

**SPECIAL ISSUE**

Guided Imagery and Music: Contemporary European perspectives and developments

Article

Guided Imagery and Music (GIM): Reflections on supervision in training and therapy

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ABSTRACT

Supervision is one of the scientifically neglected fields in music therapy and in GIM. One of the reasons for this is the different usage of the term in different countries. Clear definitions of supervision are needed. The author differentiates between supervision for training and job-related issues and reflects on a supervisor's qualifications and competencies. Is an experienced GIM therapist sufficiently qualified as a supervisor or is a double qualification needed to be GIM therapist *and* professional supervisor? In order to give an orienting with a heuristic to be used by GIM supervisors the author refers to a multiperspective and metahermeneutic concept. Political, social, cultural, theoretical, ethical and practical dimensions are taken into consideration. An example of a supervision process is given in the form of a hermeneutic spiral including different states of consciousness and reflexivity. An example heuristic could contribute to developing a broader understanding of supervision and its goals and contents.

KEYWORDS

definitions and functions of supervision; models of consciousness, states of reflexivity, hermeneutic spiral, metahermeneutic approach, supervisor's qualifications

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INTRODUCTION¹

Guided Imagery and Music (GIM) is an integrative music psychotherapeutic method where the GIM

therapist uses classical music in order to help a client to explore different dimensions of consciousness and imagery (Bruscia & Grocke 2004; Summer 2002). As GIM – both the Bonny Method and Music and Imagery (MI) – can provide very deep and existentially important experiences which can pose a great challenge, supervision is of great importance for both therapist and client.

Much literature has been published since the 1970s on music therapy in general but, in

¹ This article is based on a paper presented at the author's workshop on supervision at the 12th GIM Conference 2017 in Athens, Greece and on former articles of the author (Frohne-Hagemann 1997, 1999b, 2001)

comparison, very little has been written about GIM, and extremely little has been published about supervision in GIM.

Most of the articles about GIM supervision concentrate more or less on training issues. This, of course, is understandable, as training comes first and students have to learn the basic techniques of how to guide GIM sessions. They have to learn, for example, how to structure a prelude², find a focus and an adequate music programme for a certain client, the kind of helpful induction, the adequate guiding interventions while the client is listening to the music. Also, guides have to learn how to understand the 'message' of a mandala³ and how to handle the postlude⁴. This kind of supervision, however, does not include aspects that become important once a GIM therapist works in different psychosocial and clinical fields. A supervisor has to take in many perspectives and views in order to realise and understand, e.g., the clinical conditions for the GIM therapist, psychosocial circumstances and their impact on the supervisee's work and relationship with their clients.

Unfortunately supervision is defined and interpreted differently in different countries. The reason for this is historically based. Therefore it is essential to know the definitions which are used.

DEFINITIONS OF SUPERVISION

What is supervision? Historically the concept of supervision has developed from a controlling function to the request of quality assurance. Strobelt and Petzold (2010: 7ff) have researched supervision from the medieval times until the 17th century, and found that the concept "supervision" was based on *power and control*. Churches, prisons and the feudalistic bureaucracy controlled people's religious, moral and dutiful attitudes. It was only in 1870 that supervision started to be applied in social casework and social welfare, and served as training, education and assessment of work and motivation. Between 1900 and 1960, a "psychologicalisation" took place. Pedagogically oriented psychotherapy and psychiatric social work were related to the Freudian psychoanalysis. From 1920, *psychoanalytical supervision* (casework, control analysis) was integrated as a method into

² Preliminary talk.

³ A mandala is a painted resonance to the GIM journey. It is called mandala, because a centering circle is presaged on the sheet.

⁴ Post-talk.

postgraduate trainings of social workers and psychotherapists. Between 1960 and 1970 a "sociologicalisation" took place, and the sociological results from research were integrated into the subject area. Since then many forms have been developed for sociological issues, e.g. collegial counseling and team supervision. Supervision began to develop more democratic procedures.

Today supervision is found in many fields: in institutions and organisations as coaching (e.g. of managers), in social work, in psychotherapy and in therapy trainings.

FUNCTIONS OF SUPERVISION

In all of these different fields, supervisors work with diverse methods, intentions and goals. According to Alfred Kadushin (Kadushin 1992), supervision is always comprised of three functions in social work. However, from the author's point of view these functions should be considered in clinical and training settings as well.

Educative function

This function serves "to dispel ignorance and upgrade skill. The classic process involved with this task is to encourage reflection on and exploration of the work" (Kadushin 1992: 20). The goal is:

"to understand the client better; become more aware of their own reactions and responses to the client; understand the dynamics of how they and their client are interacting; look at how they intervened and the consequences of their interventions" (Kadushin 1992: 20).

Administrative function

Kadushin states that "the primary problem is concerned with the correct, effective and appropriate implementation of agency policies and procedures. The primary goal is to ensure adherence to policy and procedure" (Kadushin 1992: 20). For example, GIM supervisees need to be aware of their role and status in the hierarchy of a clinic or other institution. They have to follow the rules not only in regard to hours, documentation etc., but also in regard to therapeutic contents and goals. Problems may arise: for example, if the therapeutic orientation of the employing hospital is not compatible with the GIM therapist's orientation.

Supportive function

The supervisor seeks to prevent the development of potentially stressful situations, removes the worker from stress, reduces stress impinging on the worker, and helps her adjust to stress. The supervisor is available and approachable, communicates confidence in the worker, provides perspective, excuses failure when appropriate, sanctions and shares responsibility for different decisions, provides opportunities for independent functioning and for probable success in task achievement. (Kadushin 1992: 292)

Supervision has to take care of both a GIM trainee and a GIM therapist's mental hygiene to prevent burn-outs.

