
Bryan J. Muller, PhD; MT-BC
Fellow, Association for Music and Imagery
Philadelphia, Pennsylvania, USA

For his doctoral dissertation (completed at Temple University), the author surveyed Fellows of the Association for Music and Imagery regarding their use of the various practices that have become associated with Guided Imagery and Music. Modifications to the individual and group forms of GIM that were created by Helen Bonny had been reported in the literature, but their prevalence was unknown. Fellows were asked to rate specific practices in terms of the frequency used in their GIM practice. Demographic data were also gathered. T-tests, ANOVAs, and Spearman correlations were also computed; however, the results of these tests will not be presented here. Further analysis of the prevalence data revealed that practices that were part of Bonny's original design (the Bonny Method) were in frequent use by a majority of GIM Fellows. All of the modified practices were also in use, although less frequently. Factor analyses indicated that Fellows who tended to use Bonny Method practices tended not to use modifications and those who tended to use modifications tended not to use Bonny Method practices.

Keywords: Bonny Method; modifications; GIM Fellows; survey; factor analysis.

More than four decades ago, Helen Bonny conceived of the use of deep listening to predesigned programs of classical music while dialoguing with a trained guide for healing and self-actualization (Bonny & Goldberg, 2002). In her final design, an individual Guided Imagery and Music (GIM) session lasts 1½ to 2 hours and consists of four phases: Prelude (20-30 min.), Induction (10-15 min.), Music Listening/Imaging in an expanded state of consciousness (30-50 min.), and Postlude (20-30 min.). Group sessions can vary in length, structure, use of music, and guiding. Traditionally, GIM was used in private settings with adults, and practiced within a humanistic orientation that emphasizes self-exploration and integration of all aspects of the self (Bonny, 2002).

In the years that followed, GIM spread around the world, and the clinical applications and permutations of the method widened (Bonny & Goldberg, 2002; Bruscia, 2002a, 2002b; Clark, 2002; Grocke, 2002; Lewis, 2002; Summer, 2002). Mostly used in private settings to help individual adults with anxiety, depression, loss, life transitions, and self-actualization, individual and group GIM practices grew to treat persons with a wide variety of illnesses and disorders in psychiatric and medical hospitals, substance abuse programs, hospices, and nursing homes. GIM also became used with children and adolescents. In conjunction with this growth, modifications to Bonny’s individual and group forms of GIM were reported. Three reasons for modifying the Bonny Method were found in the literature: client need, practitioner preference, and setting. Modifications include variations in the length of session and duration of music listening, variations in the selection and use of music, and variations in verbal dialogue and guiding. Modifications to theoretical orientation were also reported. Some referred directly to the use of non-humanistic orientations, while others used GIM in combination with other therapeutic methods and techniques. One caveat here regarding modifications to accommodate client need (e.g., fragile ego, physical frailty, limited attention span, or impaired cognition) is that other authors report using the Bonny Method with clients in similar condition (Meadows 2002).
Parallel to this growth, imagery techniques both with and without music were being developed outside of the GIM community, and often times these were referred to as Guided Imagery (Bruscia 2002). In response to both this and to the modifications, Bonny decided in 1996 to change the name of her method from Guided Imagery and Music to the Bonny Method of Guided Imagery and Music. Despite this, there was a lack of consensus within the GIM community regarding which practices belonged to the Bonny Method, which belonged to GIM, and which belonged to music therapy or other professions (Bruscia 2002). In 2017, this lack of consensus remains.

By December 2009, when the survey data was collected, the prevalence of the various practices used by GIM Fellows was unknown. An anonymous 59 item electronic survey was designed to explore the incidence, nature, and growth of GIM practice both inside and outside of the United States. Those GIM practitioners whose listing in the 2009 Association for Music and Imagery (AMI) Fellow’s Directory included an e-mail address (207 of 210) were invited to participate in the survey.

