Addressing Shame and Guilt in Individual BMGIM Sessions: Perceptions of BMGIM Fellows Working with Individuals in Addiction Recovery

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Jared Weinstock

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Jared Weinstock
State University of New York at New Paltz

We, the thesis committee for the above candidate for the
Masters of Science degree, hereby recommend
acceptance of this thesis.

Dr. Kathleen Murphy, Thesis Advisor
Department of Music Therapy, SUNY New Paltz

Dr. Jingwen Zhang, Thesis Committee Member
Department of Music Therapy, SUNY New Paltz

Dr. Karyn Stuart-Rohm, Thesis Committee Member
Department of Music Therapy, SUNY New Paltz

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Table of Contents

Chapter 1

Introduction

Amongst the milieu of addiction treatment methods and modalities, there is a predominant emphasis on group-based treatment and recovery programs to reduce the negative individual and social impacts of addiction while mitigating recurrence. The most notable, Alcoholics Anonymous and its subsequent derivatives, including Narcotics Anonymous and other 12-step programs, largely focus on utilizing and maintaining sobriety by leveraging social fellowship and connection within a group of individuals also in recovery (Kelly et al., 2009). According to Substance Abuse and Mental Health Services Administration [SAMHSA] (2023), 48.7 million people over the age of 12 suffer from addiction. The likelihood of an individual in the United States having substance use disorder is roughly one in five, suggesting that likely every person has been affected by addiction themselves, or within their nuclear or close family. The ubiquity of addiction, its severe adverse effects on individual, social, and community well-being, as well as the high prevalence of recurrence, requires more research to understand and combat this disorder.

Much of the current literature on addiction treatment naturally focuses on group-based treatment programs. This appears largely due to many of the institutional realities including the focus on medical needs of a patient in detoxification and efficient use of limited resources (White, 2009). Treatment programs of this nature can provide effective intervention of immediate drug and alcohol use and social components of recovery through connection within a community (Galanter, 2014; Kelly et al., 2009; White, 2009). Nevertheless, The National Institute on Drug Abuse (NIDA) (2020) reports that recurrence rates are between 40-60%. The chronic nature of substance use disorder, its lifelong recovery process, and the limitations of

group-based work (e.g. limited access, co-dependence, and lack of individualized coping skills) necessitates exploring the disorder's underlying causes to improve treatment approaches.

Biological and environmental risk factors include genetic and familial predispositions to mental health disorders, as well as an individual's home, work, and school environment, access to drugs and alcohol, and other social and environmental factors (Mehany et al., 2021; NIDA, 2020). These factors may contribute to the prevalence of addiction however they do not address the underlying causes of addiction (Mehany et al., 2021). Mental health challenges such as depression and anxiety are considered risk factors as an individual can use drugs and alcohol to escape their negative feelings (Mehany et al., 2021). Yet, underpinning these mental health challenges are negative self-conscious emotions such as shame and guilt. Shame and guilt can influence an individual to choose adaptive or maladaptive responses when confronted with established risk factors to addiction (NIDA, 2020; Treeby & Bruno, 2012).

The Bonny Method of Guided Imagery and Music (BMGIM), developed in the early 1970's, is a receptive music therapy method that seeks to enable a client or patient to heal from within oneself (Bonny, 2002; Grocke & Moe, 2015). BMGIM is an experience in which a client—referred to as a traveler— moves into a non-ordinary state of consciousness to explore their inner thoughts and feelings (Bonny, 2002). The process uses music to stimulate imagery that often has metaphorical meaning and allows clients to bring unconscious content into conscious awareness (Bonny, 2002). The integrative process outlined in BMGIM, specifically related to personal coherence, suggests it can be a potent therapeutic treatment method for those with substance use disorders (Heiderscheit, 2017; Miller, 2017; Moe, 2012; Van Dort, 2015;). Despite BMGIM's origins in assisting individuals with substance use disorder, there remains a gap in research regarding perspectives of BMGIM practitioners (Fellows) towards addressing

underlying emotions such as shame and guilt in addiction recovery. As BMGIM focuses on inner healing, a sense of personal coherence, and integration between the whole self, its theoretical underpinnings make it keenly suited for addressing the inner complexities of addiction pathology. The interplay between addiction and negative self-conscious emotions such as shame and guilt, may be precursor emotions to anxiety and depression (Oh et al., 2023) and warrants deeper understanding. Within the literature, there is a dearth of research on perspectives and experiences in addressing shame and guilt with clients to sustain long-term recovery through BMGIM dyad work.

My experience with addiction is deeply personal, having grown up in an environment where addiction was prevalent. In my experience, the addiction of just one person has a variety of negative impacts on themselves and those around them. Further, the high prevalence of recurrence within individuals in addiction recovery suggests current treatment models may not be optimal for everybody. BMGIM offers an opportunity for individuals to bring awareness to their own thoughts and feelings, suggesting it may be beneficial as a complimentary treatment option that offers opportunity for self-efficacy and coping skills. This study plans to investigate how current BMGIM Fellows perceive the ways individual BMGIM addresses shame and guilt in individuals with substance use disorder. I hope to provide a better understanding of how the theoretical underpinnings—specifically related to deep personal healing and growth—can play an instrumental role in providing better opportunities, inner-resources, and outcomes of sustained recovery for those suffering from addiction when confronting shame and guilt in recovery.

Addiction As a Complex Illness

Drug and alcohol addiction is a complex and varied illness (NIDA, 2020). Clinically referred to as Substance Use Disorder (SUD) the Diagnostic and Statistical Manual of Mental

Disorders ([DSM-5], American Psychiatric Association, 2013), describes drug and alcohol addiction as a persistent, chronic condition marked by compulsive urges to seek and use drugs despite negative outcomes (NIDA, 2020). This condition is recognized as a brain disorder, leading to alterations in brain circuits related to reward, stress, and self-regulation (NIDA, 2020). These alterations can endure long after an individual ceases drug consumption. According to the DSM-5 (American Psychiatric Association [APA], 2023), the key aspect of a substance use disorder involves a combination of cognitive, behavioral, and physiological signs, demonstrating that the individual's thoughts, emotions, and behaviors persist in substance use despite encountering notable substance-related issues (p. 483). Because of the multi-faceted nature of addiction, there continue to be challenges in reducing the overall societal impact of addiction, as well as formulating comprehensive and effective long-term treatments for the disorder.

The prevalence of substance abuse and overdose deaths in the United States has continued to rise in the past 20 years (Spencer et al., 2022). The 2022 National Survey on Drug Use and Health, reported that 48.7 million individuals suffer from substance use disorder, comprising of 17.3% of the United States population over the age of 12 (SAMHSA, 2023, p.2). Despite the increase in overdose deaths, only one in four individuals categorized as needing substance abuse treatment had received treatment in the prior year (SAMHSA, 2023, p. 3). A confluence of societal factors likely contributes to this statistic, including access to illicit drugs, over-prescribed opioids, or the epidemic of loneliness and isolation contributed to by the global COVID 19 pandemic (e.g. Mojica-Perez, 2024; U.S. Department of Health and Human Services [HHS], 2023).

Another challenge facing individuals suffering from addiction is the high prevalence of co-occurring mental health disorders, referred to as comorbidities or co-occurring disorders (Han

et al., 2017; SAMSHA, 2021). Of the population living with addiction, 7.7 million individuals live with diagnosed comorbidities or co-occurring disorders, comprising 37.9% of individuals living with SUD (Han et al., 2017). Although there are several comprehensive treatment options developed for both mental health and addiction, there remains numerous barriers, including cost, complexities with healthcare access, lack of problem awareness, and stigma (Corrigan et al., 2016; Han et al., 2017; Probst et al., 2015). Despite public health advocates' efforts to address awareness of both addiction and mental health, external barriers and intra- and inter-personal challenges persist amongst individuals suffering from SUD and/or co-occurring disorders (Corrigan et al., 2012, 2016; HHS, 2023; Latkin et al., 2019).

Negative self-conscious emotions align with both maladaptive addictive behavior as well as depressive and anxious symptomology (Dearing et al., 2005; Esmaeelzadeh et al., 2018; Treeby & Bruno, 2012). As precipitating and precursory feelings to depression and anxiety, shame and guilt play a significant role in how individuals ascribe themselves to their personal identity, their ability to self-regulate, and their self-esteem (Oh et al., 2023; Snoek et al., 2021; Su & Hynie, 2022). Yet, there is a dearth of research on the perceptions of these negative self-conscious emotions such as shame and guilt within the process of substance use addiction and recovery treatment.