DEFINITIONS OF SUPERVISION IN GIM

The Cambridge English Dictionary defines supervision⁵ as "the act of watching a person or activity and making certain that everything is done correctly, safely". This definition implies that the supervisor's task is to control, to teach and to take care that things are done in the proper way they should be done. Kia Mårtensson-Blom suggests that the Swedish definition of "handledning" (leading by the hand) suggests a *mother-child relationship* between supervisor and supervisee (Mårtensson-Blom 2003/2004: 98). This concept corresponds with the English definition of a supervisor as an expert teaching the supervisee how things have to function. *Supervision* here implies a hierarchic setting. A supervisor who is part of an institution or an organisation with a mandate to train supervisees in special aspects certainly has an educative (and partly administrative) function and the responsibility to facilitate improvement in certain areas.

Compared to this definition, Mårtensson-Blom describes the Norwegian definition of supervision as "vejledning" (leading the way,) which she links to the Guiding Technique in GIM (Mårtensson-Blom 2003/2004). Here the function of the supervisor seems to be something like a guidepost who points to something that has to be worked on and reflected but who does not push the supervisee into a certain truth. As a German supervisor, the author defines supervision as a *widespread overview* on therapeutic situations and processes (Frohne-

Hagemann 2001) and the supervisee is regarded as a partner with whom one discovers the structures behind the reported phenomena.

These definitions imply different attitudes towards supervision. The required attitude always depends on the context and the conditions: students often need concrete instructions in order to develop musical and therapeutic skills, whereas therapists working in praxis would focus on clinical and sociocultural issues.

SUPERVISION FOR GIM THERAPISTS-TO-BE

Training

In the GIM literature supervision is predominantly understood as a training tool immanent in the GIM method. Madelaine Ventre (2001) argues that "GIM supervision serves the purpose of connecting theory and practice; identifying small mistakes and large problems in clinical work, alleviating stress and anxiety that can accompany clinical insecurity; providing a fresh, objective alternative to clinical decisions and styles; establishing a solid clinical support system and encouraging and acknowledging good work" (Ventre 2001: 348). In the basic and advanced GIM training levels, supervision should increasingly differentiate and deepen the supervisee's professional identity, skills and competences (including empathy and self-care). Supervision of GIM therapists-to-be (student supervisees) would aim to help them to reflect on different situations and on the specific needs of clinical and social client groups, to find a focus which is relevant to the underlying needs/structure/schemata of a client, to be able to state the reasons for choosing a certain GIM programme from the Bonny Method (modified GIM or Music and Imagery [MI]), and last but not least, to explain the choice of music which lies between the spectrum of supportive and challenging music. Trainees need to reflect on the adequate modes of induction, special guiding interventions and their competence in evaluating the client's imagery, metaphors, narratives, archetypes, myths, symbols and mandalas in the reflection.

To reach these goals, Ventre (2001) and Brooks (2002b) have outlined different techniques; for example, onsite supervision, live observations, the

⁵ <http://dictionary.cambridge.org/dictionary/english/supervision>

use of videos and transcripts within supervision, individual consultations, theme-oriented group supervision, and supervision conferences. Other techniques were added; Exner, for example, applied onsite supervision in the *Reflecting Team* (Andersen 1990) by integrating systemic concepts and methods into GIM supervision (Exner 2014). The Onsite Supervision Reflective Team (OSS-RT) was also implemented as part of the author's GIM training course.

Supervision for GIM therapists and other professionals

Supervision as a tool can be used in a training context, but also with GIM professionals. Bruscia introduced the technique of "re-imaging" (Bruscia 1998: 549) to explore transference and countertransference in GIM and to uncover projective identification. Grocke presents a case where the supervisee re-imagined a therapy situation with a client using pieces of music (Grocke 2002). Other examples of GIM as supervision were presented by Trondalen in her new book (2016).

A single piece of music or whole GIM programmes (Mårtensson-Blom 2003/2004) or creative media (Nygaard Pedersen 2015) can also be used as a supervision tool for therapists or social workers. This kind of supervision can have supportive functions and intentions, e.g. GIM as a supervision tool for self-care.

Mårtensson-Blom who, like Grocke, is a professional supervisor, introduced GIM as a supervision tool for the self-care of social workers who had to cope with difficult emotional situations in the families they worked with. She regards GIM as a tool to help people enrich their personal competencies and self-development (promoting intuition, empathy, etc.). In this respect, GIM is a *supervision tool* with the capacity to help to transcend a merely cognitive level of understanding and interpreting complicated situations and processes and to use creative inner strategies in order to enhance the ability to bear difficult emotions, develop relational knowing, empathy and so on. Its function is to give support, prevent burnouts and promote empowerment and motivation (Mårtensson-Blom 2003/2004).

However, supervision cannot replace therapy, and personal problems (including personal problems caused by administrative rules and hierarchic structures in the public health system), should be focused on only in so far as they have a negative effect on the therapeutic work.

THE SUPERVISOR'S QUALIFICATION

The qualification of a supervisor in a training context

In 2001, Ventre suggested that supervisors should have conducted a minimum of 150 GIM sessions after having completed their GIM training, and that they should attend supervision meetings. She thought that this would enable the supervisor to supervise the clinical work and to allow "the student to forge the critical link between theory and practice and to clarify professional and personal issues" (Ventre 2001: 342). Ventre did not require the supervisor to have clinical experience in a hospital (including knowledge about the administrative functions) or awareness of developments in the public health system. Former and present national and international developments as well as the influences of globalisation have a strong psychological, sociological, political, theoretical and practical impact on our personal, social and professional existence and the "science" of GIM. Therefore Ventre's recommendations could require updating.

The qualification of a supervisor in a job-related context

To supervise GIM therapists working in clinical settings and/or to supervise the application of GIM (and MI) as a supervision tool for therapists or social workers in psychosocial contexts needs a deeper discussion about a supervisor's qualification. Is an experienced GIM therapist sufficiently qualified as supervisor or should he/she have a double qualification as GIM therapists and professional supervisors in order to match the supportive, educative and administrative functions of supervision? On the other hand, is a professional supervisor (who is not a GIM (or music) therapist) sufficiently qualified to supervise GIM relevant issues of the supervisee's work? Probably not. But this is not the topic here. The question is: What do GIM trainees and GIM therapists need in supervision apart from special knowledge about, and reflection on, the use of music?

