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ARTICLE

Perceptions of GIM therapists transitioning from in-person GIM sessions to online platforms during Covid-19 restriction

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ABSTRACT

In March 2020, when COVID-19 was declared a pandemic, therapists were required to make the transition from in-person, face-to-face sessions with clients to online telehealth sessions. The challenges for therapists practising The Bonny Method of Guided Imagery and Music were particularly difficult. This study was conceived to understand how GIM therapists managed the transition and how they perceived the differences of in-person and online sessions. Seven therapists, all female, living and working in Australia completed in-depth interviews in June 2022 about each element of the session, and a thematic analysis identified grand themes and subordinate themes. Results show that there was a dislocation of physical, personal and therapy space online, with absent cues and missed opportunities for caregiving. Rapport was established online and the therapeutic process developed, but the components of the GIM session were not the same, and the transition for the therapist was challenging. Findings indicate that online GIM sessions may provide greater opportunity and immediacy for people to have therapy and experience GIM, but in-person GIM may provide greater safety and greater depth of experience. Limitations and future research recommendations are presented.

KEYWORDS

Guided Imagery & Music,
Bonny method,
therapists' perceptions,
in-person GIM,
online GIM

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INTRODUCTION

When COVID-19 was declared a pandemic on March 11, 2020 (WHO, 2020) and restrictions were imposed, therapists were faced with an immediate need to transition from in-person to online

sessions. Clients could no longer attend in-person due to restrictions on travel, density limitations, and fear of contamination, and they required therapy to cope with anxiety and fear in the emerging situation. Across many therapy and health services, therapists made the transition to offering telehealth or online sessions. This transition was particularly challenging for therapists offering the Bonny Method of Guided Imagery and Music (GIM) therapy.

GIM is a music-centered form of psychotherapy in which clients are engaged in listening to music in a deeply relaxed state, referred to as an Altered State of Consciousness (ASC) or Non-Ordinary State of Consciousness. Through the process of active imagination, the client engages in imagery, emotions and memories activated by the music. During the music listening component the therapist maintains a verbal dialogue using occasional interventions to seek descriptions from the client about their experience. This dialogue is superimposed over the playing of the music. At the conclusion of the music program clients are invited to process the experience through mandala drawing (Abbott, 2019).

The demands created by COVID-19 restrictions necessitated GIM therapists to offer online GIM sessions immediately, and this propelled many in the GIM community to adapt sessions for online delivery (Dimiceli-Mitran & Moffitt, 2020). Technological challenges where music was shared across multiple platforms necessitated new skills be learned. Initial challenges included (in part): Ensuring the client was safe and in a confidential space at home, that the music did not distort, that words could be spoken over the music, that the client felt safe with eyes closed during the playing of the music, and that if there was a drop-out of technology there were back-up plans in place (Dimiceli-Mitran & Moffitt, 2020).

In 2018, prior to the COVID-19 pandemic, Sanfi (2019) conducted an international survey of online GIM therapy. Only 8 therapists (7% of 170) at that time had used online delivery. In answer to a question about optimal conditions for online GIM, the therapists responded (in part) to have:

1. A clear verbal interaction during music listening
2. Good sound quality
3. Ability to control music continuously
4. Encryption/safe digital security
5. Rapport with client (Sanfi, 2019, p. 629).

The World Health Organisation declared COVID-19 a pandemic on March 11, 2020 (WHO, 2020), and the Association for Music and Imagery (AMI) held a meeting on the online Zoom platform to discuss how to conduct online GIM sessions via teleconference technology (2022, September 1). Topics included optimum technological requirements, ethical considerations, and all aspects of delivering a GIM session safely (Dimiceli-Mitran & Moffitt, 2020). Later, the Music and Imagery Association of Australia (MIAA) drew on the AMI documents to create Information Sheets and Consent Forms for clients, and these were made available to GIM therapists in Melbourne, Australia.

Early on in the pandemic, Milne and Costa (2020) used the term “dislocation” when referring to the changes in their primary medical health practice, in particular the spatial changes related to telehealth. This theme of dislocation, defined as a “situation in which something such as a system, process, or way of life is greatly disturbed or prevented from continuing as normal” (Collins Dictionary, 2022). During lockdowns there was a physical dislocation in that we had to stay at home, and then had

to be resilient moving in and out of lockdown. There was a time dislocation: The rhythm of the day, week, month and year, were all disturbed.