Chapter 2

Literature Review

Negative Self-Conscious Emotions in Addiction

Shame and guilt are closely related negative self-conscious emotions that involve internal attributions of negative thoughts and feelings related to the perceived role of oneself (Su & Hynie, 2023; Treeby & Bruno, 2012). Also referred to as "quintessential moral emotions" (Tangney et al., 2011, p. 710), they are innately self-directed but tend to be associated with diverging motivational and self-regulation behaviors (Tangney et al., 2011; Treeby & Bruno, 2012). Dearing et al. (2005) differentiate between shame and guilt, recognizing shame as a negative self-directed feeling about oneself (identity-related), and guilt as a negative self-directed feeling about a specific event or group of events (behaviorally or situationally related). Guilt can lead to reparative actions, motivating individuals to correct their mistakes, whereas shame can trigger avoidance, denial, and efforts to escape uncomfortable feelings (Dearing et al., 2005; Snoek et al., 2021; Tangney, 2011; Treeby & Bruno, 2012). Although distinctly interrelated and often used interchangeably, research highlights these key differences between shame and guilt in their effects on behavior, emotions, and psychological health. Guilt-prone individuals also tend to take responsibility for their actions and manage anger more constructively, suggesting it may be a protective negative self-conscious emotion (Tangney et al., 2011; Treeby & Bruno, 2012). Individuals who identify as guilt-prone are more likely to engage in non-hostile discussions and corrective actions, reducing their likelihood of aggressive and impulsive behavior. In contrast, those prone to shame are more likely to externalize blame, experience unmanaged anger, and exhibit hostility (Dearing et al., 2005; Snoek et al., 2021; Tangney et al., 2011). Shame-proneness is linked to a wide range of psychological issues, such as depression, anxiety,

substance abuse, and low self-esteem. Despite the relationship between shame and guilt, many of the externalized maladaptive behaviors do not share the same associations of psychological difficulties (Snoek et al., 2021; Tangney et al., 2011; Treeby & Bruno, 2012).

Both shame and guilt have been shown to precipitate depressive and anxious feelings, as negative self-conscious emotions have significant mediating effects on feelings of depression and anxiety (Oh et al., 2023; Shamsababdi & Dehshiri, 2024). Based on Higgins (1987) Self-Discrepancy Theory, research suggests guilt and shame can both be inciting and mediating factors in precipitating feelings of depression and anxiety (Oh et al., 2023). Similarly, self-esteem and self-compassion have a negative correlation to feelings of guilt and shame, and guilt can have only a little significant negative effect on anxiety (Shamsababdi & Dehshiri, 2024). Despite the prominent role of guilt and shame in negative self-conscious emotions, additional research is needed to best understand how shame and guilt manifests in addiction recovery, and how these negative self-conscious emotions can be addressed in the therapeutic process.

Esmaeelzadeh et al. (2018) examined Canadian post-secondary students based on perceived and diagnosed depression and anxiety and relative use of alcohol, tobacco and cannabis. Results indicated both depression and anxiety correlated with increased substance use (Esmaeelzadeh et al. 2018). Similar research has indicated that triggering emotions of shame and guilt—and feelings of depression and anxiety—help to perpetuate substance use to curb negative self-conscious emotional responses (Dearing et al., 2005; Oh et al., 2023; Snoek et al., 2021). Stuewig et al. (2015) also underscore the potent role both guilt and shame have in mediating risky behavior in children, as the role of guilt indicated adaptive behaviors, while shame was a primary indicator of problematic and risky behavior. As negative self-conscious

emotions can lead to depression, anxiety and risky behavior like drug and alcohol abuse, more research is needed to identify how treatments can best address these underlying emotions.

Prevalent Addiction Treatment Models

Alcoholics Anonymous (AA), a fellowship of recovering alcoholics, began in 1935 (Alcoholics Anonymous World Services AAWS, 2001). Founder Bill Wilson and contributor Bob Smith developed the 12 steps of recovery, which outlines a moral, psychological, and spiritual approach to achieving abstinence and maintaining recovery (AAWS, 2001, p.xxxi). The rationale behind the 12-step model is validated by current definitions of addiction, noting that addiction is a brain disease that impacts executive functioning and emotional regulation (AAWS, 2001, p. 23; NIDA, 2020). Although this model does not mandate any clinical treatment, many drug rehabilitation organizations and institutions have adopted the 12-step model for recovery in conjunction with pharmacological interventions, particularly during acute phases of early recovery.

Recent research on the mutual effects of neural reward systems shows neurological effects on various brain areas associated with addiction and recovery—these offer a neuroscientific understanding of the 12-step model's efficacy (Galanter, 2014). Some major components of the model include social, spiritual, and cognitive elements within the 12-step process. Mirroring and mutuality, social bonding, collective storytelling, and integration of memories are some adaptive behaviors encouraged by group recovery treatment models (Bourdaughs & Silverman, 2020; Galanter, 2014). These constitute many of the processes that affect areas of the brain involved in executive function (pre-frontal cortex), unconscious/conscious memory (hippocampus), craving (amygdala and ventral tegmental area),

and incentivizing and storytelling (mesocorticolimbic pathway and endogenous opioid system) (Bourdaughs & Silverman, 2020; Galanter, 2014, p.305).

Social bonding and mutual-aid are key aspects of the 12-step program of recovery and are supported by research indicating the need for social connection and a supportive social network throughout treatment and the process of recovery (AAWS, 2001; Lookatch et al., 2019; Zemore et al., 2018). Lookatch et al. (2019) noted that both family and friend social support provide benefits for an individual's sustained recovery. However, family and close friends often remain rigid regarding total and complete abstinence and are less tolerant of recurrence. This research infers the importance of an individual's own resources in sustaining recovery (Lookatch et al., 2019).

Additionally, several steps within the 12-step model allude to admission of guilt (AAWS, 2001). Particularly, Steps 8, 9, and 10 refer to the process of making amends (AAWS, 2001). This perspective aligns with current research on the divergence between shame and guilt. Guilt can display an adaptive measure for recovery, self-regulation and adaptive behavioral responses (Dearing et al, 2005; Snoek et al, 2021; Tangney et al, 2011; Treeby & Bruno, 2012). Shame, however, displays maladaptive responses, including avoidance and isolation (Snoek et al., 2021; Tangney et al., 2011). There is a lack of research into how addressing guilt—as well as feelings of shame—can manifest in adaptive recovery behavior. The innate spiritual elements presented in the 12-step model are also shown to provide a protective factor in addiction recovery (McInerney & Cross, 2021). Alcoholics Anonymous makes a broad assertion that the alcoholic suffers from a spiritual condition (AAWS, 2001, p. 44), therefore the AA/NA paradigm provides wide latitude in using non-affiliated and independent notions of spirituality that are explicitly conceptualized as secular (McInerney & Cross, 2021).

Cognitive-Behavioral and Secular-Based Programs of Treatment and Recovery

Cognitive-behavioral models for addressing addiction rely on a behavioral perspective, focusing on interactions and awareness of the dynamics between thoughts, emotions, and behaviors. As drug and alcohol misuse is a behavioral symptom of SUD, Cognitive-Behavioral Therapy (CBT) seeks to establish new relationships between thoughts, emotions, and subsequent behaviors involved in compulsive drug or alcohol consumption. A randomized-controlled trial of Integrated Cognitive Behavioral Therapy (ICBT) versus 12-step facilitation therapy (TSF) for individuals with substance use disorder and depressive disorder compared the reduction in both depressive symptoms and substance misuse (Brown et al, 2006). The findings suggested that despite similar outcomes for both groups during intervention, ICBT saw prolonged improvement in depressive symptoms when compared with the TSF group (Brown et al 2006). Similarly, Kushner et al (2006) examined the efficacy of CBT interventions on individuals in an alcohol in-patient treatment program with diagnosed anxiety disorders. Findings suggest the use of anxiety-oriented CBT interventions, particularly with group orientations, provided a reduction in anxiety and panic responses among the participants (Kushner et al, 2006). Although the study focused on co-occurring anxiety disorders in patients with SUD, it provides evidence that the use of CBT interventions may provide a shared goal in alleviating overlapping symptoms of both SUD and co-occurring mental health disorders (Kushner et al, 2006). Further meta-analysis on the use of CBT with co-occurring disorders and SUD confirm mutual benefits of utilizing CBT for treatment of addiction and comorbidities (Hobbs et al, 2011). These studies provide evidence to support CBT's use to address the multitude of overlapping symptoms with comorbidities for addicts and suggest the validity of a cognitive-behavioral model to effect sustained recovery,

focusing on present behavior modifications in relation to thoughts, emotions, and use of mentalization.

Prevalent treatment models incorporated into both inpatient and outpatient substance abuse treatment (e.g. Alcoholics Anonymous, CBT, and secular peer support groups such as SMART, LifeRing and Women For Sobriety), rely heavily on peer support and mutual assistance. Current prevalent recovery models underscore the reliance on mutuality and group support, however, there remains a gap in research which investigates the efficacy of confronting negative self-conscious emotions such as shame and guilt as a means of assisting individuals at mitigating depressive and anxious symptoms leading to drug and alcohol recurrence.

Music and Addiction

Music has been shown to play an effective role in several facets of human life for millennia (Menon & Levitin, 2005; Moore, 2017). Research has shown that music affects many areas of the brain responsible for the formation of memories, cognition, physical responses, and emotions (e.g. Salimpoor & Zatorre, 2013). Music can act as a neuromodulator, creating physiological, cognitive, and affective change in several brain areas associated with addiction, as, if not more effective as, the neurobiological effects of prevalent non-musical treatment models (Menon & Levitin, 2005; Galanter, 2014). Menon and Levitin (2005) provided evidence that music can stimulate and affect the mesolimbic system (including the nucleus accumbens, ventral tegmental area, hypothalamus and insula) suggesting a strong correlation between musical engagement and modulation of reward systems in the brain; similar areas of the brain that are affected in addictive behavior. Music has also been utilized to address spiritual needs (Clark, 2019; Tsiris, 2017; Yoshihara et al, 2024). Because of music's comprehensive activation of different areas of the brain, as well as the function of music both on the personal psyche,

spirituality, and use for socialization and social bonding, music presents a medium that offers opportunities for non-pharmacological treatment of addiction and mental health disorders (Borling, 2011; Menon & Levitin, 2005; Murphy, 2017; Salimpoor & Zatorre, 2013).