Further qualifications

GIM students and GIM therapists probably agree that their supervisors should be competent in their profession. Desirably they should have experience

in teaching their profession and sharing their knowledge and experience with colleagues. But, as Johan Lansen and Ton Haans point out:

“A profound experience of one's profession is a good basis to become a supervisor. However, this is not sufficient. One does not become a good supervisor by being an expert in one's profession. One needs extra equipment by learning how to do supervision” (Haans et al. 2007: 2). “People used to think that any senior professional would be a good candidate for giving supervision. It is not. There are many good senior professionals who are bad supervisors, and there are good supervisors who are only average in their professional performance. Supervision is an additional trade or craft, which has to be learned.” (Haans et al. 2007: 2)

It is not only important that the supervisor can lead the supervisee by the hand by giving instructions on how to guide a client or choose the right music. It is important to be able to oversee the trainee's ability to handle spiritual and transpersonal issues and psychodynamic processes, e.g. the therapeutic relationship of client-supervisee, the supervisory relationship (supervisee-supervisor), the content of the supervision session and the parallel processes (which reveals the re-enacting of the client-therapist-relation into the supervisee-supervisor-relationship and/or the supervisor-training institute-relationship).

However, in addition, a supervisor should help the supervisee to reflect on his/her person-centred view in relation to the political, social and theoretical conditions that influence situations and processes. If, for example, spiritual and transpersonal issues are themes in supervision, discourses about implicit belief systems should be included. Sometimes belief systems might not be compatible with psychotherapeutic concepts and can lead to misunderstandings and frustrations in supervision (Schreyögg 1988, 2016).

Nowadays more and more GIM modifications, adaptations and other methods using music and imagery (MI) are applied in individual and group therapies (Frohne-Hagemann 2014; Grocke & Moe 2014). There are several reasons, for example patients in hospitals are too ill and/or will not stay long enough to be able to profit from GIM (Bonny Method), or clients expect quick results of therapy, rather want to “consume” and to avoid longer processes of emotional working through. This means that supervisors need to be competent in supervising their supervisees in relation to the clinical organisational circumstances and what that

means in regard to indications and emotional working.

From what has been said until this point it becomes obvious that we need further discussions on the training requirements of a supervisor. An experienced GIM therapist might possess field competence in private practice or in his/her work at a hospital. But how much is he or she informed about research and reference theories, knowledge of organisational issues, political developments in public health systems and administrative hierarchical structures in different social fields? And to what extent is an updated expertise important for supervision of GIM processes? Further discourse is needed.

An orienting heuristic for supervisors

Mainly due to financial reasons it may be unrealistic to complete a full professional supervision training course for GIM therapists working as supervisors. But it would certainly be helpful to establish an orienting *heuristic* for supervisors, taking in “*multiperspective*” and “*metahermeneutic views*” (Petzold 1993, 1995, 1998, 2017). Awareness is needed not only of training, clinical and job-related issues but also of political and social developments and their impact on psychological disturbances. Disturbances do not only have their origins in one's childhood but may also come as the result of cultural and global developments that overstrain our ability to mentalise experiences.

GIM is not only a dyadic person-oriented therapy with personal psychodynamic and transpersonal issues. A person is not a monad, but always a part of a bio-psycho-ecological-cultural system. The client's imagery also reflects anxieties concerning the uncertain future of this planet, terror, war, new authoritarian (e.g. religious-fundamentalist or nationalistic) structures, ecological blindness to the destruction of nature, or the loss of orientation and existential meaning. These developments can overshadow or re-traumatise negative experiences made in childhood, and also affect healthy people who then become reliant on inadequate ways of coping, (i.e. spiritual pathology, internet addiction, criminal energies, etc.). The present global developments affect more than the client's GIM journeys or MI imagery – they also affect the therapist. Not only the supervisee, but the supervisor as well should ask himself how much he is affected by these developments and how much they influence his role as supervisor.

Both supervisor and supervisee need to use different interpretation foils that not only focus on a GIM client's inner psychic world and the therapeutic relationship, but also on the political and social conditions and cultural developments. Supervisors need to take *external, "eccentric positions"* (Plessner 1928/1975) and multiperspective and metahermeneutic views.

In the 1990s the author described Petzold's concept of *multiperspective and metahermeneutic supervision* (Petzold 1998) in relation to *Active Music Therapy Supervision* (Frohne-Hagemann 1997, 1999b, 2001). As it is also useful for GIM this model will briefly be described again here.

Multiperspective and metahermeneutic views in supervision

According to Petzold's concepts there are different perspectives to consider, e.g. a "phenomenological perspective", a "hermeneutic perspective" and a "valuating perspective", which mirror shared mental representations of our views of the world, of our life and of our belief systems. However, as they represent the views of diverse and different collectives, groups, subgroups and individuals and their concepts this can cause misinterpretations concerning therapy processes, situations and personal motivations, emotional coping styles and behaviour, and therefore need to be reflected upon and questioned. These limitations taken into consideration the named perspectives can reveal important issues.

The phenomenological perspective focuses on the phenomena in their complex context, including nonverbal *and* verbal techniques (atmospherically, kinaesthetically, scenically, verbal, nonverbal). Supervision techniques (such as improvisation, movement, painting, creative writing, music-listening and body-listening) can be used in order to come from the phenomena to the structures. The "*hermeneutic perspective*" interprets the phenomena in relation to the underlying structures. Here supervision groups, intervision/peer groups, or a Reflective Team Supervision Group will be very helpful because of the supervisees' variety of clinical and social experiences. The "*valuating perspective*" focuses on the *reflection and the reflection on the reflections*. The categories of assessments are reflected on, as well as concepts and interpretations regarding goals and situations and processes. Within these perspectives the supervisor has to consider different dimensions

such as political, theoretical, ethical and practical issues.

