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Definitional and Boundary Issues

Since Bonny originated GIM in the early 70's, her proponents have developed many extensions and variations in both the individual and group forms, and at the same time, many techniques have evolved in other health professions that rely upon various forms of "guided imagery," some employing music (see Meadows, 2002). As a result, definitional and boundary issues have arisen over the years, along with controversies over what to name the various practices and modifications therein. These issues have been further confounded by the fact that many different health professionals practice the model, and therefore it has been applied within the context of many different disciplines and orientations. Practitioners in GIM come from backgrounds in music therapy, counseling, psychotherapy, healing, education, medicine, psychiatry, nursing, spiritual direction, and transpersonal work.

Definitions and boundaries are not merely philosophical concerns—without them, safe, competent practice may be jeopardized. If intensive training is to be required to practice GIM, a fundamental question is which of the many variants of GIM should the BMGIM therapist know how to practice? Should all variants of GIM be taught in the training programs, or only the Bonny Method?

In an attempt to clarify these issues, Bruscia (2002) made a distinction between GIM, the generic title for myriad related practices, and Bonny's Method of GIM, which includes the individual and group forms. The individual form is commonly called BMGIM, and the group form is variously called "Group GIM" or "Music and Imagery." Already, the nomenclature difficulties should be obvious.

Bonny's individual form can be distinguished from related approaches that go beyond it by applying the following defining variables: BMGIM is defined as: "1) an individual form 2) of exploring consciousness (e.g., in healing, psychotherapy, self-development, spiritual work), 3) which involves spontaneous imaging 5) in an expanded state of consciousness 5) to pre-designed (taped) programs of classical music, 6) while interacting with a guide, 7) who uses nondirective, non-analytical, music-based interventions, 8) within a client-centered orientation, 9) all within a session that has the following components: preliminary conversation, relaxation induction, guided music-imaging experience, return, and postlude discussion" (2002, p. 46). If any of these nine features are modified, the practice should be regarded as an adaptation of BMGIM, falling under the generic umbrella of "GIM." That is, if the individual form is used for other purposes (e.g., educational), or if the imaging is directed by the guide rather than spontaneously created by the client, or if the client does not enter an expanded state, or if the music is extemporaneously selected by the guide rather than programmed beforehand, or if the guide does not work within a client-centered orientation, or if the session does not have all these components, the practice should br regarded as an adaptation of BMGIM, and considered a variant under the generic umbrella of GIM.

The Bonny Method of Group GIM is defined as: "1) a form of working with individuals in a group setting, 2) for the purposes of exploring consciousness (e.g., in education, training, self-development, or spiritual work), in which 3) each member images spontaneously, 4) while in an expanded state of consciousness, 5) to one or more pieces of music (any style), without ongoing direction or dialogue with the leader, 7) working in a client-centered orientation, 8) within a session form that includes: a preliminary conversation, relaxation/induction, music-imaging experience, and postlude discussion" (2002, p. 46). Once again, if any of these defining features are modified, the method is an adaptation of the Bonny Method, and therefore a variant of GIM. For a discussion of specific practices or techniques in GIM that go beyond the Bonny Method, see Bruscia (2002).

Since the remainder of this chapter deals only with the individual form as designed by Bonny; the acronym BMGIM will be used throughout.

Continua of Practices in BMGIM

Flowing out of the definitional, boundary, and nomenclature issues, are differences in the orientations of BMGIM practitioners (Bruscia, 2002). Orientations in BMGIM vary not only according to theories of psychotherapy (e.g., humanistic, psychodynamic), but also according to the role given to music versus the other elements of the BMGIM process. "How music is used may vary from one session to another, one client or population to another, and one practitioner to another" (Bruscia, 2002 p. 43). This can best be described as a continuum, with one end representing the use of music *as* therapy or *as* the transformational agent, and the other end representing the use of music *in* therapy or as one of many agents of transformation. When music is used *as* the transformative agent, the client's needs are accessed and addressed through the music listening experience, the client's change process is evoked, worked through, and completed through the music listening experience, and the transformation that takes place in the music experience is the transformation that takes place in the person—and throughout, there is minimal reliance on other modalities (verbal discourse, art work, etc. (Bruscia, 2002). In these cases, the music is not co-therapist, rather it is both therapist and therapy, and the guide is the co-therapist. When music becomes the therapist and therapy, it becomes both process and outcome. The musical change process is the client's change process, and the musical outcome is the client's outcome. "When this happens, the imager steps into the structures and processes unfolding in the music from moment to moment, and begins to live within them, generating images and inner experiences that arise directly out of the music. And by living in musical structures and processes as they continually transform themselves, the experiencer and the experience are similarly transformed. The entire phenomenon is intrinsically musical in nature, and similarly ineffable; and this seems to hold true, even when the imager tries to describe the experience verbally, using nonmusical referents (e.g., images of an animal, person, situation, etc.). In fact, often the nonmusical images and the verbal reports of them seem like mere artifacts of an essentially *musical* experience" (2002, p. 44). These intrinsically musical experiences may arise spontaneously, initiated by the client, or they may be evoked or facilitated by the therapist; they may also be an entire approach to BMGIM, or an occasional way of working. Much depends on how the therapist conceptualizes BMGIM and how it works,

and how the therapist guides the client. When music assumes the primary role of therapist during the listening period, the therapist continually refers the client back to the music to guide the client's moment by moment experience; then during the postlude discussion, the therapist helps the client to acknowledge and anchor the ineffable musical/personal transformations that have taken place. No attempts are made to superimpose additional interpretations or insights.