Music Therapy and Addiction

Music therapy is defined by Bruscia (2014) as "a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change," (p. 36). It has been used as a therapeutic modality in treatment for a wide range of mental health disorders including in addiction treatment. However, there is a paucity of research related to music therapy in addictions treatment. In fact, a recent Cochrane review (Ghetti, et al. 2022) reported low to moderate confidence in the current research findings with the clinical population, as most studies were conducted by the same researcher on the same detoxification unit.

The Predominance of Group-Based Music Therapy in Addiction

The predominant treatment models for addiction rely on mutual-help and group-based programs, mirroring effective non-music treatment interventions such as the 12-step model, integrated CBT and secular support groups. Research has indicated the benefits of connectivity amongst others for mutual support, social connectivity, and connection to respective groups (e.g. AA, 12-step programs), offer a protective safety net (Bourdaughs, 2020; Gardstrom et al, 2017). Gardstrom et al. (2017) identified several curative factors of group work outlined by Yalom and Leszcz (2005), noting the increased perception of universality, altruism, instillation of hope, group cohesiveness, existential factors, catharsis, and self-understanding as predominant themes of women's perceptions of the usefulness of participating in group music therapy while in a 28-day inpatient treatment program. Recent research also supports participation in group music

therapy in achieving goals related to recovery, such as social belonging, breaking down of defenses (resistance), hopefulness, and decreased depression and anxiety (Aldridge & Fachner, 2010; Gardstrom et al, 2013). The benefits of group music therapy offer positive implications on effective ways to reinforce recovery. However, the long-term benefits of participating in group music therapy have not been determined through academia or research. As addiction is multi-faceted and complex, and recovery is a life-long process, more research is warranted to understand the ways negative self-conscious emotions such as shame and guilt factor into the recovery process.

Approaches to music therapy practice encompass a broad range of orientations expressed in both the historical use of music in treatment and the therapist's perspectives and theoretical underpinnings within the treatment process (Bonny, 1998; Borling, n.d.; Shoshensky, 2001). As predominant addiction models—as well as music therapy research—have utilized group therapy as a means for change, there is a paucity of research establishing rationale in which individual music therapy (music therapists working one-on-one in dyad format) can specifically address shame and guilt in the addiction recovery process.

Addressing Addiction Holistically in Music Therapy: The Bonny Method

The Bonny Method of Guided Imagery and Music (BMGIM) is a receptive music therapy model that is rooted in psychodynamic, humanist, and transpersonal theory (Bonny, 2002; Crowe, 2017). BMGIM focuses on a holistic approach to cohesion between various elements of the self, including exploration and understanding of our unconscious, conscious, and the ability to identify and embody individual potential (Bonny, 1998). Traditionally practiced in dyadic format, the development of BMGIM has broadened to encompass group-oriented therapy. BMGIM provides a unique and person-centered approach incorporating conscious and

unconscious elements of self, emphasizing the idea that healing comes from within the individual (Bonny, 1998; Grocke & Moe, 2015). The psychotherapeutic components of GIM, as well as its use in both individual and group-based practice, provide a unique opportunity to better understand the role music, group-based therapy, or dyad-based practice may have on effective treatment and recovery.

Although many current addiction programs focus on addressing physiological, psychosocial, and spiritual elements in treatment and recovery, BMGIM offers the ability to access and explore both our inner and outer lives by utilizing music as a means for change (Bonny, 1998; Bruscia, 2014). Further research on music therapy and BMGIM provides evidence that music can be used to increase spiritual coping, self-efficacy, and craving reduction (Bourdaughs, 2016; Mathis & Han, 2017; Moe, 2012; Silverman, 2019).

As addiction research and current treatment programs rely heavily on group-based models, there remains a gap in research on different perspectives and the efficacy of individual BMGIM treatment in addiction treatment and sustained recovery. Further, group-based therapy's reliance on a group dynamic and social accountability may provide a structure that may not always be accessible or sustaining for life-long recovery and may not activate the holistic needs of an individual. Independent of social paradigms and current understanding of prevalent recovery treatment models, perspectives of BMGIM Fellows in addressing negative self-conscious emotions in clinical practice requires more research. As recovery is defined as a process of self-improvement, BMGIM is appropriately oriented to address not only behavioral abstinence but overall wellbeing. With this in mind, understanding how practitioners address pertinent negative self-conscious emotions such as shame and guilt can benefit our understanding of how we can assist individuals in various stages of addiction recovery.

Foundations of The Bonny Method of Guided Imagery and Music

The Bonny Method of Guided Music and Imagery (BMGIM) was developed by Helen Linquist Bonny in the late 1960's out of the transformational capacity of the *four forces* informing music therapy practice of the time: psychoanalysis, behaviorism, humanistic psychology, and transpersonal psychology (Bonny, 2002). Guided Imagery and Music is a receptive music therapy model that is based on the "belief that we as humans are capable of exploring the depths and heights of our potentialities and that psychological aberrations may be less an illness than a growth potential" (Bonny, 1998, p.12). The underpinnings of GIM—psychodynamic/psychoanalytic/Jungian, humanistic, and transpersonal theory—provide the perspective from which practitioners view their clients and their capacity for change (Bonny, 1998).

BMGIM and its role in Addiction Treatment and Recovery

BMGIM protocols rely on the movement of a client into a relaxed or non-ordinary state of consciousness proceeding with a musical program played for the client (Bonny, 1998; Clark, 2019). The music therapist provides a focus image or intention to set the stage for inner exploration, and assumes the role as a reflector, resonator and observer for affective states or reactions that surface throughout the session (Bonny, 1998). Once the music has finished, there is a post-session reintegration in which the client returns to normal waking consciousness. Both the client and music therapist review and verbally process the imagery experience. Although BMGIM was originally practiced in dyad form (one client and one therapist), early adaptations accommodated group-format BMGIM sessions, specifically due to its practice in psychiatric facilities (Clark, 2019, p.19). Similar to individual work, the experience is highly introspective, focusing primarily on the integration of all aspects of psyche and self.

As addiction is a multi-faceted disease that requires comprehensive approaches to treatment and recovery, BMGIM seems uniquely situated to support all paradigms of recovery. Heiderscheit (2017) examined the role of individual BMGIM on interpersonal skills, sense of self-coherence, and salivary immunoglobin A for individuals undergoing inpatient treatment for substance abuse. Although the study was limited by a small sample size, BMGIM supported awareness of maladaptive interpersonal skills, and positive changes in adaptive personal skills and overall sense of coherence (Heiderscheit, 2017). Similarly, Moe (2012) examined the impacts of group BMGIM therapy on individuals undergoing inpatient treatment for substance use disorder. He noted that participants reported increases in their sense of coherence, awareness of maladaptive behaviors, and sense of calm. Further examples of music therapy for individuals in treatment and recovery show the importance of mindfulness, self-awareness, and adaptive responses to coping and inner strength (Miller, 2017; Moe, 2015). Murphy and Ziedonis (2016) investigated group GIM within an addiction treatment program, finding that GIM offered improvement to depression, sense of coherence, and motivation amongst individuals in recovery. As addiction treatment's emphasis on recovery-oriented behavior suggests the importance of re-establishing control over oneself, BMGIM provides opportunities to develop and maintain a sense of coherence, foster adaptive interpersonal skills, increase self-awareness, and provide tools for mindfulness and self-coping. Despite limited studies involving BMGIM and addiction, there is a dearth of research on the ways in which negative self-conscious emotions have been addressed in the recovery process.

The Bonny Method of Guided Imagery and Music as a holistic therapy to address addiction has also been shown to address several mental health disorders, including anxiety, depression and PTSD. As co-occurring disorders are prevalent amongst individuals with SUD,

BMGIM may be a suitable option to address comorbidities or co-occurring disorders effectively. Maack (2012) indicated a significant reduction in dissociative thoughts and tendencies, increased sense of coherence, and positive interpersonal responses amongst individuals with complex PTSD diagnoses who received multiple BMGIM sessions. Similarly, Rudstam et al. (2017) noted significant decreases in anxiety, depression, and dissociation when using BMGIM in the treatment of women with PTSD. Additional research suggests that BMGIM is particularly helpful in reducing physiological and psychological symptoms of environmental and work-related stress (Beck et al., 2015; Mehany et al., 2021).