The city in which both authors live and work was subjected to repeated lockdowns between March 2020 and October 2021 amounting to 263 of a total 575 days (45.56%). Our motivation to conduct the study came from the shared experience of these multiple dislocations and readjustments.

LITERATURE

Music therapists had been using online technology for some time prior to the onset of COVID-19, and a large international study surveying music therapists' use of technology, including online music therapy, was conducted by Agres et al. in 2021. There were 112 participants from 20 countries including United States, Canada, Europe [9 countries], Australia, New Zealand, Asia and Bahrain. Conducted in 2020 the survey responses indicated that nearly one third of the respondents said that their practice was temporarily halted, and some lost their jobs due to the COVID-19 restrictions. A high number (76.4%) indicated that telehealth affected their listening attitude and made affect attunement difficult. Poor sound quality was an over-riding factor as was the latency of sound and poor internet functioning. The restricted view of the client was another detrimental factor. Faced with these issues the use of receptive forms of music therapy increased, including listening to music with clients, and assisting clients develop their own playlists for mood regulation (Cabedo-Mas et al., 2021).

Playlists were central to Giordano et al.'s study (2020) that was designed to reduce stress in frontline health workers (doctors and nurses) who were subjected to prolonged shift work, giving care to very sick patients, many of whom died, and the fear of being infected and infecting their own family members. Initially the participants (14 doctors and 20 nurses) were provided with three playlists (PL) to use remotely as often as needed:

1. Relaxation to reduce anxiety and stress (Breathing PL)
2. To support energy (Energy PL) and
3. To instill peace and calm (Serenity PL)

Participants were interviewed about their experience after one week and two new PLs were individualized with input from the participant. This individualized process was repeated for four weeks. Self-reports were collected and included scales on fatigue, fear, sadness and worry. Significant results (pre-post) were found on reducing fear, tiredness and worry at the end of the study.

An online group music and imagery program was devised as part of a wellbeing program (RUOK: Are you OK?) for health workers in a major hospital in Melbourne, Australia (Ip-Winfield & Grocke, 2021). The program was conducted between August-October 2020 during a lengthy lockdown of 111 days. Nine participants volunteered for the program, including psychologists (3), a prosthetic coordinator (1), occupational therapist (1), art therapist (1), music therapist (1), masseur (1) and music therapy student (1). The sessions were 30 minutes in length comprising a relaxation induction, statement of the theme (see below) and 5-7 minutes of music drawn from the GIM programs. The sessions were offered at 8:30 am before first shift of the day, and again at 2pm before afternoon shift commenced. Four themes were pre-determined and included:

- Week 1. What inspired you to become a [your profession]?
- Week 2. Best experience as a [profession]
- Week 3. Present moment feeling about the job
- Week 4. What does the future hold?

Participants gave verbal feedback on the imagery experience. A thematic analysis (Braun & Clark, 2006) identified six themes.

1. Being in nature
2. Immersed in music
3. Positive memories
4. Changed perspectives (a sense of being "part of a bigger plan")
5. Inner peace
6. Newfound strength ("I do make a difference")

In another study (McFerran & Grocke, 2022) University students were interviewed about their experience of online GIM sessions. University students were particularly impacted by COVID-19 lockdowns, and some completed two years' study without face-to-face meetings with lecturers or being on the campus. Three participants who received a series of 6-10 online GIM sessions were interviewed about their experience. Sessions were often adapted due to the clients being at home in a shared space with other members of the family, including children who were being home-schooled. The main adaptation was to use shorter pieces of music, while also maintaining interventions and the mandala drawing component. The two emergent themes from the participants' experience were that there was a sense of urgency leading to their involvement in GIM therapy, and there was an experience of surrender to the music and the process.

In a further study conducted by Giordano et al. (2022), modified individual GIM sessions were provided to hospitalized COVID-19 patients who were not intubated (n=40; Giordano et al., 2022). The study was a RCT with a control condition of treatment as usual (TAU). The experimental intervention was a modified Bonny Method session comprising five components: (1) A discussion and positive focus; (2) a customized playlist, (3) relaxation, (4) music listening with dialogue and (5) a concluding discussion to validate and reinforce positive experience. There was no mandala drawing. The aim was to evaluate the immediate effects of modified GIM on anxiety, heart rate, oxygen saturation and satisfaction with care. Those in the experimental condition had significantly lower anxiety (34.50 compared to 45.00, p=0.000) and significantly higher oxygen saturation (97.50 compared to 96.00 in the TAU condition, p=0.026).