On the opposite end of the continuum, music is used to stimulate experiences in other media (e.g., imagery, body work, art work, verbal discourse), and these experiences are used, instead of or in addition to the music, to facilitate the transformational process. At this end, the client's needs are accessed and addressed in nonmusical media, and the client's change process is evoked, worked through, and completed in these media, all with the help of music as the background stimulus. "Here the focus is not on experiencing the music as an intrinsically transformative experience in itself, instead, the focus is on generating nonmusical images and experiences with the help of the music" (2002, p. 45). BMGIM is here conceived as the use of music-evoked *imagery*, rather than the use of *music* per se. This is immediately apparent when the therapist tends to guide, explore, and discuss the meaning of the imagery rather than the transformations experienced in the music. Verbal segments of the session take on much more importance than the music listening segment, because the meaning of the images and insights gained from them are of paramount significance. It is also noteworthy that the insights gained are more verbal than ineffable (musical).

Another important distinction that arises out of this continuum is an experiential approach to BMGIM as compared to an insight-oriented approach (Bruscia, 1998). These approaches differ in both process and outcome, and very much resemble the previous distinctions between music *as* versus music *in* therapy. In an experiential approach, (also called transformational music psychotherapy), the client relives and works through his problems within the music-imaging experiences, and the transformations that take place there constitute the therapeutic process, without necessarily analyzing the transformations to gain insight about them. Here the aim is experiential change or transformation in and of itself, which in BMGIM is the experience of musical transformation, and the process of reaching that aim is also experiential (i.e., music listening).

In an insight-oriented approach (also called insight music psychotherapy), the client uses the full gamut of BMGIM experiences to gain insights into his problems and to their possible solutions, and efforts are made to implement these insights in the real world, with less attention given to whether the client actually experiences the problems and their resolutions in the music and/or imagery. Once again, these approaches may be used occasionally, or as an entire approach, and they may occur spontaneously within a session, or the therapist may purposely facilitate one or the other.

Levels of Practice in BMGIM

The BMGIM process varies in direction and depth from moment to moment within the session, and from one session or phase of work to another. In this context, direction means the domain or area of the client's life that is a focus of the work, and depth is the degree and range of change the client is called upon to make. These continuous variations in direction and depth make BMGIM an expansive and responsive process. It is

expansive in that, at any moment, the focus of the work may enlarge from one domain to many domains, and the depth of the work may intensify the work thereby increasing the degree of change the client is called upon make. BMGIM is responsive in that it expands in direction and depth according to what the client needs in the moment, within the context of what has arisen in the music-imaging experience.

It is essential to understand that, in an instant, the BMGIM process can expand from positive to problematic aspects of the client and the client's life, from comfortable to uncomfortable situations or memories, from joys and pleasures to pain and trauma, from strengths to weaknesses, and from easily managed experiences to very difficult, and sometimes unmanageable experiences. Though it was originally believed that BMGIM was self-limiting, that is, that it does not bring forth anything the client cannot manage, clinical practice has shown that this is not always the case. While BMGIM is incredibly accurate in bringing forth what the client needs to grow or change, the therapist has an ethical responsibility to insure that the client is adequately prepared to deal with what BMGIM brings forth. In short, the expansive and responsive facets of BMGIM have profound implications for safe and ethical practice.

Safe practice can be achieved through a three-pronged approach: 1) adherence to contraindication guidelines; 2) adaptation of the method when indicated; and 3) utilization of levels of practice in establishing contracts with clients. All three safeguards are interrelated. Contraindication guidelines tell the therapist when BMGIM may not be the therapy of choice, or when BMGIM should be adapted so that the direction and depth of the work is safely contained, and the safest level of practice is maintained.

BMGIM is contraindicated whenever the client lacks (Bruscia, 1992):

1. The medical and physical stamina needed to undergo the music or the images.
2. The emotional stability needed to undergo the feelings evoked.
3. Ego strength and boundaries needed to maintain one's sense of self and personal identity after deep experiences.
4. The intellectual abilities needed to understand one's own experiences.
5. The verbal abilities needed to participate fully in the session.
6. Sufficient reality orientation to distinguish imaginary and real worlds.

When any of these contraindications are present, the therapist may choose to terminate the client, or try adapting the individual or group forms of BMGIM by:

1. Shortening the music
2. Using less challenging music
3. Controlling how deeply the client goes into an altered state of consciousness
4. Directing the imaging rather than allowing the client to create it spontaneously
5. Keeping the images positive
6. Monitoring the discussion afterward so that clients can handle the insights
7. Spreading out the sessions, and limiting the total number

Based on whether any contraindications are present, and taking into account the goals of the client, the therapist and client may make a contract to work at a particular level. In this context, levels refer to the "breadth, depth, and significance of therapeutic

intervention and change accomplished through music and music therapy" (Bruscia, 1998a, p. 163–164).