Stage 2 Recovery

In addition to the physiological stabilization and abstinence that characterizes addiction recovery, Borling (2017) emphasizes the importance of "Stage 2 recovery," which addresses deeper psycho-emotional and psycho-spiritual dimensions. This stage moves beyond abstinence, calling for long-term healing through personal insight, emotional reconnection, and value-oriented living. The process often involves facing residual emotional distress—such as shame, fear, regret, and guilt—which are linked to recurrence if unaddressed. Within this framework, the concept of recovery expands into a broader continuum of human development, aligning closely with Maslow's (1971) theory of meta-needs, including autonomy, beauty, justice, and wholeness. When unmet, these needs may give rise to what Maslow termed "meta-pathology"—spiritual disconnection or "soul sickness"—conditions that often underlies addictive behaviors (Borling, 2017).

Stage 2 of recovery directly intersects with the psychospiritual and transpersonal dimensions inherent in the Bonny Method of Guided Imagery and Music (Bonny, 2002; Borling, 2017). BMGIM offers a therapeutic structure that enables clients to explore their inner

landscapes, providing a container to access and integrate these meta-needs and address spiritual dissonance. As Borling (2017) articulates, the therapeutic goal in this stage is not merely sobriety, but an experience of being deeply and authentically alive—an aim uniquely mirrored in the transformative potential of imagery and music. This expands the relevance of BMGIM from its clinical roots into a holistic tool for sustained, Stage 2 recovery.

BMGIM and Negative Emotion Processing

The interplay of negative self-conscious emotions and ubiquitous co-occurring disorders can present internal and/or external maladaptive stimulus responses such as drinking or drug misuse that require a better understanding of how individuals cope with internalized or externalized emotion (Asensio et al., 2020; Snoek et al., 2021; Treeby & Bruno, 2012). More broadly, results of McKinney and Honig's (2017) systematic review indicate that although BMGIM can have psychological and physiological benefits for adults, more research is needed to understand specific outcomes related to other clinical populations. Lee et al. (2016) utilized functional MRI imaging to validate the use of BMGIM to confront and process negative self-conscious emotions. Using functional MRI imaging, researchers were able to observe the activation of particular brain areas associated with negative emotional processing and episodic memory, suggesting BMGIM can help to bring up negative self-conscious emotions to process therapeutically.

Shame and guilt have yet to be researched explicitly in BMGIM, however they play a central role as fundamental negative self-conscious emotions that contribute to both depression and anxiety (Oh et al., 2023; Snoek et al., 2021). The use of BMGIM to address shame and guilt in addiction recovery necessitates a better understanding of how practitioners position treatment to address these emotions. Further research indicates that BMGIM may be effective in

addressing symptomology of addiction by improving motivation, self-efficacy and mood symptoms (Moe, 2012; Murphy & Ziedonis, 2016). Borling (1992) discusses the benefits of BMGIM's transpersonal orientation as a "chain of transformations from an unconscious state to a conscious state" (p.11) that require an individual approach, as prevalent group-based treatment programs may not help an individual fully realize their ability at long-term recovery. BMGIM presents a unique opportunity for addressing underlying negative emotions that otherwise may not entirely be addressed in 12-step or group-based treatment programs.

Individual and Cultural Considerations Addressing Shame and Guilt

Individual perspectives and cultural perceptions of shame and guilt play a fundamental role in how individuals react to these negative self-conscious emotions. Su and Hynie (2022) identified different responses to perceived shame and guilt amongst individuals with different cultural backgrounds, suggesting that, although the feeling of shame and guilt is universal, cultural background plays a role in how individuals react and cope with these negative self-conscious emotions. When addressing negative self-conscious emotions in addiction recovery using BMGIM, cultural differences require understanding and cultural humility in the therapeutic process. Choi and Lee (2014) investigated perceptions of clients undergoing BMGIM therapy for mental health issues, noting that the importance of trust (trust of the music, process, and therapist) played a pivotal role in the positive outcomes of BMGIM work. Yoshihara et al. (2024) identified resonating themes regarding cultural factors when utilizing BMGIM therapy, noting micro- and macro-cultural factors play a large role in utilizing BMGIM effectively. They concluded that various cultural differences, or trans-cultural factors, can effectively be accommodated in BMGIM work (Yoshihara et al., 2024, p.57-58). Implications of these studies support the notion that reflexive approaches to BMGIM —including adaptation to cultural

factors and the reliance on trust within the therapeutic relationship—can promote positive change (Choi & Lee, 2014; Yoshihara, et al., 2024). A person-centered approach to treatment and recovery can also provide a solution to resistance and cognitive dissonance seen in 12-step models that advocate for a higher power (Galanter, 2014). A highly individualized therapy program offers an opportunity for broader spiritual flexibility that could complement an individual's sense of identity and culture, addressing components of intersectionality in addiction recovery. Implications of the research supporting the use of BMGIM to engage clients through cultural and trans-cultural factors bolster the notion that individual GIM therapy may be able to provide a deep level of support for clients in addiction treatment and recovery.

Implications of Guided Imagery in Treatment of Negative Self-Conscious Emotions

The Bonny Method of Guided Imagery and Music offers a promising avenue for addressing substance use disorder and co-occurring mental health disorders when addressing shame and guilt, however, there has been no research on how BMGIM Fellows address these negative self-conscious emotions in dyadic work. While group-based recovery programs and group music therapy have been researched for addiction treatment, there is a notable gap in research regarding the potential of individual BMGIM , particularly regarding the role of internalized emotions and the role shame and guilt play in precipitating depression and anxiety. Despite its potential, there is not any research on the efficacy of individual BMGIM to mitigate the feelings of shame and guilt in the recovery process. This highlights the need for further exploration of addressing these emotions in addiction treatment and sustained recovery.

Purpose and Research Question

Current research indicates that BMGIM, whether in group or individual settings, has positive effects on various aspects of recovery, including increasing self-awareness, enhancing

interpersonal skills, and fostering a sense of coherence (e.g. Grocke & Moe, 2015, Murphy & Ziedonis, 2016). Despite BMGIM's researched efficacy, addiction and mental health disorders remain a serious societal concern. The ubiquity of social support programs like Alcoholics Anonymous and Narcotics Anonymous, as well as inpatient and outpatient treatment programs, offer opportunities for recovery. Nevertheless, increases in alcohol and drug use, overdose deaths, and mental illness remain pervasive. Individual BMGIM therapy holds the potential to address the holistic needs of individuals in addiction treatment and recovery. By providing tailored support and focusing on inner-resourcing tools, individual BMGIM therapy can empower individuals to navigate their journey toward recovery more effectively. Moreover, its person-centered and holistic approach makes it well-suited for addressing the complex interplay of shame and guilt in the context of addiction and co-occurring mental health disorders.

Therefore, the purpose of this study is to develop a better understanding of the perspectives of BMGIM Fellows in addressing negative self-conscious emotions such as shame and guilt within BMGIM experiences. By better understanding how BMGIM Fellows address shame and guilt, the profession can be better equipped to provide effective, person-centric, and deeply impactful treatment and recovery tools to individuals in need. The research questions are:

1) How do BMGIM Fellows perceive and address negative self-conscious emotions, such as shame and guilt, within the context of Bonny Method of Guided Imagery and Music (BMGIM) experiences?
2) What implications do their approaches have for therapeutic practices in addiction recovery?

Chapter 3

Method

Research Design

For this study, a thematic analysis was utilized to examine how Fellows of the Bonny Method of Guided Imagery and Music (BMGIM) address shame and guilt when working with individuals in addiction recovery. This qualitative approach, guided by qualitative thematic analysis (Braun & Clarke, 2006), enabled the identification of emerging themes, concepts, and theories through inductive reasoning and systematic coding (Daveson, 2017; Hiller, 2016).

Institutional Oversight and Ethical Review

Institutional oversight and ethical review were conducted by the Human Research Ethics Board (HREB) at SUNY New Paltz. The study was determined to be exempt from further review prior to data collection (see Appendix A). Participants were informed of their right to withdraw from the study at any point without penalty. Confidentiality was maintained through the use of pseudonyms and the removal of identifying information from transcripts. All data were stored in password-protected files (OneDrive) accessible only to the researcher. Identifiable materials were destroyed or deleted within one week of transcription after de-identification.

Reflexivity

As in qualitative research broadly, the researcher's epistemological background shaped the inquiry. An epistemological assumption was that the researcher and participants were engaged in a collaborative relationship, with data quality influenced by the researcher's skills in facilitating the interview. The researcher's training in music therapy and familiarity with BMGIM informed the development of the interview prompts and the probing of participant responses. A reflexive journal was maintained to document biases and evolving insights

throughout the research process. This practice helped ensure openness and attentiveness to emergent themes while minimizing undue influence on the analysis.

Participants

Participants were recruited from the active membership of the Association for Music and Imagery (AMI) who met the following inclusion criteria:

- 18 years of age or older and able to give consent
- Work in the United States
- Fellow of AMI for at least two years
- Minimum of two years' experience facilitating BMGIM with individuals who have a history of or are in recovery from substance use disorder
- Hold the MT-BC credential with at least five years of experience as a music therapist
- Read and speak English

Interview Guide

A semi-structured interview was used to explore how BMGIM Fellows address shame and guilt in their clinical work with individuals in addiction recovery. The open-ended question guide (Appendix B) provided a general framework for the interviews, with probes and clarifications used to elicit further detail. Questions addressed participants' approaches, strategies, and reflections on using BMGIM in this context.