Political, theoretical, ethical and practical dimensions of supervision

As Moser and Petzold (2007) pointed out, these dimensions focus not only on conditions, influences and structures underlying the supervisee and his client's therapeutic work but also the supervisor's assumptions.

Reflections on the *political* conditions, influences and structures relate to actual social and global developments and to the situation of the public health service. For example, is a GIM therapist legally allowed to treat patients? If GIM is regarded as psychotherapy, the therapist - at least in Germany - has to have the authorisation of the state to work psychotherapeutically; otherwise GIM cannot legally be offered to mentally ill or disturbed patients. Registered psychotherapists are not allowed to offer GIM as a spiritual method for healing. What are the consequences for GIM therapists (and GIM supervisors) who understand their work as a spiritual healing process?

How does the current political situation influence the supervisee's relationship with the client? Who pays for the supervisee's supervisions (e.g. the hospital)? Who pays for the GIM therapy (e.g. the client or the hospital)? In other words, supervision has to consider the supervisee and his client not as private bodies but as social bodies in social realities. Many problems that a supervisee reports have to do with the issues mentioned above. To consider and discuss these aspects can prevent feelings of personal incompetence and help to mobilise resources.

Theoretical reflection is extremely important. It includes ethical issues. The therapist/supervisee's *power of knowledge* can consciously and unconsciously be used in a *manipulating way*. Therapists have a great sphere of influence and should be aware of it. Supervision must include a reflection on the *supervisee's "philosophies"*, on their anthropological and clinical concepts about health and illness, on concepts of personality and psychological development and the therapeutic concepts that relate to the supervisee's power of knowledge. And furthermore what are the concepts of music, music therapy and GIM the supervisee relates to?

On the other hand, what are the *supervisor's "philosophies"* and concepts? Is the supervisor's

psychotherapy background a psychodynamic one, or a systemic, humanistic, behavioural, transpersonal, or shamanic one? And most importantly, are the supervisee, the client and the supervisor's philosophies and concepts compatible with each other? If not, both might be confronted with severe attribution-bias problems.

A GIM therapist (the supervisee) should, of course, know when GIM is indicated and when GIM is contraindicated. This very idea touches a fundamental theoretical question: *is GIM – the Bonny Method – regarded as a psychotherapeutic tool or technique within a therapeutic process or is GIM a self-contained method?* Music and Imagery methods (MI) can be regarded as special interventions within psychotherapy, but in the case of the Bonny Method this is not so clear. This issue has repercussions for the acknowledgment of GIM within the public health system.

Ethical reflection is connected to *theoretical* issues as well. The supervisor must be aware of his/her basic ethical attitudes in regard to the danger of abusing his/her powers of knowledge. This could happen if the supervisor imposed theoretical concepts on the supervisee which are incompatible with the supervisee's theoretical background (e.g. systemic theories versus esoteric belief systems). Misinterpretations of the supervisee's and the client's motivations, intentions, emotional styles, needs and behaviour can be the result. Thus, both, supervisor and supervisee need to know about each other's reference theories. For example, gender specific views have to be considered. What are the implications, if the GIM client is a woman who was raped in her youth, her GIM therapist is a man and his supervisor is also a man? Or if her therapist is a woman and the supervisor is a man? What are the supervisor's ethical values with regards to difficult ethical situations? For example, how does the supervisee cope with a client's intention to leave his partner who is suffering from paraplegia after a car accident and needs care? A supervisor's ethical attitude commits them to taking an *open, agnostic position* instead of a judging "know-it-all" attitude. If this is not possible the supervisor is emotionally too much involved and loses his/her competence to supervise.

Ethical reflection includes *cultural issues* as well: prejudices and misunderstanding are quite common, and mostly unconscious, because of a lack of cultural sensitivity, different communication styles and different worldviews. Prejudices and misunderstandings mostly are caused by different

learning styles, emotional styles, traditions of behaviour, coping strategies, scientific concepts, worldviews, belief systems, traditions and norms that have in form of embodied interactional experiences been interiorised and form the mental representations (Vygotskij, cited in Petzold 2016). They produce multifaceted barriers in communication (Daniels et al. 1999). To give an example, one of the author's supervisees reported that a female Japanese client resisted expressing her feelings during her GIM journeys. She diagnosed the client's illness as alexithymia. However, the supervisee had not realised that the client was much older than herself, and that according to Japanese culture she outranked the younger therapist. She did not know that it is considered an affront to ask an older person intimate things. The client was not suffering from alexithymia, but from the therapist's – in her opinion – disrespectful and impolite attempts to try to "examine" her emotions. This lack of cultural sensitivity (or knowledge about other cultural norms and traditions) is based on the human predisposition for correspondence bias caused by *attribution errors* (Hewstone 1990). It happens when a person does not take into account other factors contributing to a person's behaviour than the seemingly obvious. Supervision therefore is necessary in order to discover, negotiate and transcend the barriers in communication.

Practical reflection is based on information about both the supervisor and the supervisee's roles: is the supervisor a counsellor, a coach, a teacher, a preventer of burnout for GIM students, patients and teams? Is the supervisor self-employed or employed? If self-employed, who pays for the therapy? If employed, what are the psychotherapeutic traditions, cultures and medical treatment concepts in the hospital? Furthermore, what status do supervisees have? Are supervisees working in their own offices or in group practices? If supervisees work in an institution or for an organisation how do they cope with the hierarchical structures? How much are the supervisees acknowledged and paid for their work? With whom do they work (adults, children)? How long do the patients stay, on average?

All these different dimensions concerning culture, society, one's social worlds, personal and collective history, personal values, belief systems and concepts represent the *highly complex nature of the different realities we live in* and supervisors should of course try to *reduce complexity*. To be informed and educated in many ways, be able to

adopt research findings, and be able to *reflect on the reflections* would enrich the process of the first *actional reflection* (to be described later) in order to find all the interventions and techniques that could be helpful for the supervisee to support, challenge, confront and change his client's mental representations of reality (situations) and models of reality (systems).

