

**SPECIAL ISSUE**

Guided Imagery and Music: Contemporary European perspectives and developments

Article

The future of the Bonny Method: A perspective on Danish practice with a forecast to the future

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ABSTRACT

The article presents the current status of the Bonny Method of Guided Imagery and Music (GIM) in Denmark, with an outlook to the international context. The central focus is on the results of a survey (2016) of Danish GIM practitioners (n = 20), with relevant international surveys introduced as comparisons. Clinical applications of the different formats within the 'spectrum of GIM' are also presented and discussed in a Danish context; the future potential of the many Bonny Method session formats is then outlined, and implications for training are discussed.

KEYWORDS

Guided Imagery and Music (GIM), GIM spectrum, clinical applications, training

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INTRODUCTION: CONCEPTS AND SURVEYS

The purpose of this article is not only to present and discuss the future of the Bonny Method of Guided Imagery and Music, but also the current

situation of Music and Imagery-based therapy in Denmark, with reference to international trends. 'Guided Imagery and Music' (GIM) is the umbrella term for receptive methods combining music, imagery and therapeutic dialogue. 'Music and Imagery' (MI) is a rather new conceptual framework

for therapeutic formats including music-listening, multimodal imagery and artistic/verbal processing of personal experience (Grocke & Moe 2015). The original or 'generic' format is nowadays called the 'Bonny Method of Guided Imagery and Music', sometimes (and in this article) abbreviated as BMGIM. The format was developed by Helen Lindquist Bonny in the 1970s for individual therapy. She defined it as a process where mental images are evoked while listening to classical music, and explored a therapeutic dialogue between 'traveller' and 'guide' (Bonny 2002).

Inspired by Helen Bonny's work, and evolving as a result of the clinical work carried out by (music) therapists in many countries around the world, several other (less demanding) session formats have been developed. They all include: (1) a verbal pre-talk, (2) a relaxation/induction, (3) a music-listening period with multimodal imagery, and (4) a processing of the experience, artistic and/or verbal. In this article, I refer to the three formats identified by Grocke and Moe (2015), which they present as a 'spectrum model':

1. *Music and Imagery*, used for individual therapy (MI) and in groups (GrpMI). In these formats, there is no guiding during the music-listening, which typically lasts 2-8 minutes. Music is not defined or limited by genre or style, but selected by clinical relevance, at the therapist's discretion.
2. *Guided Imagery and Music*, used in therapy for individuals (GIM), and occasionally for groups (Group GIM). In these formats, there is supportive (therapist-led) guiding during the music-listening. This typically lasts 2-8 minutes, but can last longer when a manuscript is used in guiding ('a guided music journey'). Most often, classical music is used.
3. *Shortened Bonny Method of GIM* (BMGIM) sessions, for individual therapy only. In this format, all elements of a full BMGIM session are present, but the music-listening period is shorter, typically 10-20 minutes. Classical music is used (including Bonny's own short music programmes).

Internationally, these formats are used increasingly alongside BMGIM, and a few surveys have been carried out to document the situation.

An international survey (Muller 2011) was carried out prior to the publication of the book outlining the GIM spectrum, however, Bryan Muller identified the same elements as Grocke and Moe (2015) as those most commonly modified to suit the client's needs: length of the session, length of the 'music travel', music selection (classical as well as non-classical), and verbal dialogue/guiding (e.g. with clients sitting up/with eyes open). Overall, 107 respondents contributed to Muller's survey. About half of these reported that they offered shorter sessions with shorter music-listening periods. This could be done by: eliminating pieces (86% of respondents); using short programmes designed by others (80% of respondents); designing their own short programmes (72%); or programming ('improvising') the music extemporaneously within the timeframe (60% of respondents). 88% of the respondents reported that they used classical music 'often' or 'always'. Other music-genre options were movie (14.6% often), world (6.4% often), and new age (8.2% often).

In an AMI survey from 2008, 83% of respondents reported that they used GrpMI sessions, while 77% used short BMGIM sessions. 70% reported using non-classical music.

A survey by Denise Grocke and Alison Short (2015) was answered by 17 of 21 Australian GIM practitioners. Five of the 17 answered that they currently do not work with GIM in their clinical practice. The 12 active therapists reported as follows:

- Ten therapists had between one and five regular clients at the time of the survey; two had between six and ten.
- Nine therapists used the full BMGIM session with some of their clients; only three used it with all.
- The GIM clients were reported to have the following health concerns: anxiety ($n = 12$), depression ($n = 9$), grief and loss ($n = 12$), stress ($n = 3$), PTSD ($n = 4$), physical illness ($n = 6$), relationship issues (11). Others specified were: drug and alcohol addiction ($n = 3$), life direction ($n = 2$), life transition ($n = 2$), history of abuse ($n = 2$), stress management, eating disorders, child trauma, sexuality and intimacy, relationship with the sacred (spirituality / religious beliefs), blocked creativity, training sessions for students, bereavement and palliative care.