The first level is auxiliary in nature, and is concerned with self-development and growth. The client is seeking GIM for any of the following purposes: to develop one's imagination, to promote creativity, to improve one's learning skills, to learn how to relax and reduce stress, to facilitate self-discovery, to enhance one's spiritual life, and so forth. At this level, the client has a healthy way of being in the world, and is managing any ongoing health threats without need for outside assistance. Thus, the focus is on self-improvement rather than therapeutic intervention into a defined health problem. At this level, the client is called a traveler, and the therapist is called a guide. The therapist maintains a non-intrusive, supportive stance that encourages the client to work independently. The relationship is not usually a medium or agent of change, but is nonetheless important. Depending on client preference, the music may be of any genre and style, though classical music is ideal. The programs are short, and the music is not too challenging. The work is most often done in groups, and is usually short-term or at widely spaced intervals. This is the level of Bonny's original Group GIM, which was done in workshop settings. Individual sessions may be used at this level, but usually require adaptation to contain the amount and nature of material uncovered.

The second level is supportive or augmentative in nature. The aim is twofold: 1) to discover, restore, and build upon existing structures and resources that an individual needs to deal with a health threat of some kind; and 2) to stimulate and support psychological adjustment and healing. Additional objectives may be to return the client to psychological equilibrium as rapidly as possible; to ameliorate psychological, physical, or behavioral symptoms; to strengthen existing defenses; to develop better coping mechanisms; and to reduce the effects of negative influences, both from oneself and one's environment. Here the focus is on dealing with the health threat, taking a deliberately positive and motivational approach that reframes problems. Thus, rather than accessing or working through problems underlying the health threat, the therapist seeks to help the client to rediscover and reclaim parts of the self that are needed to cope with the present situation and either adapt to or improve it. Catharsis is not necessary, but may occur when needed. Efforts are made to bring resources into the conscious mind, rather than to uncover hidden unconscious material that requires further work. The approach is structure-building rather than deconstructive, focusing on resources rather than problems. Primary clientele for this level are individuals who are recovering from a psychiatric disorder and drug or alcohol dependence, individuals with a medical condition (e.g., cancer), individuals in crisis, and clients who are preparing for or taking a break from deeper levels of psychotherapy. The format of work at this level may be: individual BMGIM, if used intermittently or in short series with music programs that invite positive and uplifting experiences; adaptation of individual BMGIM, so that it minimizes the uncovering of conflictual material, and capitalizes on the insightful and healing potential of positive BMGIM experiences; or Group GIM therapy (see Summer 2002). Most often, the music is easy, safe, and structure-building rather than challenging. Certain BMGIM programs may be used in part; however, in most cases, efforts are made to limit the length of the music. At this level, the traveler is a client and the guide is a therapist. The client-therapist relationship is important in facilitating the music experiences, and enhancing the therapeutic value of the imagery; however, often, because of the length of

treatment, the relationship does not develop the depth needed for it to serve as a medium or agent of client change.

The third level is intensive or re-educative. The aim is to help the client to uncover and work through unconscious material, and thereby gain insight into oneself, and the specific problems experienced by the problem. Specific objectives may be: to examine problematic childhood experiences and their effect on the present; to facilitate and support self-expression and the release of feelings; to uncover and better utilize unconscious defenses; to identify alternative ways of being in the world; to examine and work through past and present relationships with significant others; and to facilitate adaptive changes. Here the work usually focuses on resolving problems within a particular domain of the client's life, and this may require acknowledging and working through certain resistances and defenses that impede progress. Clientele for this level of therapy are those who have the ego strength needed to confront and understand unconscious material. This includes nonpsychotic adolescents or adults with affective, situational, anxiety, behavioral or less severe personality disorders, those with drug or alcohol dependence problems, individuals who have been traumatized, as well as individuals who are neurotic or have problems in living. The format of work at this level is the individual form of BMGIM, used over an extended period (9-24 months). The full range of BMGIM music programs are used in their entirety; thus, the music is only classical, and includes both supportive and challenging pieces. The client-therapist relationship plays a significant role, as both medium and agent of client change. Relationship issues such as transference, working alliance, countertransference, authenticity, and congruence may be examined, depending on the orientation of the therapist, and the relevance to the problem area.

The fourth level is primary or re-constructive. The aim is to stimulate pervasive changes in the client's personality, life, and way of being in the world. Specific objectives may be to survey, uncover, and work through unconscious conflicts stemming from the past, to integrate unconscious material into the conscious, to make pervasive changes in the person's identity (or personality structure), and to build new approaches to psychological adaptation. Primary resistances are examined and resolved in a way that allows the BMGIM process to go forward; primary defenses are also examined and reorganized for healthier use. Clientele for this level are the same as for the previous level—all must have the ego strength needed to withstand this level of uncovering, along with the intellectual ability to find and make meaning of the material. The format of the work at this level is the individual form of BMGIM, used over an extended period. The BMGIM music programs are used extensively, including the most challenging ones. The client-therapist relationship is crucial, serving as the primary container for the client's experiences.