CONSCIOUSNESS AND THE HERMENEUTIC SPIRAL

GIM therapists are used to guiding clients into altered states of consciousness and helping them find meaning in their imagery. They use different concepts of consciousness: e.g. Helen Bonny's *Cut-Log-Model* (Bonny 1978: 6), Frances Goldberg's *Holistic Field Theory Model* (2002), Martin Lawes' model of levels of consciousness (2012/2013), or Hilarion Petzold's model of *Complex Consciousness* (Petzold 1993/2003; Frohne-Hagemann 2007).

The author's interpretation foils in supervision refer to Petzold's concepts of *Complex Consciousness* and *Reflexivity* (Petzold 2003) and the *Hermeneutic Spiral* (Petzold 1993) and are very useful for supervision.

Petzold's model, used in Integrative Therapy, relates to the different states of consciousness and, in addition, includes the *states of reflexivity* which we need in supervision in order to discover the conditions, influences and structures of the phenomena. For that reason, the model is presented here in a shortened form.

The spectrum of Consciousness contains gliding transitions between the realms of the Un-Consciousness, the Pre-Consciousness, the Co-Consciousness, Awareness, Ego-Consciousness, Hyper-Consciousness and the No-Consciousness. The *darkest* area, on the left side of the graphic, is the *Un-Consciousness*. Merleau-Ponty (1968) called it *l'être brut* (the rough being). The Unconscious includes the neurobiologically embodied collective memory of mankind's biopsychosocial and cultural worlds, waiting – silent and voiceless – for interaction and words. Meaning unfolds in the form of bottom-up processes from the depths of the "archive of the body" (Petzold 1993: 290). From the lighter area, meaning gradually unfolds through top-down processes through different states of reflexivity. The *lightest* area, at the right, symbolises the *No-Consciousness* which Merleau-Ponty called *le néant absolu* (the absolute nothing), and which Jungian-oriented GIM

therapists would connect to the transpersonal or transcendent dimension. It is also silent and nothing can be said about it.

Awareness emerges from the *Un-Consciousness*, the *Pre-Consciousness* and the *Co-Consciousness* in different *states of reflexivity*. Music and other creative media can activate material from the embodied collective memory to reach the pre-reflexive and co-reflexive stages of the *Pre-Consciousness* and *Co-Consciousness*.

Insights emerge from there into *Awareness*, and can be reflected in the eccentric position of the *Ego-Consciousness*. The next reflection on the reflections should lead into the state of *Hyper-Consciousness*. The lightest state of the *No-Consciousness*, however, is not part of normal supervision, but sudden feelings of *quintessence* or *clairvoyance* can happen nearing a spiritual *trans-reflexive* insight.

What does this concept mean for supervision?

In order to get a sense of the supervisees and their clients' situations and processes we need to plunge into the Un-, Pre- and Co-Consciousness in order to become aware of hidden interiorised information. We first need to *seize*, to *sense* and *perceive the phenomena* using our *body as a "total sense organ"* (Merleau-Ponty 1966), just as we do with Helen Bonny's *Body Listening* (Bonny 1993) in order to experience the essence of the music. Music which is associated with a supervisee's report and problem (or which is even improvised) can play an important role by evoking *emerging corporal arousals, moods and atmospheres, associations, memories, metaphors and feelings* (see also Bonde 2013). Here cognition and reflexivity are of secondary importance.

Only when these sensed impressions form gestalt in our *Awareness* can we continue the process by taking an *eccentric position*. Here the ability is required to change between the cognitive and emotional/sensory perception: a rhythmical and oscillating process between polarities, especially between feeling and reflecting, empathy and distancing. This epistemological process has been described by the author as the *Rhythmical Principle* (Frohne 1981; Frohne-Hagemann 1999a). The rhythmical process of self-perception and perception of the other, of feeling and reflecting, develops in *spirals*, and each new insight or knowledge is the basis for a new spiral.