For clients who could not use full BMGIM sessions, the following adaptations/modifications were reported: Music Drawing Narrative ($n = 4$); Group MI/GrpMI ($n = 3$); Supportive MI ($n = 3$); Shortened 50-minute sessions ($n = 2$); Single piece of music at the end of a verbal session; Verbal session and relaxation; Repeating single piece of music; Sometimes clients bring their own music; Music and mindfulness script for stress; GIM by Skype, ISM (imagery, sandplay and music); Graded process of verbal sessions first, relaxation and static image, then trial unguided MI, then short GIM. For palliative care, the following adaptations / modifications were reported: Relaxation only and non-GIM music; Short MI (client silent), short GIM (patient speaking), one piece of music with mandala-drawing; Focus on breath supported by music. In general, sessions were shorter, the music lighter, and the focus more supportive than exploratory.

The therapists reported that their choice of adaptations was influenced by: The here-and-now presentation of the client ($n = 13$); Suggestions from supervisors or colleagues ($n = 7$); Suggestions from the literature ($n = 8$).

GUIDED IMAGERY AND MUSIC IN DENMARK – CURRENT STATUS

In Denmark, there are four primary trainers, 14 Fellows, and 26 trainees or former trainees (having completed a minimum of Level II GIM training). More than 100 music therapists have completed Level I as part of their master's training programme at Aalborg University. The course was mandatory between 1998 and 2008, and since then has become an elective that almost all students choose (Bonde 2014b). Other receptive formats are also taught in the programme. In other words, all GIM formats are well-known among the majority of Danish music therapists, and many of them practise MI techniques, as described above (Grocke & Moe 2015), while only a minority (the respondents of the survey described below) also use BMGIM.

Between 1998 and 2008 there was a Danish Association of Music and Imagery. In 2010, this was replaced by a network hosted by Aalborg University, the so-called *Network of Receptive Music Therapy*, which is open to all professionals with an interest in the topic. At present, the network has 25 members and meets once or twice a year.

GIM topics are always on the agenda.

THE SURVEY

What are your thoughts about the place of the Bonny Method in its original form in contemporary practice? This basic question formulated by Martin Lawes (for the roundtable mentioned in the opening note) made me first look back on my own practice since becoming a fellow in 1999. I realised that I have almost exclusively used the classical Bonny Method (BMGIM) in training contexts and with non-clinical clients working on non-clinical, self-development issues. As a clinician – primarily in psychiatry – I worked a lot with GrpMI, and sometimes with MI, but never once with the complete classical session format. My GIM-trained colleagues in psychiatry worked in a similar way; using methods from the spectrum mentioned above (Bonde 2010; Bonde & Pedersen 2014; Fønsbo 2013; Lund & Fønsbo 2011).

However, as the survey results demonstrate, the classical Bonny Method session does have its place in a Danish context. Not only as the core element in the GIM training (the dyadic experiences of being guide or traveller are unique as experiential learning) and in self-developmental work, but also in the treatment palette of a (BMGIM-trained) music therapist/psychotherapist with certain clinical target groups.

I designed a survey that was sent to 28 Danish GIM practitioners, asking them about how they use methods from the GIM spectrum in their work. 20 of the 28 questionnaires were returned, and thus the response rate was 71.4%. Respondents could also add other clinical areas to those suggested (in bold), and comments on present and future. Table 1 shows the results and gives an overview of GIM-spectrum methods used in major clinical settings in Denmark. The numbers in the table show the percentages of respondents answering 'yes' to the specific categories.

All in all, this shows that the full spectrum of receptive methods is used in five areas, and part of the spectrum in three or more areas ('stress' was added as well as other non-clinical areas). The full Bonny Method format is used by 10% or more of the respondents in four of the eight areas, and short Bonny Method sessions in all areas. Also, in the areas of palliative care, refugees/trauma and brain injury, at least one respondent reports that the full Bonny Method session can be used, even if

rarely.

I now turn to each of the clinical target groups to observe how receptive music is used with these different populations.

Self-development: Danish GIM therapists in private practice use both the classical and the short form of the Bonny Method with their clients. Research has documented the rich benefits of even a very short series of sessions (Blom, Thomasen & Bonde 2012; Bonde & Blom 2016).

Psychiatry: In Denmark, almost the whole spectrum of receptive methods is used in psychiatry (Lund & Fønsbo 2011), however, classical BMGIM sessions are very rare. Recently, the GIM spectrum was officially accepted as a treatment modality at Aalborg University Hospital's psychiatry department (C. Dammeyer, personal communication, March 9, 2017).

Palliative care/hospice: Patients admitted to hospices in Denmark have on average little more than two weeks left to live. They are fragile and frail, and therefore full or short BM sessions are rarely possible. The individual MI session is the most appropriate and most frequently used format in this context (Bode & Bonde 2011).