Procedure

Prospective participants received email invitations describing the study and requesting participation in a one-time interview. Those who expressed interest were sent an informed consent statement for review. Upon scheduling, interviews were conducted via a secure video conferencing platform (Webex). Each session began with a brief eligibility screening, review of

the study's purpose, and the opportunity to ask questions. Verbal consent was obtained before beginning the interview.

Interviews lasted approximately 40 minutes and explored participants' use of BMGIM to address shame and guilt in work with individuals who have a history of substance use disorder. Sessions were audio–video recorded with permission and transcribed via Webex. Demographic information was collected and verified using an anonymized Qualtrics survey.

Data Analysis

Interview transcripts were analyzed using thematic analysis (Braun & Clarke, 2006). A multi-phase process was employed in which initial codes were generated to capture concepts relevant to how BMGIM Fellows address shame and guilt. Codes were reviewed, refined, and organized into potential themes. Reflexive journaling documented the researcher's insights and analytic decisions throughout, supporting the development of a synthesized thematic structure.

Trustworthiness

Several strategies were used to enhance trustworthiness:

- Data triangulation: Interview data and reflexive journal entries were used to corroborate findings.
- Reflexivity: Ongoing reflection helped ensure that researcher biases and assumptions did not unduly influence the analysis.
- Peer review: Excerpts of transcripts were reviewed by the thesis advisor, who independently noted themes and provided feedback.

Chapter 4

Results

The purpose of this study was to explore how Fellows of the Bonny Method of Guided Imagery and Music (BMGIM) address the experiences of shame and guilt within individual sessions for individuals in addiction recovery. To achieve this aim, qualitative interviews were conducted with two BMGIM Fellows (Participants 1 and 2). A thematic analysis was performed independently for each interview transcript to identify and organize significant patterns and themes that emerged from the participants' experiences and professional insights.

Through detailed coding procedures and comparative analysis of both interviews, six major themes consistently emerged across the narratives provided by each participant: (1) GIM as a Container and Catalyst for Emotional Processing, (2) Music Program Selection and Emotional Tone, (3) Therapist Presence, Strategy, and Contracting, (4) Integration of 12-Step Ideology, (5) Spiritual and Transpersonal Dimensions, and (6) Group vs. Individual Approaches. These themes collectively provide a comprehensive view of the therapeutic dynamics and clinical considerations central to BMGIM's application in addiction recovery contexts, especially in addressing complex emotional experiences such as shame and guilt. Participant's thematic analysis tables and emergent themes can be found in Appendix C.

Theme 1: GIM as a Container and Catalyst for Emotional Processing

BMGIM was strongly endorsed by both participants for its dual role as a therapeutic container and an active catalyst in managing negative self-conscious emotions such as shame and guilt. Both emphasized GIM's structured yet expressive environment, supporting clients in safely encountering deep-seated emotional content. Participant 1 stated, "GIM itself really begins to honor the emotional part—gives a container within which the clients can explore in a safe way,

move into and through, and that gets stuck." Similarly, Participant 2 highlighted the importance of emotional safety: "I create a space of safety and containment, both physically and emotionally... the music allows for a slow unfolding, and with the right container, those images begin to shift…First, I create a space of safety and containment, both physically and emotionally. I start with…. pre-talk and listen carefully for cues of shame language—statements like 'I was disgusting' or 'I can't forgive myself.'"

The synthesis of containment and catalyzation suggests a balance between safety and challenge, essential for therapeutic growth and recovery. Moreover, the capacity to safely confront difficult emotions may provide essential groundwork for addressing underlying psychological issues driving addictive behaviors, potentially improving long-term recovery outcomes.

Theme 2: Music Program Selection and Emotional Tone

Both participants elaborated on selecting specific music programs tailored to clients' emotional states and therapeutic objectives. Participant 1 emphasized the importance of energetic tracking: "I always have a parallel assessment of what is the energy or intensity in the room... that's gonna influence my music choice…"If there's chaotic energy in my client, I'm going to go with something like Paradox or mostly Bach… more about anger and moving through."

Participant 2 emphasized this alignment: "During the session, I may use music with slow-changing harmonic density, tonality, and tempos—music that invites introspection and doesn't overwhelm."

When addressing shame and guilt within the therapeutic process, carefully attuning to clients' needs was conveyed as fundamental to providing a necessary therapeutic experience. Participants noted that careful matching of music to emotional states not only supports

immediate emotional processing but also potentially enhances longer-term emotional awareness and regulation, essential components for recovery stability. These insights underscore the critical role of nuanced music selection in effectively resonating with clients' emotional landscapes, enhancing emotional awareness and regulation, crucial components in addiction recovery.

Theme 3: Therapist Presence, Strategy, and Contracting (A Therapeutic Alliance)

The therapeutic alliance emerged prominently from both participants, highlighting trust, emotional safety, and mutual understanding. Participant 1 described their role in actively engaging clients: “The clinician has the responsibility to help the client connect... Johnny, you're feeling that right now, aren't you?” Participant one further expressed the need for presence and therapeutic contracting: “Do we have a verbal contract that if you feel uncomfortable during the session, you verbalize that and you’re giving me permission to hold you there?” Participant 2 emphasized therapist presence: “I see myself as a witness and guide more than a rescuer...I listen carefully for cues of shame language—statements like 'I was disgusting,' or 'I can't forgive myself'…The music acts as both a catalyst and a container. And the guide’s role? To hold the process gently, not to fix it.”

Both participants underscore how an attuned, responsive therapeutic presence profoundly enhances emotional safety, facilitating deeper healing in Stage 2 recovery. Shame and guilt exemplifies, through the umbrella of negative self-conscious emotions, the concepts associated with psycho-spiritual pain. The participants emphasized strategies such as pre-session verbal contracts and invitational language, reinforcing the therapist's role as both emotional anchor and guide. The capacity of the BMGIM therapist to sustain presence amidst vulnerability becomes critical in helping clients reconnect with values and meaning, foundational to long-term recovery.

Theme 4: Integration of 12-Step Ideology

Integration of BMGIM with 12-step recovery principles was highlighted as beneficial by both participants. Participant 1 explicitly connected BMGIM's psychodynamic components with 12-step concepts: “I'm a fan of bringing the gifts of GIM together with the structure of the 12 steps. The 12 steps by themselves are really powerful, but when you bring GIM in, then people begin to experience it on their own level.” Participant 1 elaborated, “When I hear somebody speak about things like shame and guilt… I can help in a delicate way bring them back to, ‘Well, these sound like shortcomings… let’s view it through the lens of AA… and take it into the GIM session.’”

Participant 2’s comments also supported this integration, expressing a desire for increased collaboration: “I’d love to see more collaboration between GIM practitioners and 12-step programs, especially around the 4th and 9th steps—where shame and regret often surface.”

The participant’s perspectives on integration of other recovery models reflects a broad and informed approach, acknowledging and building upon successes and ubiquity of 12-step ideology (as demonstrated in Alcoholics Anonymous). In utilizing elements of 12-step ideology in processing stages of BMGIM, the participants highlighted benefits in utilizing traditional recovery paradigms to address shame and guilt in addiction recovery. Aligning BMGIM with 12-step practices could potentiate more meaningful engagement, encouraging deeper psychological insight and sustained behavioral change.

Theme 5: Spiritual and Transpersonal Dimensions

Spiritual and transpersonal dimensions emerged significantly as therapeutic motivators. Participant 1 emphasized "Often it's a push for the transpersonal that got them into the addictive lifestyle in the first place. Participant 2 similarly articulated BMGIM’s spiritual potential:

"Ultimately, I believe BMGIM can help people say, 'I am not just what I've done. I am more.' That's the heart of recovery—and the heart of this work."

The emerging spiritual and transpersonal theme emphasizes BMGIM's unique capability to address existential dimensions of recovery, highlighting a critical, though sometimes overlooked, component of comprehensive addiction treatment. Engaging clients on a spiritual and existential level may foster deeper meaning-making, significantly contributing to sustained recovery and personal growth. Both participants noted an inner narrative shift away from pathology and toward wholeness. BMGIM's core use of metaphor and archetypal imagery allows clients to express internal experiences that may be otherwise inaccessible or unnamed.

Theme 6: Group vs. Individual Approaches

Participant 1 discussed advantages of both group and individual contexts, noting individualized depth in BMGIM: "The same thing could be whittled down to a GIM session... allow the music to help you be there." Participant 2 predominantly focused on individual therapeutic work, emphasizing tailored emotional processing: "Much of my BMGIM work with this population happens individually...it's about witnessing and making space for something new to emerge."

The participants discussed the comparative advantages of individual and group therapeutic contexts. The participant acknowledged group therapy's benefits for collective validation yet emphasized individual BMGIM's potential for deeper, personalized emotional work. Individual approaches in BMGIM may offer critical therapeutic advantages by directly addressing specific emotional themes such as shame and guilt, suggesting a powerful alternative or complement to more conventional group therapies.

Summary

The participants underscore BMGIM's therapeutic depth, particularly in addressing negative self-conscious emotions such as shame and guilt in addiction recovery. The six themes illustrate the complex, multifaceted nature of BMGIM practice, emphasizing its unique integration of emotional containment, strategic music selection, therapeutic alliance, 12-step alignment, spiritual exploration, and personalized therapeutic contexts. BMGIM, as a holistic framework, facilitates resilience and integrates mind, body, and spirit, offering profound therapeutic potential in addiction recovery.