The fifth level is transpersonal, where the work moves from any of the previous levels to the transcendent level. Here the aim is to move beyond the world of the body, beyond the world of the psyche, and beyond personhood to reach the world of the spirit, the collective all-inclusive, the Self, or the Divine. Goals of insight and adaptation related to physical, emotional, cognitive, and social problems are replaced with the human drive for fulfillment of one's potential as spirit. A client cannot simply come for a series of transpersonal sessions, nor can a therapist plan for transpersonal experiences to occur; transpersonal work emerges on certain occasions, when the conditions are ripe, and only

when the client is ready—almost like unexpected blessings that reward and encourage work at the previous levels. Thus, a transpersonal experience may be a part of one session, permeate an entire session, or occur over a few sessions; but there is no manipulating them to happen, at least authentically. There is also no way to prevent them from happening, as they seem to occur whenever the client is ready, regardless of at what level the client and therapist are working. Moreover, transpersonal experiences in BMGIM emerge directly out of the personal work done at the previous levels, and the experiences themselves are often linked to the material that was worked through and resolved.

The Dynamics of Consciousness

This theory evolved out of the author's experience teaching GIM, and is taken from the training manual for Level II (Bruscia, 1998). The theory describes the many changes in consciousness that takes place for client and therapist during each phase of the GIM session. The author defines consciousness as "a state of awareness maintained by any psychological activity, including both covert and overt processes (e.g., sensation, affect, behavior, thought, etc.)" (Bruscia, 1995, p. 167). A change in consciousness is any shift or movement in the *locus* or *focus* of one's awareness. A change in *locus* of consciousness occurs when the person moves from one experiential space or position to another, and attends from that perspective. When a person "locates" his consciousness somewhere, that location serves as the center of his apprehension and perception. A change in *focus* of consciousness is when the person moves the target of awareness and attention from one place or thing to another. Thus, together, locus and focus pose the questions: Where am I as I attend? And what am I attending from this place?

Changing the client's consciousness is both the process and desired outcome of BMGIM. Each phase of the BMGIM session effects very specific changes in the locus and focus of the client's consciousness, and as time passes, the cumulative changes in consciousness that a client makes around significant life issues, begins to effect a more permanent change in the client's way of being in the world. The essential change is that, hopefully, BMGIM helps the client to gain the fluidity of consciousness needed to continually find alternatives—in the way one perceives oneself, one's problems, and one's resources, and in the myriad ways of being in the world that are adaptive, fulfilling, and growthful. Every shift in consciousness brings a new possibility or alternative into awareness: when one's locus of consciousness changes, one becomes aware of new and different perspectives that can be taken; when one's focus changes, one becomes aware of new issues to consider; and when both locus and focus change, one becomes aware of alternative loci and foci that may be more relevant to the problem at hand, or even to life in general.

This theory deals with the specific changes in consciousness characteristic of each phase of the BMGIM session. The opening phase of the session, the preliminary conversation, is a period of transitions in consciousness for both client and therapist. It can likened to a dance of consciousness between the two parties. The client is continually moving and shifting locus and focus to be in relation to both self and therapist; and the therapist is doing the same. When the client enters the therapy room, the locus of his consciousness shifts from the outside world to a special space that has been created for

him in the therapy room. The environments are drastically different; the perspectives and frames through which one apprehends the world are different. Driving a car on the highway provides a different perspective for self-focusing than sitting in a comfortable chair in the intimacy of a BMGIM therapy room. Then, as the dialogue unfolds, the client's focus of consciousness begins to change, moving from the outside self operating in the outside world, to the inner self operating in the inner world. Once again, the client has an opportunity to change locus: he can locate himself in the inner self and focus on the outer self; he can locate himself in the outer self and focus on the inner self; he can locate himself in either location and focus on the therapist; or he can locate himself in the therapist, focusing on his own inner or outer self. These very same potential shifts of consciousness are also available to the therapist. So the ultimate question for the client and therapist is "where are you?" and how can we come together in either locus or focus? Metaphorically, there are two entities of consciousness in the room searching for a way to meet one another in the same locus or focus. When artwork is introduced (e.g., mandala), both parties have another possible focus for their interaction.

The prelude comes to an end when the client and therapist have harmonized their states of consciousness. Through the dance, they both share the same focus (or range thereof), and they both understand where the client is located in relation to it. In more concrete terms, the client and therapist have arrived at potential themes, emotions, metaphors, or ideas that could be the focus of the music-imagery experience, and they both have an understanding of where the client stands in relation to it. This information leads organically into the induction.

In the induction, there are several more shifts of consciousness that may occur. First the client moves from an upright position to a reclined position—a completely different attitude toward experience, and even life itself. From opposing gravity, and standing or sitting upright, the client moves to surrendering to gravity, and allowing oneself to be held up by the ground—from the vertical to the horizontal plane of experience. During the relaxation, the client is also moving the locus of consciousness away from the here-now of the therapy room to the there-then of the imaginary world. Time and space locations change. In addition, the client is also moving the focus of consciousness from the outer, active self to the inner, receptive self, from the world of seeing to the world of listening, and from verbal dialogue to the experiencing of imagery provided by the therapist as part of the induction.

Another major shift in consciousness occurring in the induction is when the therapist synchronizes and entrains with the locus and focus of the client's consciousness—their joint consciousness becomes unified in point of departure and goal. The coming together of consciousness that evolved in the prelude is now set into motion, and both parties expend their energy together to transport the client's consciousness in the intended direction. Both person's energy is enhanced by the other, and the rapport that is built, brings even more energy to the field in support of the client's work. The therapist also dips in and out of altered states of consciousness while helping the client to deepen. Synergy, then, evolves from the mutuality in shifts of consciousness between client and therapist.