Refugees (with or without PTSD): Receptive

methods, including MI, have been used with refugees in Denmark for a decade. An ongoing research study has focused on the effect of short BMGIM sessions and individual MI sessions on trauma. Results are promising (Beck et al. 2017).

Brain injury: Only a few music therapists work in this area, and very few reports are published (Hald 2014; Moe & Thostrup 1999). However, it is possible to work with Short BMGIM and MI sessions in this field.

Somatic problems: Full BMGIM sessions have been documented as effective for cancer survivors (Bonde 2005, 2007), and an ongoing Scandinavian study is revealing the potential of the full GIM spectrum with children and teenagers in cancer care (I. Sanfi, personal communication, February 22, 2017).

Many GIM therapists work with *pain management* in different clinical contexts. In fact, it seems to be a common denominator in all the clinical areas mentioned in the table.

(Music therapy) *supervision* could be added to the list. Short BM sessions (re-imagination) and individual MI work can be very effective elements in supervision (Bonde 2013, 2014a).

		Method				
		BMGIM	Short BMGIM	MI Individual	GrpMI	Other Receptive Methods
Areas	Training	40%	40%	15%	25%	25%
	Self-development	85%	60%	35%	20%	20%
	Psychiatry	10%	40%	20%	15%	20%
	Palliative / hospice	5%	15%	30%	0%	20%
	Refugees / trauma	5%	30%	35%	5%	15%
	Brain injury	5%	5%	10%	0%	10%
	Somatic problems	10%	20%	30%	10%	20%
	Stress	5%	0%	0%	0%	0%
	Other	0%	10%	5%	5%	5%

Table 1: A spectrum of receptive methods, including the Bonny Method, used in clinical settings in Denmark (n = 20 (of 28 invited); 5% = one respondent. Other areas mentioned were nursing homes/institutions for the elderly in particular)

The future of the Bonny Method in Denmark

Based on the results of the survey, the future seems promising for GIM in Denmark. The full BMGIM session is of course used in private practice, and it has been proved applicable and effective in areas such as cancer care and psychiatry, while other methods in the GIM spectrum have also been established in palliative care and in rehabilitation of refugees with PTSD. Full sessions could be used in palliative care, particularly if GIM therapists have access to patients receiving care at home (i.e. earlier in the trajectory). MI can also be used in the rehabilitation of people with acquired brain injury as more clinicians become employed in this area.

DISCUSSION

Comparison of surveys

The results of the Danish survey can be compared to the international survey by Muller and colleagues (Muller 2011; Muller & McShane 2014), and to the Australian survey by Denise Grocke and Alison Short (Grocke & Short 2015).

A direct comparison with the two surveys is not possible, since the questions were not formulated in the same way. However, many similarities can be observed. The general pattern in the surveys is the same: a majority of the therapists use both the full BMGIM session format and other formats, either from the 'spectrum of GIM' or personal modifications tailored to the client's needs. Anxiety, depression, grief & loss are dealt with in many sessions, while non-clinical, self-developmental issues are often of a relational nature. It is not possible to compare the clinical contexts of the respondents directly.

The overall pattern seems to be consistent: the full BMGIM session is used when possible and appropriate, while elements of the session are modified to meet the needs of the client in the specific clinical context. Thus, the GIM spectrum is applicable to, and used by, most GIM practitioners.

Implications for training

The fact that the GIM spectrum is used extensively leads me to the conclusion that GIM training should be more inclusive of other formats, not just the full BMGIM session. In Scandinavia (Denmark,

Norway, Sweden), MI formats have been included in the training by most trainers for several years. The most logical way seems to be that the simpler formats (individual and group MI), including relaxation techniques, are taught first, while the more complex skills of non-directive guiding/dialoguing are primarily taught in the advanced training.

The educational committee of EAMI is currently working on a set of Training Standards that reflects this: the session requirements will include both full BMGIM sessions and other formats from the spectrum. The trainers will be free to structure their programme to include these formats in the training. Personally, I think this is in line with Helen Bonny's vision and practice. She developed the GrpMI format in her very first book (Bonny & Savary 1983); she developed *Music Rx* as a finely tuned MI format for hospital use (Bonny 1998); and, together with Ken Bruscia, she developed short music programmes for short sessions (Bruscia 2014). GIM trainees come with experience from many different clinical settings, and often the full session is not applicable to their specific work. The vision could be to make the GIM spectrum a clinical reality in as many contexts as possible, and therefore the whole spectrum should be integrated into the training.

CONCLUSION

This article presents the current status of GIM in Denmark, as reported by Danish GIM practitioners in different clinical and non-clinical settings. The Danish survey is in line with other, international surveys that document how the full BMGIM session is the jewel or cornerstone of a whole spectrum of MI formats developed by Helen Bonny and her followers to fit the needs of their clients within a large range of contexts. In recent years, this spectrum has been systematised and described in detail by Grocke and Moe (2015). It is now time to include the whole spectrum in clinical training and in the requirements of the international associations.

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