MAIN CONTRIBUTIONS/SELECTED RESULTS

Demographics, Client Characteristics, and Treatment Delivery

107 GIM fellows responded to the survey, a response rate of 52%. 16% of these respondents were male and 84% were female. Compared to the percentage of males in the 2009 Fellows’ directory (12%), males were slightly overrepresented. More than 50% of the respondents reported being 50 years of age or older; it is unknown whether these data are representative. 9% of respondents reported having more than 20 years in practice, 30% percent reported 11-20 years, another 30% reported 6-10 years, and 32% reported having 0-5 years in practice. These data seem to correspond to the length of time that the GIM method has been in existence and seem to indicate a gradual expansion in the number of GIM fellows in practice. The number of respondents who indicated practicing within the U.S. (54%) and outside the U.S. (46%) closely matches that of the demographics in the 2009 Fellows Directory where 53% of fellows had U.S. addresses and 47% had addresses outside the U.S. Most respondents reported a master’s or doctoral degree as their highest level of education, while the remaining 12% reported having a bachelor’s degree. 61% of respondents reported being primarily trained as music therapists. The majority of the non-music therapist respondents indicated being primarily trained in a mental health profession (e.g., psychology, counseling, social work).

Respondents were asked to indicate the age and the health concerns of the clients they treated in their past and current GIM practice. Past GIM practice was defined as the time frame between the date the respondent became a GIM fellow and December 31, 2008. Current GIM practice was defined as the time frame between January 1, 2009 and the December 2009 when the survey was conducted. Predictably, the data indicated that Adult clients aged 18 to 64 years dominate the past and present caseloads of GIM fellows. There was a marked decline from past to current practice in work with the other three age groups: Older Adults, Adolescents, and Children. A majority of the respondents reported never having worked with children in the past (88%) or in the present (98%).

Seven client concerns were presented for respondents to rate in terms of the percentage addressed in their past and present practice. In summary, Normal Neurosis, Anxiety and/or Depression, and Psychological Trauma were the most common clinical issues addressed in their past and current practice. Overall, the data showed a decrease from past to current work with each of the client concerns included in the survey. The greatest decreases from past to present were in therapists’ work with Substance Abuse/Addiction, Cancer, and Terminal Illness. There was, however, an increase in the mean percentage of practice that each of the client concerns occupied, suggesting increased specialization.

Respondents were asked how many individual and group GIM sessions they provided on average per month (0, 1-5, 6-10, 11-15, or More than 15). Adding the responses together revealed that
prior to 2009 at least 417 and as many as 680 individual, and, at least 78 and as many as 215 group GIM sessions were offered worldwide each month. During the year 2009, at least 317 and as many as 557 individual, and, at least 79 and as many as 215 group GIM sessions were offered each month worldwide. This indicates a decrease in the number of individual sessions and virtually no change in the number of group sessions provided from past to current practice but since the respondents were asked to rate ranges of sessions per week it is impossible to be certain.

Regarding practice settings, 85% of respondents indicated that they primarily practice individual GIM in private practice. In contrast, 93% of respondents conducted group sessions in therapeutic facilities or agencies, psychiatric hospitals, medical hospitals, universities, and conferences/workshops.

Concerning their primary theoretical orientation to GIM practice, respondents favored humanistic/existential (30%), followed by psychodynamic (22%), transpersonal/spiritual (19%), and Jungian (13%). Few respondents indicated Bioenergetic, Somatic, and/or Chakra (1%) or Cognitive/Behavioral (1%) and no respondents indicated “Gestalt” as their primary theoretical orientation. The remaining 14% of respondents indicated ‘Other’ orientations: Eclectic (9%), Integrative Psychology (3%), Feminist (1%), and Resource-Oriented (1%).

**Practice Ratings**

The remainder of the survey was devoted to the individual and group practices, though the ratings for group practices will not be presented here. Respondents were asked to rate each of 59 practice items in terms the frequency used in individual sessions since becoming a GIM Fellow using the following scale: never, seldom, sometimes, often, always. What follows is a summary of the frequency data for individual practices.

