traveler or his representative often sees himself as a dancer on a stage in front of an empty or full auditorium, which he is often embarrassed about at first because he feels ashamed. The guide perceives the conflict of showing oneself and being looked at and explores whether there were earlier negative evaluations that had a traumatic effect or whether there was a complete lack of resonance experiences (deficits) or contradictory stimuli. Depending on this, the guide will respond to it with appropriate mentalization aids for the satisfaction of inner needs and the overcoming of associated fears.

Guilt conflicts: Here it is about self-blame and blaming others, i.e. whether one has actually or supposedly violated another person or their needs or rights. Coping with feelings of guilt requires the ability to feel guilty and, accordingly, a certain maturity to work through unconscious, repressed or transgenerationally inherited as well as existential feelings of guilt. Shame, which is based on conflicts and contradictory stimuli, plays a major role (should I, may I, am I good, am I bad...). Since music itself lives from polar tensions like consonance and dissonance, solo - tutti, loud and quiet, accelerando – ritardando, restless and calm, etc., it can provide a space and time for music-induced imagery in a GIM journey (for more details see Frohne-Hagemann, 2008).

Oedipal-sexual conflicts concern the satisfaction of sexual and erotic desires and their rejection or inhibition. Again, the imagery music experience can provide a theragnostic approach to repressed or blocked sexual and erotic desires, because music contains all the elements associated with eroticism and sexual desire (drive/desire, tension, excitement, enhancement, release, longing, tenderness, ravenous desire, etc.). The erotic stimulation potential in music reveals conflicts encoded in the imagery, often in a symbolic way in the form of fear of caves in which one can disappear, through bunkers in which one hides from intruders, as volcanoes that spit fire or -oedipally seen- in triangular constellations.

Identity conflicts are about the question of whether the balancing of self-attributions and attributions to others is successful and whether external values and requirements are in harmony with one's own needs can be brought into harmony. In GIM journeys it becomes recognizable to what extent the traveler can identify himself as an *actor and as a spectator* in his imaginations, i.e. the way he is able to recognize and evaluate himself also with "foreign" eyes and on which psychic structural level he is able to get involved in GIM experiences or in the reflection of the contents of his imaginations.

The reciprocal or triadic stimulations by music, guide and traveler are highly complex in terms of a procedural diagnosis or theragnostic. An inadequate stimulation on the part of the guide, e.g. through wrong choice of music or inconsistent guiding can trigger existing

deficits, traumata, disturbances or conflicts, but also set new ones. If the guide himself comes into contact with his own disorders (e.g. his own deficits, trauma etc.) and his ability to mentalize is blocked, he in turn triggers the traveler's feelings of abandonment, sadness, anxiety, anger or speechlessness. Therefore, it is very important that the guide himself has a well-developed **mentalization** ability (Frohne-Hagemann, 2014a, b, 2015, 2017, 2019; Herold, 2014).

Inadequate Stimulation and Mentalization

Damage caused by inadequate stimuli impedes, prevents, or blocks mentalization processes (Allan & Fonagy 2009; Fonagy, 2012). They have, depending on the area of life, a correspondingly negative impact on personality and identity development and on the capacity for affect regulation, conflict management, attachment and relationship skills. A dysfunctional development of stable "pillars of identity"[11] (Petzold, 1993) and a mature level of psychic structure must be countered by nurturing, soothing, corrective or compensatory experiences.

90% of what we sensually perceive is intermentally complemented by the culturally mediated process of perception and evaluation (Kosslyn, 1995; 2006). Only the permanent exchange of mutually stimulating and mentalizing emotions, motivations and volitions of individual people and social and cultural communities enables linguization and thus the differentiating identity development (cf. Petzold, 2008, 34). When intramentally embodied and interiorised, this shared knowledge determines what we perceive as embodied cognition (cf. Profitt & Baer, 2020). Mentalizing then is a constant transformation of sensory and cognitive perceptions and assumptions into metacognitive information which again, can be shared.

The Guide’s mentalizing ability reveals whether he is able to surmise origins and sources of mental damages. For this, the guide must have the ability to empathize, i.e. to be able to feel as the other person feels, without being infected by the client’s emotions or, if necessary, rashly wanting to protect or save him or her because one cannot withstand violent affects oneself. Empathy is the prerequisite for mentalizing and includes being able to name mental states, to make them conscious and to reflect on them. In therapy, it is necessary to be able to mirror the client in a marked way (cf. Fonagy et al. 1993; 2012).

Giving mentalization support as a guide means to help regulate the mental state of a traveler, an affect, by mirroring it somewhat exaggeratedly (marked) without dramatizing the state. This would be an adequate way to stimulate. One decisive factor is the Guide’s emotional affirmation (yes, that sounds really sad!). Only this enables the traveler to regulate his emotions without flooding him with his own emotions. The verbal stimulation stimuli (interventions) should basically help to mentalize the client’s experienced imaginations, images, affects, sensations, memories, narratives and metaphors taking an

[11] These are: Physicality; social network; work, performance and free time; material securities and values (Petzold, 2012).

interest in them, mirroring them or even questioning them sometimes. In the follow-up conversation, further processes of mentalization can be developed through ideas about the lifeworld background of the traveler's imaginations.