So far, the BMGIM session has taken the client and therapist through two spaces of consciousness: the upright dialogue space, and the induction space. As the music begins, another space of consciousness emerges, this time one that contains many

additional elements: the client, the music, the imagery, the states of consciousness, and the presence of the therapist. This is the music-imaging space. In this space, these five elements continually shift between foreground and background, each serving their own functions in the experience. At one moment, they may be active agents in changing the experience, at others they may provide a medium or vehicle for another element to shape or change the experience. In the ideal situation, these elements work synergistically, so that the presence of one enhances the others in a way that goes beyond the potential of any combination of them. Thus, the music deepens consciousness and elaborates the images, while the images deepen consciousness and sensitizes the client to the music, and the therapist's presence supports the client, amplifies the image, and deepens the client's relationship with the music. There is no linear cause-effect chain of events: all elements of the experience are in constant interplay with one another, motivated and fueled by the immediacy of each unfolding moment. One never knows the turns of consciousness that can take place, as music, image, client, and therapist concentrate their efforts and contribute their energies to the ongoing experience.

The primary organizing and managing force within this space of consciousness is the client. As the various elements interplay, coming into and leaving the foreground of the client's experience, the client is continually shifting locus and focus of consciousness—from the music, to the image, to the self, to the therapist's presence, depending upon what captures the client's attention, and upon what the client needs to do. But this is not necessarily a fragmented or incoherent state, the advantage of consciousness is that it is not limited to one space. A person can expand his consciousness to be in more than one locus, attending more than one focus. This enables the client to either focus very intently on one element in the music-imaging space and go deeply into it; or to focus simultaneously on more than one element, or even all of the elements of the experience, as they move in and out of foreground and background. The music-imaging experience is a Gestalt, with all elements continually sharing figure-ground relationships, with all elements apprehendable within either a focused or expanded state of consciousness. Given this extemporaneous state of affairs, at any moment, the client may choose to: shift consciousness continually producing an unpredictable stream of foci or imagery; explore emotions, images, metaphors in short cycles; construct a coherent narrative for each piece of music or the entire program, or resist the entire process. Several factors contribute to the way the client organizes and manages the music-imaging space. These include his personality, developmental level, personal needs and wants, defenses, anxieties, and degree of trust in the process and therapist.

The secondary organizing and managing force within this space is the therapist; however, it must be quickly stated that the therapist always follows the client's lead, and then facilitates by leading or encouraging the client to go in that direction. The therapist does not organize, manage, or direct the client while in this space unless, for some reason, the client is unable to do so, and the client's safety is at risk. Nevertheless, the therapist's presence is an important factor in how the client manages this space, and what the client derives out of the experience. Ideally, the therapist takes a fluid approach to sharing the music-imaging space with the client, the music, the client's imagery, and the altered states of consciousness of both parties. Being fluid in this context means being able to move to various locations within the space, and focus on various things of import

to the client, while also going with the flow of the moment in terms of which element is in the foreground of the client's consciousness. When the music comes forth, the therapist can revert to the background; when the image dominates, the therapist can help the client to further develop it. The therapist has to be as fluid as the music, the images, and the states of consciousness, which are always in a state of flux and transformation. For more details on the role of the therapist, see the writer's theory on the guiding process.

The return phase of the session occurs when the music is nearing the end, and the image is nearing closure at some level. Ideally, these two closures are synchronous. The music brings closure to the image, and the image brings a sense of completion to the music. As the music and image recede into the background, they usually continue to resonate in the client's consciousness—the music still resonates in the body and the environment after it has gone, and the images remain as strong aftermath impressions of a deep experience. What were previously strong foci in the client's consciousness now move out of the foreground to form a very richly configured background. As these foci of consciousness shift, the therapist helps the client to also shift the locus of his consciousness, moving the client out of the imaginal world to the real world, from where he was located in the image to where he is reclining in the therapy room, and from internally stimulated experiences to an awareness of the environment and its ongoing impingement upon the here-now experience of the client. The client moves from a reclined position to an upright or seated position, and from surrendering to gravity to resisting it again. The client opens his eyes, and perceives the therapist's presence at a different level of reality, not as merely a heard presence, but now as a real person who can be seen and heard in the flesh. Client and therapist are back in the "upright-seated" relationship, as the client moves out of the space where he needed to be held and supported, to a position of equality and independence. The return is the opposite of the induction, it moves the client from there-then space and time to here-now space and time, from imaginary to real, from inner to outer experience.