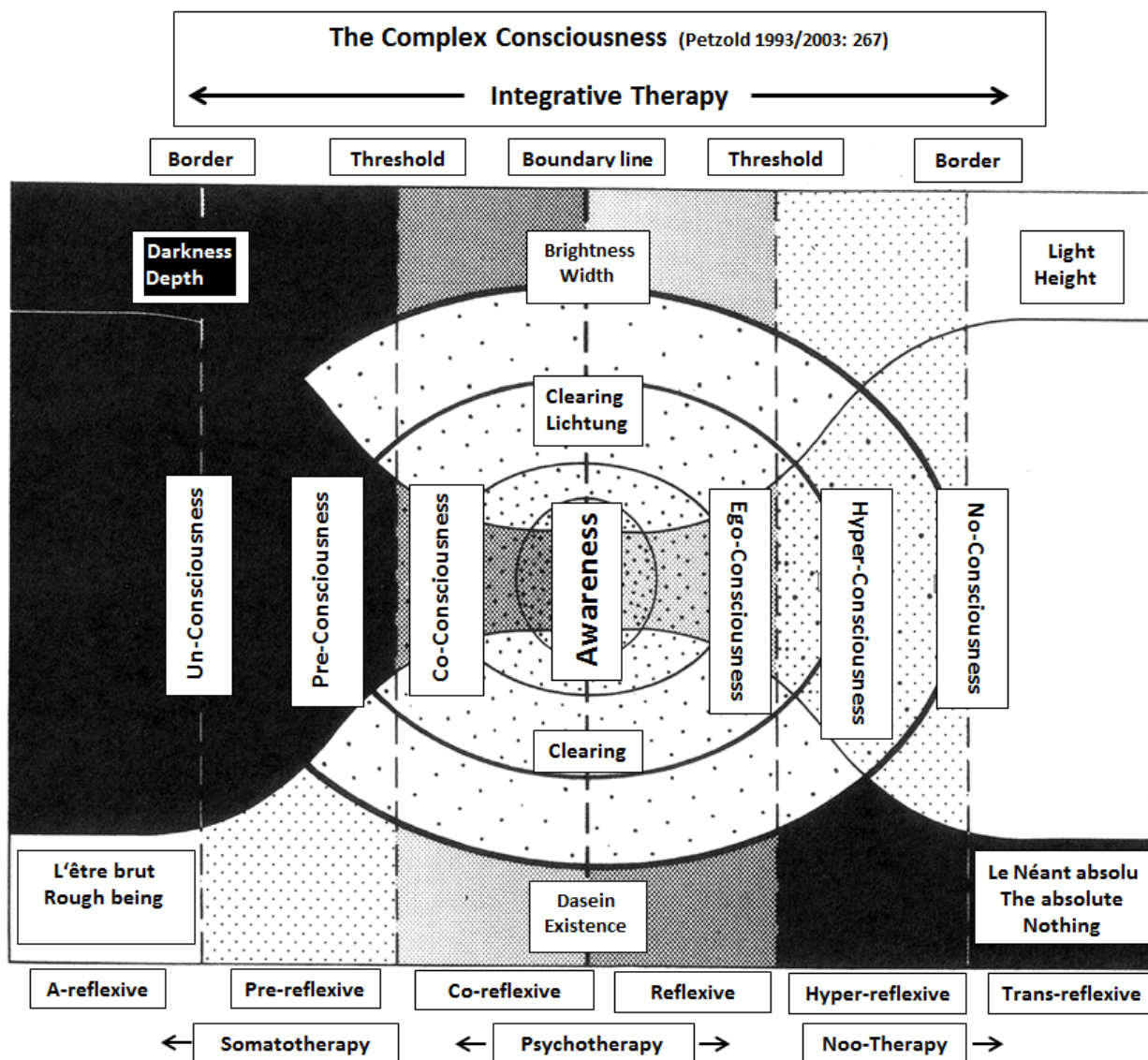


Figure 1: The complex consciousness and reflexivity (Petzold 1993/2003: 267, English translation of the figure by I. Frohne-Hagemann, confirmed by H. Petzold in 2017)

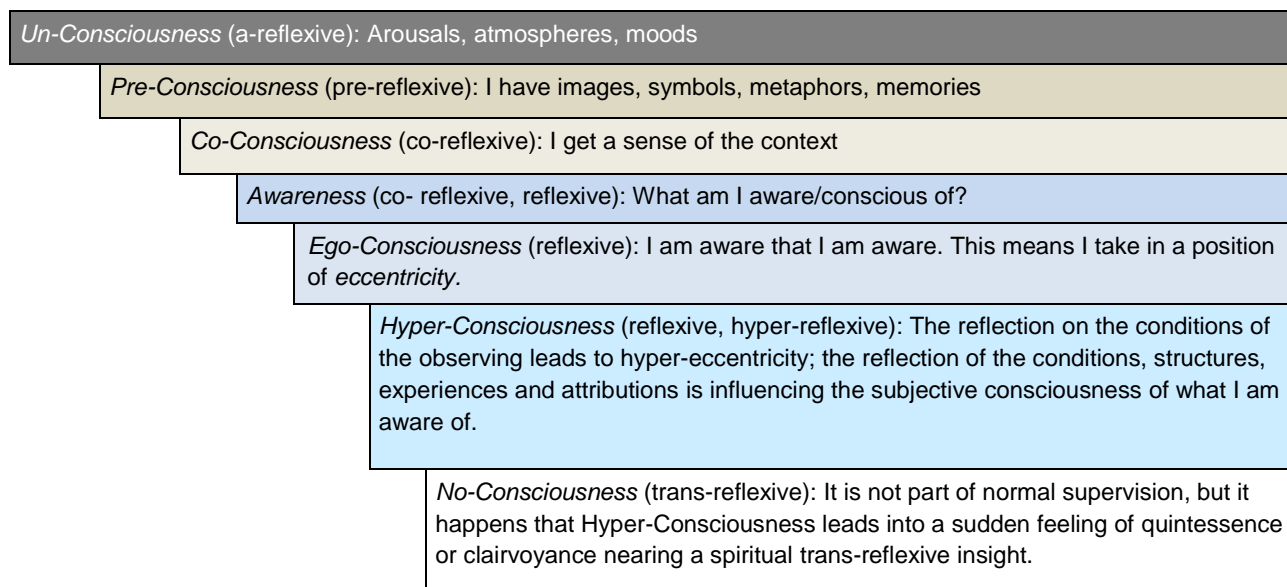


Figure 2: The states of reflexivity in consciousness

The supervision process of reflecting on the therapeutic work is a *hermeneutic spiral process*. The last step in a hermeneutic spiral is always the start of a next spiral of wider knowledge. This assumption is based on Ricœur's theory that any hermeneutic interpretation needs a deeper understanding. To follow a text from the surface to the underlying conditions and structures entails the challenge to take in new perspectives (Ricœur 1972; Welser 2005). Here the phenomenological perspective, the hermeneutic perspective, the valuating perspective and the actional perspective find their order.

In supervision a *Hermeneutic Spiral* (Frohne-Hagemann 1999c; Petzold 1993, 2008, 2015) includes four phases:

1. The phase of phenomenological perceiving and relating
2. The phase of working through, uncovering the structures and understanding
3. The phase of multiperspective reflection, including discourse analysis and deconstructions
4. The phase of integration and training⁶, with a metahermeneutic step into the next circle

AN EXAMPLE OF GIM SUPERVISION

There is a difference between supervising MI sessions and Bonny Method sessions. MI interventions concentrate on certain therapeutic themes, whereas interventions in the Bonny Method support exploring a traveller's imagery, which makes supervision more complex. It also makes a great difference whether there is an interactive dialogue between the client and the therapist or not. In order to give an example for the hermeneutic spiral as a heuristic the author will now describe the supervision of an MI session⁷ with regards to the importance of reflecting on implicit views.