Chapter 5

Discussion

The aim of this study was to explore how Fellows of the Bonny Method of Guided Imagery and Music (BMGIM) address experiences of shame and guilt within individual sessions for individuals in addiction recovery. The findings presented highlight several key themes related to the therapeutic application of BMGIM, specifically emphasizing how therapists manage and therapeutically transform these complex emotional states. Each theme is discussed with reference to participants narratives, theoretical frameworks, and clinical implications, aligning with existing literature. In synthesizing extemporaneous research with perspectives and clinical practices articulated by the study's participants, the following discussion expands upon each identified theme, providing deeper insights into the clinical implications and significance of BMGIM in addressing shame and guilt, thus contributing to enhanced recovery outcomes.

GIM as a Containing and Catalytic Space

One of the most resonant themes emerging from the participants' interviews was the centrality of BMGIM as both a containing space and an active catalyst for emotional processing. This duality mirrors what Bonny (1998) described as the "inner journey of healing"—a structured improvisational space in which the client safely encounters vulnerability and latent emotional material. Shame and guilt, which often dwell beneath the surface of addiction narratives, require an invitational, rather than confrontational, therapeutic presence. The participant's description of the GIM session as a "container" reinforced this critical function—one in which emotional content is not suppressed or prematurely interpreted, but instead allowed to emerge organically through music-facilitated imagery.

Literature repeatedly affirms that containment is a core therapeutic requirement when working with shame (Dearing et al., 2005; Treeby & Bruno, 2012). Unlike guilt, which can catalyze reparative behavior, shame can elicit collapse, withdrawal, and recurrence—making it a clinical priority (Tangney et al., 2011). Within BMGIM, this containment is not passive. The music is an active field of resonance, wherein the music itself becomes a co-therapist, guiding emotional experiences. It is able to achieve opportunities for integration for individuals who have lacked attuned emotional witnesses throughout their lives, understood through the participant's emphasis on the capacity of the facilitator to encourage a client to "stay with" overwhelming imagery and/or affective states. This approach is consistent with literature describing the safety and structure provided by GIM, facilitating emotional exploration without overwhelming the client (Bonny, 2002; Grocke & Moe, 2015). Bonny (1998) further articulates how emotional containment is essential for building internal coherence and emotional resilience.

As music can be both grounding (containing) and moving (catalytic), this duality urges clinicians to reconsider the pacing and framing of emotional processing within addiction recovery. One must be attuned to an endogenous (change from within), therapeutic approach. However, emotional safety must precede catharsis or change. The BMGIM session, by virtue of its structure and emphasis on attunement, offers an ideal format for exploring shame and guilt, while at the same time reducing the risk for re-traumatization.

Music Program Selection and Emotional Space

Closely linked to containment is the therapist's sensitivity to the emotional tone of the session. Participant 1 described "energetic tracking" as a guiding clinical strategy—assessing and responding to a client's inner state in real-time through program selection. Participant 2 also discussed the attunement to the needs of the client. This notion reflects a sophisticated

integration of clinical intuition with musical knowledge and supports Bruscia's (2014) assertion that clinical musicianship is central to the efficacy of music therapy. Programs like *Melancholy*, *Secret Garden*, and *Paradox* were named for their emotive potency in accessing states of sorrow, abandonment, or unresolved rage—states often beneath shame and guilt. This practice aligns with neuroscientific research that shows how music evokes powerful autobiographical memories and emotional activation (Menon & Levitin, 2005; Salimpoor & Zatorre, 2013). In addiction treatment, where emotional numbing or avoidance are common, this emotional resonance becomes not just therapeutic—it becomes essential.

The literature also suggests that shame, in particular, may be dissociated from conscious awareness (Snoek et al., 2021). Through symbolic or imaginal resonance, clients may first "hear" their shame before they can name it. The role of music, then, becomes a subtle yet evocative conduit for reintegrating fragmented parts of self.

Clinically, both participant's discussions about attunement to the music and emotional space highlights the importance of therapist fluency in both the affective dimensions of music and the emotional vocabulary of addiction. Matching program to client is not merely technical—it is archetypal, poetic, and highly relational. How the music manifests as a co-therapist directly affects the depth with which practitioners can address shame and guilt in the therapy room. It speaks to not only to the empathetic concepts innate with psychodynamic and humanistic positions within the therapy process but also lends autonomy and partnership to the change elements within a therapeutic process.

Therapist Presence, Strategy, and Contracting

Throughout the interview, Participant 2 emphasized the therapist's role not as an expert or fixer, but as a resonant presence—someone who "holds space," listens deeply, and contracts collaboratively for emotional safety. Participant 2 noted:

> *I see myself as a witness and guide more than a rescuer...I listen carefully for cues of shame language—statements like 'I was disgusting,' or 'I can't forgive myself'...The music acts as both a catalyst and a container. And the guide's role? To hold the process gently, not to fix it.*

The use of pre-session verbal contracts reflects best practices in working with clients who carry unresolved trauma or emotional volatility. These contracts become rituals of mutual accountability, as stated by Participant 1: "I will not push you, and you will allow yourself to stay with discomfort as it arises." This dynamic is essential when working with clients steeped in shame—a state where the mere act of being seen can feel threatening.

The therapeutic relationship also becomes a container in its own right. As noted by Heiderscheit (2017), the therapist's ability to regulate their own affect, provide grounded empathy, and trust the client's process significantly impacts therapeutic outcomes. This mirrors what Borling (2017) identifies in Stage 2 recovery: the need for a mature therapeutic presence that does not rescue but witnesses, does not direct, but invites. In practice, this means clinicians must continually deepen their own emotional capacity and clinical intuition—not only to "hear" shame, but to remain with it when it surfaces. The therapist's ability to hold this space becomes integral to addressing shame and guilt, and using this space to confront and work through deeply seeded emotions can be remarkably beneficial in the BMGIM process.

Integration of 12-Step Ideology

The participants integration of 12-step philosophy into BMGIM practice reflected an elegant merging of communal, spiritual, and transpersonal recovery paths. In particular, the participant interviews highlighted how GIM sessions can complement the moral inventory, amends-making, and spiritual awakening emphasized in steps 4–11, particularly step four and step nine.

This alignment is not incidental. The 12-step model centers recovery around personal responsibility, restitution, and connection with a Higher Power. BMGIM provides experiential scaffolding for this journey. Imagery experiences can become living metaphors for forgiveness, transformation, or surrender—thus bridging insight with affective embodiment. Guilt, when differentiated from shame, can be a powerful motivator for restitution and behavioral change (Tangney et al., 2011). The use of BMGIM to access guilt through emotionally evocative programs may thus serve a reparative function—helping clients locate personal responsibility without collapsing into shame.

Moreover, the participants' insights that many clients carry ambivalence about spirituality reinforces the need for flexible, inclusive, and experiential frameworks. BMGIM does not prescribe a belief system; it offers a direct encounter with mystery, meaning, and the abstract nature of a numinous position. In this way, it mirrors the 12-step emphasis on spiritual awakening while honoring each client's unique path. For clinicians, this suggests that integrating 12-step language into BMGIM may enhance client resonance and retention, especially for those already embedded in these communities. However, it must be done with care—ensuring that spiritual language invites rather than alienates.

Spiritual and Transpersonal Dimensions

If shame and guilt are the "little firecrackers" for relapse, as the participant suggested, then spiritual disconnection may be the powder keg. Clients often enter addiction treatment having severed ties with their own meaning-making systems—whether spiritual, existential, or relational. BMGIM's transpersonal orientation offers a re-entry point into those deeper layers of self. Participant 1 noted that many clients are 'looking for something larger', saying "I think often it's a push for the transpersonal that got them into the addictive lifestyle in the 1st place, and that's a broad statement, and it could be argued, but you often hear people in recovery say, Oh my God," and that transpersonal imagery often meets that longing. In addressing recovery, Participant 1 discusses that some clients express the "...whole recovery thing is what I was looking for the whole time." Whether a client encounters a guiding light, a wise figure, or a rebirth metaphor, the imaginal field of BMGIM offers a path back to dignity, coherence, and inner wholeness, aligning with a process that allows shame and guilt to be integrated and processed.

Borling's (2017) framework of Stage 2 recovery as a psycho-spiritual reawakening is deeply relevant here. Shame fractures the self. Spiritual experience reassembles it. Reflected in Participant 2's interview, when a client visualizes a burned landscape regrowing, or a lost object being returned, they are not merely "imagining"—they are rehearsing healing (Borling, 2017). This was reflected in Participant 2's interview, in which the participant stated imagery in BMGIM sessions carry a "...belief that the psyche knows how to heal if given the right conditions." In this way, BMGIM becomes a sacred ritual of reconnection to self, one that has the potential to restore not only affective balance but existential alignment. For music therapists,

this invites a deeper trust in the symbolic and archetypal. It also challenges us to remain present to mystery—to hold space for what cannot be measured but can transform.