Once these subtle and sometimes challenging transitions of consciousness are accomplished, client and therapist move into the postlude discussion. Here the final reversals of consciousness take place, completing the entire cycle of the session, and bringing the client back to the level of consciousness with which he entered the room. During the postlude, the challenge is to make some kind of meaning out of the entire experience. This meaning can be sensed in the body, felt in the heart, or understood in the mind—it does not have to be, and in most cases will not be, a cognitive, linear explanation of cause-effect relationships operating in the client's life history. It can simply be a holistic grasp of oneself, the conditions of one's life, and the qualities of one's world. No matter how ineffable or intangible the outcome, however, the meaning making process invariably requires some level or kind of self-reflection. Minimally, the client has to move from "being" in the experience and "living" in the music, to "observing" and "recalling" what happened in the imagery and music. The client is being called upon to consider the there-then in terms of the here-now—to reflect upon one's lived inner experiences so that they can be fulfilled or implemented in life. It is this repetition or re-telling of one's there-then in expanded consciousness in one's here-now ordinary consciousness that anchors the experience in the client's being. In some ways, this anchoring is a condensation process—the postlude helps the client to remember the

experiences in expanded consciousness by tagging them with a particular locus and focus in the here-now. There has to be one thread that gives the client access back into the full tapestry of the expanded experience; otherwise, it is easy to lose in the vast sea of consciousness. This thread then is like a short-cut or expressway connecting the inner and outer, imaginary and real worlds of consciousness, around a particular issues or experience of import to the client.

Therapist Presence in BMGIM

This theory originated in a heuristic qualitative research study, entitled "Modes of Consciousness in Guided Imagery and Music (GIM): The Therapist's Experience of Guiding." (Bruscia, 1995). This self-inquiry was a systematic examination of the author's experience while guiding one GIM session which posed particular challenges with regard to "being there" for the client, or what is also called therapist presence. The purpose of the theory was to explicate the many ways that a therapist can be present to the client, and the myriad factors that shape the quality and intensity of that presence.

Consciousness is defined as a "state of awareness maintained by any psychological activity, including both covert and overt processes" (1995, p. 167). This state of awareness is elusive to understanding because it is not limited in space or time. The author explains:

> The idea of moving my consciousness through space without occupying it is both challenging and freeing. I can be there without having to leave here, and I can be here without having to leave there. Or if I so wish, I can stay there without being here, or stay here without being there. Thus, I can be transported to another space without moving there in the literal sense of leaving where I was before. Hence I can be in more than one space at a time, and the process of transporting myself can be described as one of expansion rather than migration. Conversely, I can be in one space at a time, and the process of staying there can be described as one of centering. As my consciousness expands and centers, I also have the option of varying its intensity. That is, I can be 'less here than there' or 'less there than here" thus shifting the weight of my consciousness, just as I shift the weight of my body from one side or part to another" (p.167–168).

Continually Shifting Consciousness

Flowing from these conceptions of consciousness, the first proposition of the theory is that guiding a client throughout the entire GIM session requires the therapist to move, center, vary, and expand his consciousness.

- To move one's consciousness is to change the locus and focus of awareness.
- To center one's consciousness is to stay in one locus and focus for an extended period.
- To expand one's consciousness is to occupy more than one locus and/or maintain more than one focus at the same time.

- To vary one's consciousness is to distribute one's awareness across different loci or foci with varying degrees of intensity.

Attending Three Experiential Spaces

The second proposition is that to remain present to the client, the therapist must continually move, center, expand, and vary his consciousness in three experiential spaces: the client's world, the therapist's personal world, and the therapist's world as a GIM practitioner.

The Client's World. When the therapist move his consciousness into the client's world, he tries to apprehend, experience, witness and/or understand what the client is experiencing from moment to moment. Minimally this involves the therapist moving his consciousness to the locus and/or focus of the client's consciousness. That is, the therapist moves his consciousness to where the client is located, either in the image, or the discussion, or in relation to the music and attempts to experience the image, music, or discussion from that perspective; or the therapist focuses his consciousness on the whatever the client is attending in the image, the discussion, or the music, and attempts to attend to it in the same way. The therapist moves into and along with the client's consciousness.

Therapist's Personal World. When in one's own personal world, the therapist brings into awareness what he himself is experiencing, physically, emotionally, cognitively, spiritually, and so forth, both independently (apart from the client), and in response to the client. In this world, the therapist allows his attention to focus on what is happening in his own body, or what emotions he is feeling, or what memories are being aroused, and whence these reactions are coming from. Here the therapist is finely attuned to himself, his own private experiences, and his shared experiences with the client. As such, it is an intense way of being in the world of the self in the here-now of the client's moment-to-moment unfolding. In addition to having thoughts and feelings arising from within, the therapist becomes acutely aware of what the client is doing to him, or how the client is making him feel on a personal level.

The Therapist's World. When in the world of therapists, the therapist brings into awareness what is happening within the GIM process, and in the client-therapist relationship. This may involve thinking about what the client's imagery might mean, or sensing its effects on the client's body; or it may involve intuiting what music would be most appropriate or deciding what intervention to use. Or, the therapist may bring into awareness his relationship with the client, and its implications within the client's ongoing experience. Here the therapist is finely attuned to the therapeutic process, and how both client and therapist are contributing to or detracting from it. As such, it is a way of being in the client-therapist relationship, as facilitator for the therapeutic process. In the example above, when the therapist feels tension in his shoulders and had a memory of carrying his sister, in moving his consciousness to the therapist's world, he would be asking himself whether the client is developing a dependency transference on him, and whether he is unwittingly falling into that dynamic. He may also realize that he sees his client like his sister, and depending on his relationship with his sister, will have to manage his relationship with this client carefully.

Four Levels of Experiencing

The third proposition is that the therapist's experiences in these three worlds can be described at four levels: sensing, feeling, thinking, and intuiting. At the sensory level, the therapist uses his body to apprehend the experience physically, no further elaboration of or reflection upon the experience, other than simple description . . . For example, I see the client's body tension, I feel a knot in my stomach, I see his face reddening, I feel my hand on his shoulder, I hear the music getting louder" (p. 170).