The supervision example refers to a real case and was chosen because the described problems are typical and often occur in supervision. The

⁶ Training in the sense of a learning process

⁷ The setting is: sitting position, prelude, the therapist gives an induction focusing on a relevant intention (relaxation, body awareness, promotion of enjoyment, etc.), client listens to (mostly) one piece of music, no interactive dialogue, client can paint a mandala (a painting resonating one's experience) while listening or afterwards, postlude.

supervision takes place in a supervision group. The supervisor is a woman. "Thomas"⁸ is the supervisee. He works as a music therapist in a hospital. He is not paid very well. He had invested a lot of money into his training and he tries to apply MI and GIM whenever it is possible. The medical doctors are not familiar with GIM and sceptical as to whether the method is science-based and scientifically proven. Thomas has already spent much energy on explaining his work. Now he feels he has to prove quick, positive results with GIM. However, as most patients are too ill for longer GIM journeys, Thomas very often offers MI sessions.

Thomas describes a situation with his client "Mrs E.", who has been in hospital for four weeks due to depression. For him it is important to have impartiality when meeting a client, therefore he does not wish to have too much information regarding a client's pathology and anamnesis. He only knows that Mrs E. is 42 years old and grew up in the former German Democratic Republic (GDR). She is married, a housewife and has three children aged 23, 20 and 18 (the youngest suffering from drug addiction). Her husband is an alcoholic.

Mrs E. had so far had three MI sessions, of which the first two sessions were "OK", but the last session turned out to be problematic. Thomas had had the intention of offering her J.S. Bach's "Air on the G String"⁹ as a very supportive piece of music, in order to nurture her. The opposite had happened: Mrs E. had no positive images at all. Thomas showed a photo of her mandala and reported her narrative: a young woman is kept between two huge rocks; she wants to reach a wide-open landscape behind the rocks, but she cannot. In the post-talk, Mrs E. had said she felt "*very desperate not being able to change the situation and to reach the promised land*". Thomas was very annoyed about the message of the mandala. He felt stuck in the situation and insecure about how to continue.

Phase 1: Perceiving and relating

In the first phase of the spiral, the supervisor and the supervision group members perceive the supervisee's report in a pre- and co-reflexive holistic way. They sense and seize, atmospherically, kinaesthetically, symbolically,

⁸ The supervisee, here called "Thomas" gave his consent to serve as an example for this purpose.

⁹ 2nd movement from the 3rd Orchestra Suite, D major, BWV 1068).

metaphorically, scenically, in which mood and way. The group senses how Thomas transports the quality of information about Mrs E.. They become aware of his and their own bodily reactions, images, associations, memories of familiar situations that come up (or not). They sense what kind of music comes into their minds and what it feels like. Music that the group members associate with images could sound somehow spine-chilling, not at all like the “Air” which, if associated with a promised land, in this case is unreachable. Apparently the music had touched the shadow side of a promise. In their countertransference, the group members also experience tightness and helplessness. The atmosphere seems burdensome and images of prisons arise. The group members’ emotional resonance confirms that Mrs E. is depressed. Thomas assumes that she is stuck between the addicted family members (the two rocks), and that she does not feel strong enough to leave the family for a better future.

Phase 2: Working through and understanding

This assumption has to be verified and worked through. What does this interpretation have to do with Thomas’ feelings of being stuck and insecure about what to do?

The supervisor invites Thomas and the group to imagine Thomas as a guide in relation to Mrs E.’s imagery. She gives an induction mentioning Mrs E.’s domestic situation – her family, her husband’s alcoholism, her youngest son’s drug addiction – but also Thomas’ feelings of distress and drive to succeed. She then invites the group to re-imagine Mrs E.’s imagery from Bach’s “Air”. The group members reflect on the conflict pre- and co-consciously. It strikes the group that Thomas is in a similar position as Mrs E.: being kept in an immobile position. Thomas is struggling to be effective in his work. He needs quick success and acknowledgement. Mrs E. seems to be stuck between responsibility for her family and the necessity to attend to her own needs. Leaving the family would cause feelings of guilt. This aspect becomes comprehensible. But why is Thomas stuck with this conflict?

Thomas feels released by the group having identified a similarity between Mrs E.’s and his own dilemma. He feels that the reason for his own distress and helplessness was triggered by Mrs E.’s situation. He becomes aware of his need for quick, good results as a result of his boss’ sceptical attitude and the lacking appraisal of his work. He

interprets his helplessness not only as a countertransference but also as his own transference and, by taking the eccentric position, he regains for the moment, his therapeutic role.

Phase 3: Multiperspective reflection

This phase includes the valuating perspective. Beliefs, theories and personal experiences have to be reflected on in order to *detect presumptions* that can possibly harm the client (Petzold & Heintz 2015; Petzold et al. 2012). In this phase of the hermeneutical spiral, the supervisor, the supervisee and the group members need to take a reflexive/eccentric *and* a hyper-reflexive/hyper-eccentric *metahermeneutic position* based on multilayered reflections and the analysis of discourses and their deconstructions (Derrida, see Culler 1999; Petzold 2008; Völkner 1993). It would demonstrate the multivalency of explanations. Thomas is an example.

The assumed similarity between Thomas’ and Mrs E.’s situations has to be reflected upon: comparing the supervisee’s and the client’s situation in an *eccentric position*, it becomes obvious that Thomas’ situation is not at all the same as Mrs E.’s! He *could* quit the hospital if he wanted; Mrs E. could *not* leave her home, because she is housewife and mother and has no employment. If Thomas left the hospital he could find another job and the hospital would survive without him. If Mrs E. left, her family would possibly break down and she had nothing but her guilt feelings. Her husband had apparently not benefited from the breakdown of the GDR, as in West Germany he could only work *under* his former qualification. This may have been a contributing factor in the development of his addiction.