GIM music experience often begins sensory and often the traveler only finds words gradually for the experience. The guide will help with mentalizing. Bonde (2000), with reference to Ricœur, even refers to *GIM as a whole as a metaphorical process*. It is always helpful to use metaphors: “I feel as if I was a mashed potato”, “the confrontation with XY looks like a frontal collision of two locomotives”, “there is a nothing like the black hole”, etc. M***etaphors*** give clues of diagnostic information behind the imagery.

The principles of mentalization-based therapy (MBT) (Allan & Fonagy, 2009; Fonagy et.al, 1993; Fonagy, Bateman, and Luyten, 2012) also apply to GIM.
This is shown by a comparison of MBT interventions with the verbal interventions of a GIM guide (Frohne-Hagemann, 2012)

General characteristics of MBT interventions	**General characteristics of interventions during <u>GIM</u> journeys**
• Express yourself simply and briefly • Focus on affective processes (love, desires, pain, disasters, and agitations)! • Always focus on the client's mental events, not on her behaviour! • Refer to current events or activities and to their mental reality! • Addressing not unconscious, but 'almost-conscious' and conscious content!	• Use short sentences • Support affective experience and exploration of associated mental states, e.g., "what are you experiencing right now?" “What does it feel like?” (if appropriate, guide offers categories: threatening, worrying, confidence-inspiring...) • Acknowledge feelings: "Yes this is sad!" • Stay in the here and now. For memories of past, ask: "What is it like to experience this now?" • Be interested in the client's imagination experience and the musician's life in the here and now • Do not rescue, do not give advice • Do not interpret while listening to music
Supportive and empathic (MBT)	**Supportive and empathic (GIM)**
• Show respect for narrative and expression	• Show respect towards the client's experience.

• Be positive / hopeful, but questioning • Practice the attitude of 'not-knowing curiosity' • Clarify the desire to want to understand what is happening mentally • Reassure "Did I understand it correctly: You ..." • Explicating the emotional impact of what is being told based on everyday psychology and the client's own experiences. • Not acting for the client	• Ask questions in order to better empathize with the client's experience • Be curious about how the client's imaginings are developing • Encourage the client to explore his/her inner world further. • Do not want to understand everything right away • Share and witness the emotional impact of what is experienced and narrated (ah! Is that so! Yes, this sounds like …. Allow yourself to experience this feeling!) • Use maieutics[12]
• Circular questioning • Try to stimulate naming of causative feelings • If mixed feelings are evident: probe for feelings other than those named • Reflecting on how it must feel to be in such a situation • Trying to figure out what should have gone differently so that the client could have had different feelings	• Ask circular questions • "How is this for you? • "Can you say more about this?" • "Where do you feel these feelings in your body?" • "What does this sound like" • "What does this feel like?" • "as if…? • Does this feeling/pressure have a colour/a form? "Does the fog/the monster/the energy have a name?" • "How is it for to be there?" • "How is it for you to have XY see you?" • "What must happen for the situation to change?" • "Can the music help?" • "What would happen if you...?" • "Is there anything that can help you?"
MBT • Relate statements to generalizations • "It does seem the same to me as before. Could it be that ...?"	**GIM in the postlude:** • Name the experience of the imageries and the music again (first with the help of looking at the resonance picture)

[12] The term "maieutics" (literally: midwifery) is used in a broader sense in reference to the conversational techniques of the philosopher Socrates in conversation with his students in the sense of a "dialogical method of seeking truth" that leads a learner to knowledge by skillfully asking questions himself (https://www.zqp.de › ZQP_Naturheilkunde_Mäeutik, translated by I.F.-H.))

• "When this kind of thing happens, you always feel desperate and left out." • Identify patterns	"It seems to me that you are expressing in your image much of what you experienced in the music, but perhaps you have not yet been able to communicate, am I seeing this correctly?"
• "It seems to me that whenever you feel hurt, you start yelling, lashing out, etc., and get in trouble because of it." • "Let's think about how this could go differently."	• Focus on the guiding you experienced: "Obviously I asked you something too many times; could you have used more time so you could stay in the experiencing?" Guide: "I felt myself that I could disturb you in the experience by asking too many questions. Did you experience it the same way, or would you have even wished for more guidance from me?"
• Point out transference situation • "I feel like this could happen to you with me, if you feel hurt by what I say."	• Limit transference situations to the imageries and the music: "The singing voice seemed to threaten you a lot, what exactly disturbed you so much?" "Do you ever feel that way about female voices?"

A deeper knowledge of the above-mentioned different perspectives and how they interact in GIM should make it possible to better understand our clients and patients and use music and imagery in GIM sessions in the corresponding adequate way.

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