At the feeling level, the therapist experiences affectively, bringing into awareness feelings and emotions being aroused. Here the body sensations are elaborated until the feeling or emotion is recognized with some degree of clarity. Thus, the client's body tension feels like fear rather than anger, or the knot in the therapist's stomach feels like frustration rather than anxiety.

At the thinking level, the therapist attempts to make meaning out of the sensory and affective levels of experience, going beyond simple description and elaboration, and analyzing the experience more cognitively. This requires stepping out of the experience, observing oneself, and reflecting upon the nature of the experience in order to find possible meanings or explanations. Thus, the client's body tension feels like a fear that relates to his relationship with his father; the knot in the therapist's stomach feels like frustration that relates to his own ideas about what the client should be doing.

At the intuitive level, the therapist goes beyond the data, moving beyond the sensory, feeling, and thinking level, but yet integrating them into a new understanding that is unverifiable. This understanding is a spontaneous "inner knowing" that is based on the data available, but not directly tied to it in any logical fashion.

> To summarize: the sensory level involves spontaneous description of immediate physical experience with no elaboration of it; the affective level involves spontaneous elaboration of immediate physical experience within the affective domain; the reflective live involves self-observation and elaboration of sensory and affective experiences within the cognitive domain; and the intuitive level involves spontaneous integration of sensory, affective, and reflective responses" (p. 171–172).

Relationship Parameters

As the therapist moves between these three worlds, experiencing the client and self in sensory, affective, cognitive, and intuitive ways, various kinds of relationships are formed among the therapist, client, music, and imagery.

The Client's World. When entering the client's world, the therapist has several options with regard to how empathic or distant he will or can be with the client. Theoretically, five positions (loci) can be taken by the therapist within the client's world. When "fusing" with the client, the therapist is experiencing what the client is experiencing—entraining to the client's body rhythms, being in the same body positions, feeling the same sensations, going through the same emotions, thinking the same things, being in the same images, reacting to music in the same way, and so forth. When the therapist fuses with the client, he is in deep empathy, and in direct rapport with the client.

Ideally, in this position, moving toward the client is the same as moving toward the self in that the therapist neither loses his own boundaries, nor has to adapt significantly to be with the client. Thus, the therapist and client are fused but maintain separateness. The danger of this position is that the therapist can lose his own boundaries in relation to the client.

When "accommodating the client," the therapist enters the client's world and has to adapt his own boundaries and structures to be in empathy with the client. The therapist experiences what the client is experiencing, but because of differences between them, the therapist has to move away from or against his own self, to accommodate how and what the client is experiencing. Here the therapist moves toward the client, but away from or against the self. The therapist experiences the client's anger, but the client's way of experiencing anger is not innate to the therapist. This position takes more effort.

When "assimilating" the client's experience, the therapist incorporates what the client is experiencing into his own boundaries and structures. To experience the client, the therapist moves toward the self, to be closer to the client in his own way. Here the therapist recognizes the client's experience as similar to his own, and then uses his own experience to understand the client's. For example, the therapist experiences the client's anger in the therapist's own way, because he experiences it the same way the client does. When assimilating, the therapist has to be careful not to distort the client's experience to fit his own.

When "differentiating" from the client's experience, the therapist enters the client's world but distances himself in some way from what the client is experiencing. Here the therapist maintains his own identity, boundaries, and structures while still "living in" the client's world, and in doing so recognizes that the client's experience is quite different from his own. For example, the client is experiencing anger, while the therapist witnesses it, but does not identify with it, or experience it.

When "objectifying" oneself in the client's world, the therapist serves as an object, target, or receiver for the client's actions, images, or feelings. Here the client is acting or impinging upon the therapist, and the therapist experiences being on the other end of the client's intent or effort. When the client interacts with the therapist based on qualities or actions of the therapist (rather than significant others in the client's life), the interaction or relation is an authentic one; however, when the client projects qualities or actions onto the therapist that actually belong to significant persons in the client's past or present life, and not the therapist, the interaction or relation is a transference. In a transference, then, the client projects qualities and actions of others onto the therapist, and then relates to the therapist as if he were the other person.

The Therapist's Personal World. When moving into one's own personal world, the therapist is attending to his own ongoing self-experiences—body sensations, emotions, thoughts, and so forth. Sometimes these experiences are in direct response to the client or the client's images, and sometimes they are stimulated by the music or emanate from within the therapist's self.

These self-experiences provide valuable material for recognizing transference reactions from the client. When the therapist is in his own personal world, it is easier to recognize if the client is relating to him authentically (based on who the therapist really is), or within a transference relationship (when the client is treating the therapist like a significant other). Thus, moving into one's personal world helps the therapist to question

what he is experiencing, and whether that experience belongs to him, or is being projected onto him by the client. For example, if a therapist feels as if the client is depending upon him too much, the question arises whether the client is reliving a dependency relationship with another person or whether the client is actually depending on the therapist because the therapist has invited this dependence.