The group and the supervisee now begin to question and deconstruct their assumptions and consider Mrs E.’s background in more depth. This includes questioning Thomas’ concept of not wanting to disturb a creative process in the here and now by partiality and prejudices as he had declared. He wanted to stay completely open for his client. Therefore Thomas had always pushed information from the clinical team about his clients’ biographies aside.

As a possibility to reflect what Mrs E. had said the supervisor picks up the so called *promised land* which Mrs E. had mentioned. What did Mrs E. mean when she talked about the “promised land”? Did this metaphor refer to the so called *Promised Land in the bible*? Was she religious? Or was there a wish for rescue from the authoritarian system in

the GDR like the rescue of the Jewish people by Moses? Did Mrs. E.'s promised land have something to do with East and West Germany?

What did it mean for Mrs E. to have grown up in the GDR? She was 16 years old when the GDR collapsed and her family moved to West Germany. Was she happy with the promised land she found? Her husband is much older, and before the reunification had worked as a top GDR civilian administrator. After reunification he had to take employment in West Germany for which he was overqualified. For him West Germany was possibly not the promised land. Was there a secret that had to be silenced using alcohol and drugs?

The supervisor questions the message of the imagery represented in the mandala (being stuck between two rocks). Is Mrs E. stuck, imprisoned, caught and trapped, or secured, held and sheltered between the two rocks? Who or what are the rocks? Are they just a symbol for her husband and her drug-addicted son in the actual situation of her real life? And/or is Mrs E., metaphorically speaking, virtually still living in a former GDR where West Germany, for *her* family, represented open landscapes and the promised land? Or is the reality that she in fact does live is the promised land but cannot feel it because her husband feels the opposite? And what about Mrs E.'s actual situation in her family and in her social network? What other factors may have contributed to her depression? Thomas now understands that meeting clients in the here and now without knowing anything about their political, social, cultural and ethical background and their present situations is naïve and can lead to misinterpretation of countertransference.

Not all aspects can be worked through and be reflected on in one supervision session. Therefore a decision has to be made in order to reduce complexity. The supervisor, the supervisee and the group decide which aspect to focus on and investigate further. The supervisor, however, must reflect on this choice of focus and keep the other concerns in mind.

Intuitive techniques stimulate the emergence of complex themes. Intuition may emerge from our inner wisdom of collective memory (sensu C.G. Jung 2011) or from embedded and embodied interiorisations of collective mental representations (Petzold 2016). Sometimes intuition seems to emerge from the No-conscious dimension into awareness. But as subjective assumptions intuitively often *seem* to feel right they also run the risk of leading to overhasty presumptions.

Therefore all momentary insights need to be reflected and re-reflected on in this never-ending hermeneutic spiral. For supervision it is necessary to switch consciously between the reflexive-eccentric and the involved positions.

The meta-hermeneutic step facilitates the *Phase of Integration and Training*, where the learning processes and the promotion of Awareness for the new insights and perspectives take place. The supervisee finds an orientation and ideas for what could be the next step. This new orientation is at the same time the starting point for a new hermeneutic spiral.

Phase 4: Integration and training

So, what did Thomas learn in this supervision session and what insights can he take with him? Certainly most important is the insight to reflect on and review the idea to be open, impartial and not biased by pre-knowledge by refusing any information about the client before starting to work music therapeutically with him or her. It is quite common for music therapists not to want to meet their clients in their pathology, but as themselves. This is understandable, as music is a field beyond pathology that can be shared. However, music is experienced in different ways depending on one's basic satisfied or unsatisfied needs, wishes, motivations, appraisals, etc., and this can lead to misinterpretations. The experience of music discloses the broad spectrum of one's interiorised social, cultural and political experiences and triggers personal psychodynamic processes that need to be mentalized.

The supervision and reflections helped Thomas develop a deeper understanding and awareness of the complexity of Mrs E.'s situation and her assumed background. As there is still a large gap in information, Thomas is motivated to investigate the conditions in Mrs E. and her family's biographical, cultural and political situation that may have led to her depression.

In this phase Thomas and the group discuss new perspectives and possible interventions and techniques. This is part of "training" the practice of new insights. Depending on how long Mrs E. stays in the hospital, how stable her psychic structure is and what she wants for herself, Thomas could offer Bach's "Air" again in two directions: 1) by giving an induction which focusses on *what has been lost or what could have been* the music would be used to allow grief and mourning with the intention to feel *compassion* (instead of despair or pity) for herself. 2) by giving an induction to *what*

could be in the future the music could help to get a feel for a promised open land.

With the help of the guide, the “Air” could allow for the expression of sadness (or anger) and possibly lead to emotional support and self-care. This could help Mrs E. to share her feelings and narratives about her biography and her current situation and the music could support her to imagine a way to find her Self (her own promised land).

CONCLUSION

Supervision has become more and more important as a part of training and also for professional GIM therapists. The necessity to develop methods and apply reference theories is agreed on within the GIM community; however, it is very difficult to implement training, and training standards, to become a professional GIM supervisor. Because of the lack of qualified supervisors, even GIM therapists with relatively short experience give supervision. This is not acceptable and should of course only be given for curtailed themes for training such as discussing the choice of music or inductions for special experiences.

Supervision is an art and needs training in a broad sense, including musical, philosophical, sociological, clinical and psychotherapeutic concepts. Differing orientations and reference theories within the Bonny Method and MI need to be discussed. They have an impact on supervision and should be investigated further.

With the presented heuristic model of supervision the author hopes to contribute to the development of a professional GIM supervision qualification. The concept of the hermeneutic and metahermeneutic spiral can serve as a heuristic. Like GIM therapists who design special GIM programmes for their clients by incorporating their intuitive and cognitive competencies, the professional GIM supervisor “travels” with the supervisee(s) through the hermeneutic circle(s) within different stages of reflection. This method of processing – from the bottom up and the top down, feeling and thinking, intuition and rationality – can enrich supervision for GIM trainees and supervision for professional GIM therapists as well as for other creative therapists.

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