Implications for Bonny Method of Guided Imagery and Music in Addictions Treatment

The results of this study suggest that individual Bonny Method of Guided Imagery and Music (BMGIM) sessions hold significant therapeutic potential for addressing the underlying emotional content that often drives or perpetuates substance use—particularly negative self-conscious emotions such as shame and guilt. For music therapists, who are also Fellows of the Association of Music and Imagery, working in addiction recovery contexts, the themes outlined in this study offer a practical and theoretical map for deepening therapeutic impact. Shame and guilt are not surface emotions; they are internalized beliefs about the self, often linked to early relational wounds, moral injury, or trauma. They carry existential weight and are frequently left untreated in group-centered recovery approaches where vulnerability is constrained by time, trust, or setting. The BMGIM process allows these emotions to be accessed, felt, and transformed within a relational container.

The clinical containment created through the music, imagery, and presence of the therapist provides clients with an opportunity to approach shame and guilt without fear of immediate exposure or judgment. Shame and guilt—like addiction—thrive in isolation and secrecy. The GIM process can gently challenge that isolation by offering a space where the client's imagery can externalize the internal and invite emotional engagement. This is not about confronting clients with their guilt or shame; it is about accompanying them into those emotional landscapes with compassion, allowing for integration and coherence to emerge organically. In practice, music therapists must develop the capacity to hold this emotional intensity while

avoiding interpretive overreach—letting the music and imagery lead rather than rushing to insight or resolution.

The music selection, akin to the BMGIM concept of music as a co-therapist, is fundamental for evoking and supporting these emotional states with intentionality. Participant 1's concept of "energetic tracking" points to the need for therapists to deeply attune to their client's affective presence or energy, and then choose music that can either meet or shift the emotional field. Shame and guilt often carry embodied tones—tightness, heaviness, disconnection—that can be mirrored and then softened through programs like *Melancholy* or *Secret Garden*. Music becomes a companion to the client's emotional experience, providing a sound-based path for feeling and metabolizing difficult emotions. For BMGIM Fellows, the implication is clear: program selection should not be aesthetic or abstract—it should be affectively precise and responsive.

As the music selection and program itself is essential, so too is the therapeutic relationship. The ability to remain emotionally attuned, to verbally contract for safety, and to gently name affective shifts ("stay with that") becomes a form of reparative relational practice. Clients who carry shame are often hypersensitive to judgment; thus, the therapist's non-anxious and non-judgmental presence is not ancillary—it is central. In BMGIM, the therapist serves as the guide, the resonator, and the witness. The implications within this emphasize the therapist to prioritize clinical presence, embodied awareness, and trauma-informed verbal practice as essential competencies.

Integration of 12-Step concepts into the BMGIM process begins to marry transpersonal and spiritual components often felt in both modalities. Many clients in recovery already resonate with the language and structure of 12-step models. Integrating these principles—particularly

around confession, forgiveness, and connection with a higher power—into the BMGIM process allows clients to deepen their recovery using a familiar and accepted scaffold. Importantly, BMGIM provides a space where shame-inducing beliefs can be re-examined in the imaginal realm, often resulting in reframing or symbolic healing. For music therapists, this integration invites a culturally responsive stance—using familiar recovery language not as dogma, but as metaphor, bridge, and entry point.

Limitations

As this study is preliminary, exploratory, and deeply personal, it is not without its limitations. The most prominent limitation is the participant pool, in which two participants were interviewed. This narrow participant pool restricts the breadth of the findings. This limitation points to a possible concern within the field itself—the topic of shame and guilt in individual BMGIM sessions, particularly related to addiction recovery, may be addressed within different, broader contexts, or simply not adequately addressed within BMGIM work.

Another key limitation lies in the scope and timeline of the project. The research was conducted within a constrained academic timeframe, limiting both the duration and depth of participant recruitment and data collection. A more extended study period may have allowed for a broader recruitment strategy, potentially resulting in a richer and more diverse participant sample. Furthermore, the specificity of the research question—focusing exclusively on how shame and guilt are addressed in individual BMGIM with clients in addiction recovery—created a highly niche area of inquiry. While this specificity allows for depth, it also limits the study's applicability to other therapeutic contexts or broader populations. Further, the specificity of the emotions shame and guilt may have provided a narrow focus of the study, further reducing the participant pool.

As this study was a qualitative inquiry rooted in semi-structured interviewing, the study's findings are inherently interpretive and influenced by the researcher's perspective. Reflexivity was employed throughout to mitigate potential bias, but the dual role of the researcher as both a deeply invested individual and the primary analyst introduces the possibility of subjective framing. Given the researcher's personal background and lived experience growing up in a family system affected by addiction, this positionality may have subtly shaped the thematic lens through which the data was analyzed. While this connection to the material offered a sense of purpose, personal understanding, personal impact, and empathy, it also underscores the necessity for additional research to be conducted.

Lastly, limitations must be acknowledged in the form of the emergent nature of BMGIM as a treatment modality for addiction. Despite its inception roughly 50 years ago—somewhat based on addiction and adjacent mental health concerns—we have a dearth of research on the subject. While BMGIM is well-established in music therapy circles, its use with individuals addressing addiction—especially with an emphasis on negative self-conscious emotions—remains woefully under-researched. This lack of an established research base, while providing justification for this study, also limits the ability to draw strong comparative conclusions or ground findings within a broader empirical context.

Future Research

Given the limitations outlined above, several directions for future research emerge, each aimed at expanding the understanding of BMGIM's role in addressing shame and guilt in addiction recovery. First, expanding the participant pool is paramount. Future studies should aim to include a broader and more diverse group of BMGIM Fellows, with attention to variations in cultural background, years of experience, and therapeutic settings. This would allow for a richer

set of perspectives and potentially highlight divergent strategies for working with shame and guilt. The case currently is the expansion of individuals that are capable, qualified, and passionate about using BMGIM to address particularly addiction, but more specifically negative self-conscious emotions associated with negative social behavior.

A promising direction is to explore the experiences of clients themselves. While this study focused exclusively on practitioners' perspectives, an important complement would be research into how clients perceive and experience shame and guilt in BMGIM sessions. Such work could highlight the felt sense of therapeutic change, offering important validation—or challenge—to clinician perspectives.

Further exploration of the intersections between BMGIM and 12-step ideology also warrants attention. While the present study highlighted points of philosophical alignment, future work could investigate how BMGIM complements or challenges traditional recovery paradigms in practice. Does the transpersonal and individualized nature of BMGIM resonate with or disrupt the collectivist ethos of 12-step work? Are there specific strategies BMGIM therapists use to bridge these models for clients actively engaged in 12-step recovery?

Finally, as BMGIM hopefully continues to evolve and gain validation within this population, future studies might examine how emerging developments—such as culturally responsive adaptations or the incorporation of trauma-informed practice—shape the therapeutic process when addressing shame and guilt. These directions will help ensure that the therapeutic promise of BMGIM continues to grow in its relevance, accessibility, and effectiveness across diverse populations.

Conclusion

This study explored the nuanced and deeply personal ways in which shame and guilt—two of the most prominent negative self-conscious emotions—are encountered, contained, and transformed through the Bonny Method of Guided Imagery and Music (BMGIM) in the context of addiction recovery. By analyzing the clinical perspectives of two BMGIM Fellows, this research contributes to a growing, yet still sparse, body of literature at the intersection of music psychotherapy, emotional and spiritual healing, and substance use disorder treatment. Through the lens of this case study, it became clear that BMGIM offers a unique psychotherapeutic framework that enables clients to engage in safe, contained, and imaginal work around shame and guilt—emotions often linked with relapse, isolation, and spiritual disconnection.

The findings illustrate the importance of BMGIM as both a container and a catalyst. In this process, clients are not only protected in their vulnerability but also invited into a space where emotional truths can emerge organically through music and imagery. By utilizing tailored music programs and energetic tracking, therapists are able to match the emotional tone of the session to the client's inner world. This personalization allows shame to be met with compassion, and guilt to be transformed into adaptive motivation for growth, healing, and reparative action. The intentional use of pre-session contracting and verbal agreements adds another layer of emotional safety, reinforcing the therapeutic alliance as a key foundation for confronting difficult inner material.

Furthermore, the spiritual and transpersonal dimensions inherent in BMGIM were described as not merely adjunctive, but central to addressing shame and guilt. The imaginal space allows for symbolic experiences—such as encounters with forgiving figures, experiences of rebirth, or journeys through light and shadow—that reconnect clients with a sense of inner

coherence and existential meaning. These experiences mirror the core tasks of what Borling (2017) refers to as Stage 2 recovery, where the work is not only about sobriety, but about reclaiming the self from fragmentation. Shame, in this framework, represents a spiritual wound, and BMGIM becomes a method of soul retrieval.

Importantly, the participants' integration of 12-step ideology into BMGIM practice highlights the compatibility and potential synergy of these approaches. Themes of self-examination, amends, and spiritual awakening within the 12-step model find fertile ground in the experiential, imaginal work of BMGIM. As the participants noted, without directly addressing shame and guilt, recovery efforts may be short-lived. Thus, BMGIM stands out as a powerful and needed modality in a field often dominated by group-based, behaviorally focused approaches.