This naturally leads to an examination of countertransference. Being in one's personal world is the mode of consciousness where the therapist can identify countertransference. In a countertransference, the therapist replicates with the client a previous relationship in either the client's life or the therapist's life. For example, if a therapist feels tension in his shoulders, and upon observing the client, realizes that the client has the same tension when speaking about a significant person, an empathic countertransference has occurred. The therapist is fusing with the client's experience. If on the other hand, the therapist realizes that a character in the client's imagery has tension in the shoulder, then, a complementary countertransference has occurred. The client is making the imaginary person and the therapist both feel this tension. Another scenario is if the therapist suddenly recalls that this is the same tension he had when he used to carry his baby sister around. Gaining further insight into these countertransference reactions usually requires the therapist to move into the world of the therapist.

The Therapist's World. When moving into the world of the therapist, the therapist takes a larger view of what is happening in the relationships between client, music, entities in the imagery, and therapist. Thus, it is here that the therapist analyzes details of the transference and countertransference interactions among and between all the components. It is also in the therapist's world, that client and therapist form the "working alliance" where both parties work as equals to benefit the client's life.

Media of Transportation

The act of moving one's consciousness in GIM is relatively easy, as there are several media that can be used. The main ones are altered states of consciousness, music, imagery, physical interactions, and verbal interactions. Altered states of consciousness, by definition, provide a space for exploring the various areas and layers of consciousness. Thus, during a session, the therapist can go into and out of altered states of consciousness in order to move from one world to another (client, personal, therapist), and from one level of experience to another (sensing, feeling, thinking, intuiting).

In addition, like the client, the therapist is subject to the altering effects of the music and the client's imagery. The music provides a transitional or intermediary space shared by both the client and therapist. It is within this space that client and therapist interact with their respective imaginations. Thus, music provides a bridge between the client's world and the therapist's worlds, and from one level of experiencing to another. At the same time, the client's imagery provides a transitional or intermediary object. "That is, it provides the occasion, container, and medium for multifaceted interactions between client and therapist" (p. 183).

Physical interventions can also help to move the therapist from one world to another. Such interventions "include the subtler forms of eye contact and body language, as well as more direct forms, such as touching and holding" (p. 183–184). Verbal

interventions, including the actual words as well as the tone of voice, phrasing, and rhythm, also serve to connect the therapist and client's worlds.

Implications for Therapist

In order to move one's consciousness to address the ongoing demands of the client and therapeutic process, the therapist must have both fluidity and timing. Fluidity in this context is free access to the various worlds, levels of experience, and media. "Within understandable limits of personal and professional boundaries, he should have no major problems or limitations in moving—at will—anywhere within the worlds, levels, and media" (p. 191). The therapist cannot get stuck in one world, and not be able to move to another, using any of the media; nor can the therapist be limited to only one level of experience. To have fluidity, also requires maintaining boundaries. "A therapist who works in this way needs to have clearly defined yet flexible and permeable boundaries, both as a person and therapist. At one moment, the therapist may need to maintain clear physical and affective boundaries in his interactions with the client, and at another, he may need to allow these boundaries to dissipate" (p. 196).

"Closely related to free access is timing. A therapist has to move not only wherever the situation demands but also *whenever* it [so demands]" (p. 191). Thus, the true skill of being a GIM therapist is knowing when to move from one world to another, or from one level of experience, while also knowing when to use each media of transportation. Helpful cues are the client's rhythms, the music, and one's own body. Most importantly, a therapist learns where, when, and how to move his consciousness through experience. "Thus, it is the very process or expanding, centering, and shifting consciousness that informs the therapist whether is in the right place at the right time" (p. 192).

Another essential quality is "the ability to go beyond either-or polarities. The whole idea of expanding consciousness is that I do not have to be either here or there but can transcend that distinction" (p. 196). This enables the therapist to manage challenges to his boundaries while also staying open to whatever needs emerge in the moment.

Given the emphasis this theory gives to consciousness, and the art of using one's consciousness and imagination creatively in tandem with the art of music, the role of the BMGIM therapist can be summarized as "an artist of consciousness who uses his creativity and the creative process to 'be there' for the client, with the music as the primary co-therapist" (p. 196).

Gender Orientation

Recognizing that his theory was based on a male therapist working with a male client, and that the nature of moving one's consciousness may be more male than "holding" or "containing" the therapeutic space as espoused by female theorists in music therapy, the author proposes the need for therapists to be aware of their own gender theories and biases. Gender is an important consideration in all forms of psychotherapy for three reasons: 1) Therapists have to acknowledge the unavoidable biases that their gender brings to their ways of working with clients; 2) Therapists need to understand when or under what conditions their client needs to work with male and/or female therapists; 3)

Therapists often have to function from the opposite gender's point of view; thus, male therapists must have free access to their feminine sides, and female therapists to their masculine sides.

The Nature of Transpersonal Experiences

Work at the transpersonal level grows out of three elements of BMGIM: expanded states of consciousness, imagery, and music. Transpersonal work occurs when one's consciousness expands from being conscious of something (e.g., image, music) to an all-inclusive conscious; or when one's consciousness expands from having a particular locus and focus to occupying consciousness fully, with no need for the limitations of locus and focus. The consciousness expands to its fullest potential , a state which has been called pure consciousness. Transpersonal work occurs when the person surpasses the limits of one's imagination, moving from dichotomies of potentiality and limitation, to only potentialities and all existing alternatives.

This is unfinished.

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