A majority of respondents reported using the following session and music lengths often or always: 1½ to 2 hour session (83%), 30 minutes or more of music for a 1½ to 2 hour session (76%), and 21-30 minutes or more of music for a 1½ to 2 hour session (67%). A majority of respondents reported using a 1 hour session at least sometimes (39% sometimes, 27% often, 2% always) while a ½ hour session was used seldom or never by 90% of respondents. For sessions lasting less than 1½ hours, a majority of respondents reported using 6-30 minutes of music sometimes or more frequently.

A large majority of respondents reported often or always using pre-designed programs (89%) while extemporaneous programming was used less frequently (35% seldom or never, 44% sometimes, 18% often, 3% always). 70% or more of respondents reported sometimes or less frequently using directive interventions during the prelude and postlude and directive guiding techniques.

At least 70% of respondents indicated using the following orientations sometimes or often in formulating interventions during the prelude and postlude and during the music: humanistic/existential, transpersonal/spiritual, psychodynamic, and Jungian. Ratings of always were low (2%-9%) in using humanistic/existential and transpersonal/spiritual to formulate intervention during all session phases. Except for one respondent’s report of an exclusive use of a psychodynamic orientation during the prelude and postlude, no respondents indicated always using psychodynamic or Jungian orientations to formulate interventions during the prelude and postlude or during the music imaging. At least 80% of the respondents reported sometimes or less frequently using the following orientations to formulate interventions during the prelude and postlude and during the music imaging: Gestalt, Bioenergetic Somatic Chakra, and Cognitive/Behavioral.

Respondents were also asked to indicate how frequently they offer clients theoretical interpretations of their imagery and/or process during the prelude and postlude. 95% of respondent’s indicated sometimes or less frequently using theoretical interpretation during the prelude while 81% used it sometimes or less frequently during the postlude.
Respondents were asked what types of music they use when programming extemporaneously or in creating pre-designed programs for use in GIM. 85% reported *often* or *always* using classical music. The following types of music were used *sometimes* or less frequently by a majority of respondents: Movie (85%), World (90%), and New Age (90%). 100% of respondents reported that they *seldom* or *never* use Pop music.

Ratings for other practices used in individual sessions that were collected but are not included here include use of: mandalas during the prelude and postlude, specific programmers’ programs, a starting image, dialogue during the music imaging, having the client sit upright during the music, having the client travel with their eyes opened, music-centered interventions, introducing an image during the music, specific approaches to shortening music programs, types of extemporaneous programming, physical intervention, and making music during the prelude and postlude.

**Bonny Method and Modifications**

*Cross item analysis.* Using distinctions evident in Bonny’s writings and detailed by Bruscia (2002), a cross item analysis was conducted on respondent ratings for six practices associated with the Bonny Method. The results revealed that 72% *often* or *always* used at least one of the following: 1½ to 2 hour session, 30 minutes or more of music, verbal dialogue during the music imaging, and pre-designed programs. In contrast, only 46% of respondents *often* or *always* used all four of these. As previously revealed, 49% of respondents *often* or *always* use a humanistic/existential or transpersonal/spiritual orientation, yet only 25% *often* or *always* use one or both of these orientations in combination with all four of the practices listed above.

*Factor analysis.* Two factor analyses were computed to study the relationship among frequency ratings for individual practices; one of these is presented here. In simple terms, a factor analysis is an advanced level correlation that calculates relationships among several variables at the same time. Variables were chosen for analysis by observing a Pearson’ correlation matrix that allowed each of the ratings for practices in individual GIM to be viewed in one to one relation to each other. The matrix showed significant positive correlations between frequency ratings for practices associated with the Bonny Method, and, significant positive correlations between frequency ratings for practices associated with modification. The matrix also showed significant negative correlations between frequency ratings for Bonny Method practices and modifications, and vice versa. Thus, for the first factor analysis, frequency ratings were chosen to represent a balance of Bonny Method practices (1½ to 2 hour session, predesigned programs, humanistic/existential orientation, and verbal dialogue during the music imaging) and modified practices (1 hour session, extemporaneous programming, psychodynamic orientation, directive interventions, directive guiding). The results provided statistically significant support for the observation that respondents who tend to use practices associated with the Bonny Method tend not to use practices associated with modifications, and vice versa. Only two practices were positively related to each other across this boundary, verbal dialogue during the music imaging and extemporaneous programming.

**DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS**

Some of these survey findings seem ripe for discussion. That 70% or more of respondents indicated using *sometimes* or *often* using a humanistic/existential, transpersonal/spiritual, psychodynamic, and Jungian orientation in formulating interventions is curious. Are GIM practitioners using multiple

---

1 Correlations were initially computed using the Pearson coefficient, but were later more accurately recalculated using the Spearman coefficient with no/minimal impact on the results (Muller 2014).
orientations within a single session? Where did they learn how to do this? Are some GIM trainings teaching more than one orientation to the method? Is this reasonable? Perhaps respondents confused the notion of intervening from within an orientation with using concepts from different orientations to understand the client’s unfolding process. From the beginning, Bonny found concepts from many orientations helpful in understanding clients’ myriad experiences in GIM. This explanation seems supported by the vast majority of respondents’ sometimes or less frequent use of theoretical interpretation during the prelude and postlude. Perhaps more fellows are intervening from within a humanistic orientation than is shown by the data? More research is needed to investigate how theoretical orientations are used in the Bonny Method and in modified GIM.

That only 46% or less of respondents often or always use, in combination, the four practices and theoretical orientation(s) included in the cross item analysis of Bonny Method practices raises some questions. To what extent are GIM trainers teaching the combined use of these practices? To what extent are practitioners modifying the Bonny Method to accommodate client needs, to suit their own personal preference, or to adopt to a therapeutic setting? As mentioned in the introduction, both the Bonny Method and modified GIM have been used with clients who have similar health concerns. As presented in the previous section, 85% of respondents identify private practice as the primary setting for individual GIM. Private practice is also the primary focus of training under the AMI. In contrast, many authors who write about modifying the Bonny Method to accommodate psychologically or physically fragile clients refer to sessions occurring in non-private practice settings (e.g., inpatient and outpatient hospitals). Add to this the questions raised in the previous paragraph regarding using theoretical orientation(s) to understand the client’s process versus intervening based on one or more. Further research is needed to investigate the relationship between modifications, client need, therapist preference, setting limitations, and the impact that different configurations of these have on the client’s experience and process in GIM.

That boundaries detailed by Bruscia (2002a) are reflected in GIM fellows’ practice ratings raises some questions: Do some training programs favor Bonny Method practices, while others favor modified practices? If so, are some GIM fellows better trained in modified practices than they are in the Bonny Method and vice versa? Should some degree of mastery of the Bonny Method precede being trained to use modified GIM? Can the reverse be true? In learning the Bonny Method, is being a client in modified GIM as informative as being a Bonny Method client, or vice versa? Can modified GIM be safely and effectively practiced without prior supervised practice and personal experience? Research is needed to explore these questions objectively. Moreover, it is recommended that the GIM community get together and adopt a system for distinguishing between the Bonny Method and modified practices. Bruscia (2002a, 2015) has detailed clear boundaries between the Bonny Method, modified GIM, and non GIM practices, some of which have been validated by analysis of the survey data. Without clarification of these boundaries who knows who is trained to do what? Who knows what practices are potentially harmful and what training is needed to practice them safely?

In conclusion, the survey data show that many forms of individual and group GIM are being practiced worldwide in a variety of settings to help a wide range of clients. The results also indicate that there is more to learn about GIM practice, and that deeper study of modifications can help practitioners to better know the Bonny Method. Given the recent proliferation of modifications in the GIM literature, it is important that GIM practitioners endeavour to more fully explore the nature and potentials of the Bonny Method, and to remain vigilant in noticing and detailing how even the slightest modification might compromise its alchemy.

Address for correspondence
Bryan J. Muller, PhD; MT-BC Email: brymul@protonmail.com
Note
This paper contains a summary overview of the author’s doctoral dissertation and portions of a subsequently published book on variations in GIM. The full versions can be found at:

References