Ultimately, this research preliminary affirms the potential value of BMGIM as an individualized, emotionally attuned, and spiritually integrative treatment method that uniquely addresses shame and guilt in addiction recovery. As the profession of music therapy continues to evolve, studies such as this highlight the imperative to center emotional depth and personhood within our clinical work—particularly for those navigating the complex terrain of recovery.

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Appendix A
HREB Study Exemption Form

New Paltz
STATE UNIVERSITY OF NEW YORK
Human Research Ethics Board
Sponsored Programs & Research Compliance
1 Hawk Drive, New Paltz, NY 12561
Faculty Office Building, Office N2

STUDY EXEMPTION

November 21, 2024

Jared Weinstock
8458748021
weinstoj1@newpaltz.edu

Dear Jared Weinstock:

On 11/20/2024, the Human Research Ethics Board (HREB) approved the following submission:

Type of Review:	Initial Study
Title of Study:	Addressing Shame and Guilt in individual BMGIM Sessions: Perceptions of BMGIM Fellows Working with Individuals in Addiction Recovery
Investigator:	Jared Weinstock
IRB ID:	STUDY00005415
Funding:	None
Grant ID:	None
Documents Reviewed:	• 2024-25 NP HREB Proposal-Jared Weinstock, Category: IRB Protocol; • Informed Consent Form-Jared Weinstock, Category: Consent Form; • Recruitment Email, Category: Recruitment Materials;
Exemption	104 (d)(2)(ii) Tests, surveys, interviews, or observation (low risk)

The Human Research Ethics Board (HREB) has considered the submission for the project referenced above and determined it to be Exempt under one of the categories specifically waived under Section 104 (d) (1-6) or 101(i) of the Code of Federal Regulations (45 CFR 46).

IRB exemption is given with the understanding that the most recently approved procedures will be followed and the most recently approved consenting documents will be used, if applicable. If modifications are needed, those changes may not be initiated

until such modifications have been submitted to the HREB for review and have been granted approval.

As principal investigator for this study involving human participants, you have institutional responsibilities as follows:

1. Ensuring that no subjects are enrolled prior to the study's approval date.

2. Ensuring that the HREB is notified via PACS IRB module of:
- All Reportable Information in accordance with the "Reportable New Information" Smart Form.
- Project closure/completion by the "Continuing Review/Modification/Study Closure" Smart Form in PACS.

3. Ensuring that the protocol is followed as approved by the HREB unless minor changes that do not impact the exempt determination are made.

4. Ensuring that the study is conducted in compliance with all HREB decisions, conditions, and requirements.

5. Bearing responsibility for all actions of the staff and sub-investigators with regard to the protocol.

6. Bearing responsibility for securing any other required approvals before research begins.

If you have any questions, please contact the Human Research Ethics Board (HREB) at either (845) 257-3282 or by email:

HREB Chair: hrebchair@newpaltz.edu
HREB Coordinator: hrebcoordinator@newpaltz.edu

Appendix B
Interview Questionnaire

1. What specific training, certifications, or professional experiences have shaped your background in BMGIM? Could you also describe any areas of expertise or populations you've worked with extensively?
2. What is your experience working with individuals in addiction and recovery?
3. How do you consider addressing shame and guilt in the addiction recovery process?
4. What are specific strategies are used to address shame and guilt in BMGIM sessions? What is the rationale for these experiences?
5. What are your perspectives on the role of music in processing shame and guilt within BMGIM work?
6. Are there any further comments or questions you may have?

Appendix C

Table 1

Participant One Thematic Analysis Table

Category	Key Words/Phrases	Context	Supporting Quotes (Participant 1)
Core Emotions	Shame, guilt, regret, forgiveness, emotional pain	Central barriers driving relapse; forgiveness essential in healing	"Shame and guilt...primary motivators for relapse…until that's addressed, recovery is difficult."
Therapeutic Process	Container, safe context, witnessing, holding, healing, integration	Safe environment for emotional exploration	"GIM itself begins to honor the emotional part... a container within which clients explore safely."
Client Experience	Recovery, relapse, sobriety, stage 2 recovery, transpersonal	Emotional transitions post-initial recovery	"Stage 2 recovery... emotions begin to surface, acknowledged not pushed away."
Techniques & Strategies	Pre-session, post-session, silence, music & imagery, verbal contract	Structured elements for emotional safety	"Pre-session... silence, 'What are you feeling right now?' Verbal contract to stay with discomfort."
Therapist Role	Clinical maturity, facilitate, motivational container	Therapist guides clients deeply and gently	"We say 'stay with that…allow the music to help you be there.'"
Theoretical Frameworks	12-step, psychodynamic, spiritual, transpersonal, AA/NA	Therapeutic alignment with recovery models	"Bringing the gifts of GIM together with the structure of the 12 steps."
Programmatic Choices	Melancholy, Secret Garden, Paradox, Bach	Music selected based on emotional energy	"Melancholy comes to mind…loss, sorrow, abandonment to bonding."

Table 2

Participant Two Thematic Analysis Table

Category	Key Words/Phrases	Context	Supporting Quotes (Participant 2)
Core Emotions	Shame, guilt, regret, self-loathing, identity rupture	Deep feelings of unworthiness; fragmented identity	"Most people...don't start with guilt—they start with shame…'I am fundamentally unlovable.'"
Therapeutic Process	Container, safe space, witnessing, integration, naming	Non-verbal space to process emotional wounds	"Music allowed that truth to rise safely, somatically, without shame shutting it down."
Client Experience	Recovery, identity rupture, stigmatization, transformation	Layered shame tied to identity and stigma	"A cracked mask floating in water... symbolizes stigmatization and the inner split."
Techniques & Strategies	Somatic grounding, metaphor, music selection, journaling	Methods helping clients externalize shame	"I often use journaling or drawing to externalize shame-based material."
Therapist Role	Witness, gentle guide, emotional tracking	Supports emotional exploration, listens for shame	"I see myself as a witness more than a rescuer."
Theoretical Frameworks	Jungian, psychodynamic, transpersonal, trauma-informed, IFS	Integrated approach to deep emotional pain	"Jungian concepts—the shadow, the wounded child, search for wholeness."
Programmatic Choices	Sorrow-Abandonment to Bonding, minor tonality	Music reflecting introspection and emotional depth	"Using music with low harmonic density, minor tonality, slow tempos."

Table 3

Emergent Themes

Themes	GIM as a container and catalyst for emotional processing	Music programming and Emotional Tone	Therapist Presence, Strategy, and Contracting (Therapeutic Alliance)	Integration of 12-step ideology	Spiritual and Transpersonal Dimensions	Group vs. Individual Approaches
Core Emotions	Container to safely hold shame and guilt (P1, P2)	"Music evokes emotions like sorrow, abandonment" (P2)	"Listening carefully for shame cues, inviting deeper exploration" (P2)	"Guilt and shame integrated with 12-step principles of self-forgiveness" (P1)	"Push for transpersonal as motivation for healing" (P1, P2)	"Witnessing emotional pain powerful in groups, individualized in GIM" (P1, P2)
Therapeutic Process	"GIM honors emotional exploration and supports integration" (P1)	"Low harmonic density, minor tonality supports emotional processing" (P2)	"Verbal contracts establish emotional safety" (P1)	"GIM aligns seamlessly with Steps 4, 8, 9" (P1, P2)	"Clients access spiritual dimensions without verbalization" (P1)	"Therapeutic witnessing profound individually and in groups" (P1)
Client Experience	"Clients experience deeper emotional healing after initial sobriety" (P1, P2)	"Music choice tailored to client's emotional state" (P1, P2)	"Therapist presence critical in emotional safety and trust-building" (P1, P2)	"12-step language resonates deeply with clients in recovery" (P1)	"Transpersonal experiences deeply transformative in recovery" (P1, P2)	"Individual sessions provide personal depth, groups provide communal validation" (P1)
Techniques & Strategies	"Grounding, journaling, metaphor used to process shame" (P2)	"Program selection matches client's emotional energy (Melancholy, Secret Garden)" (P1)	"Therapist gently encourages clients to stay present with discomfort" (P1, P2)	"Combining journaling and music experiences with 12-step reflections" (P2)	"Facilitating transpersonal connections through GIM sessions" (P1, P2)	"Strategies adapted for individual emotional states, group witnessing strategies used in groups" (P1)
Therapist Role	"Guide acts as non-directive witness, facilitating deep emotional exploration" (P2)	"Therapist assesses emotional intensity for music choices" (P1, P2)	"Clinical maturity critical for safe emotional exploration" (P1, P2)	"Therapist integrates recovery model concepts into sessions" (P1)	"Guide facilitates safe access to spiritual dimensions" (P1, P2)	"Therapist's role differs in group settings, focusing on shared experience" (P1)
Theoretical Frameworks	"Psychodynamic, Jungian, and trauma-informed frameworks underpin emotional containment" (P2)	"Emotional congruence matched by therapeutic musical frameworks" (P2)	"Therapist presence informed by psychodynamic and trauma-informed theories" (P1, P2)	"12-step philosophy deeply integrated into therapeutic approach" (P1, P2)	"Jungian shadow work and transpersonal theories support spiritual exploration" (P2)	"Therapeutic efficacy viewed through individual psychodynamics and group process theories" (P1)