Honig et al. (2021) designed a multi-site RCT to determine if 10 biweekly sessions of The Bonny Method of GIM has an effect on depression, anxiety, stress and mental wellbeing. The study was designed for a sample of 28 participants, however COVID-19 intervened, and recruitment had to be terminated. A cohort of 10 participants completed the program, which was re-cast as a feasibility study (Honig et al., 2021). Two participants from the study were also interviewed. They had experienced both formats – they started with in-person sessions and then transitioned to telehealth via platforms such as Zoom technology. When asked to describe the differences in the delivery formats they indicated that 1) telehealth was beneficial, but initially less effective than in-person, 2) the therapeutic

relationship was developed and supported their transition and 3) their experience of telehealth improved as they gained familiarity (Honig & Hannibal, 2022).

Several studies have investigated the experiences of music therapists in making the transition from in-person to online sessions (Baker & Tamplin, 2021; Forrest et al, 2021; Fuller, 2021; McLeod & Starr, 2021; Molyneux et al., 2022; Shoemark et al., 2022). Baker & Tamplin (2021) interviewed 60 music therapists offering telehealth and found that they perceived telehealth as an adequate interim measure to maintain access to therapy, but in-person therapy was preferred by most. Telehealth was an alternative when circumstances required, or clients preferred. Advantages of telehealth cited were reduced travel time/costs, increased access for clients in remote areas, and increased engagement for some clients and caregivers. Disadvantages included technology/latency issues, more tiring to facilitate, decreased client engagement, and increased support needed for clients. In comparing telehealth with their usual face-to-face sessions, 56.7% (n=34) experienced it as similar, 36.7% (n=22) found the telehealth experience worse than face-to-face, while 6.7% of therapists (n=4) found telehealth superior to face-to-face and that the telehealth modality was better than their expectations.

The present study was designed to gather information about the experience of GIM practitioners using The Bonny Method of GIM who transitioned from providing in-person sessions to online sessions. It was envisaged that the findings would enhance the practice of GIM and inform the training of future GIM therapists. The study was approved by the Human Ethics Committee, University of Melbourne, HASS: 2022-23819-28560-3 (May 12, 2022).

Aim of the study

This study sought to understand the experience of GIM therapists in making the transition from providing in-person GIM sessions to online GIM sessions during 2020-2022, and to compare and contrast their views of online GIM therapy with the traditional in-person format. The study was conceived as a qualitative study in which in-depth interviewing was implemented to gain a sense of the GIM therapists' lived experience (Kvale, 1996) and to capture multiple perspectives of their experience

METHOD

The stance of the researchers

As qualitative research is inherently interpretive, the stance of the researcher is critical to the transparent process of identifying codes and themes (Braun & Clarke, 2020). Both authors in this study are experienced researchers having conducted multiple qualitative studies that have incorporated phenomenology, grounded theory and thematic analysis to elicit knowledge (Grocke, 2002, 2019; McFerran & Grocke, 2007; McFerran & Hunt, 2022; McFerran & Saarikallio, 2014). Both researchers are accredited Bonny Method GIM therapists with MIAA and author 1 is also accredited with AMI. Both have experience offering GIM in-person. Author 2 has also given GIM sessions online and received GIM sessions online. Both authors designed the study, co-wrote the ethics application, and consulted on the thematic analysis and write-up of the study. Author 1 conducted the interviews. Author 2 read the reduction of each participant's transcript and the emergent themes (see below under Data Analysis)

and then validated the sub themes and emergent grand themes. Any discrepancies were discussed until both authors were in agreement.

The Epoché

In the tradition of Husserl's descriptive phenomenology in which we were both trained, an Epoché is often used as a way to reflexively consider what pre-assumptions and biases the researcher brings to the investigation. It has been described as a way to bracket preconceptions in order to put aside assumptions that might otherwise lead us to generating false descriptions (Roberts, 2019). The idea of an Epoché has been thoroughly and repeatedly critiqued (Zahavi, 2021), but we choose to use it here because our own lived experience of the phenomenon we are seeking to capture through qualitative analysis is deeply relevant to our findings. We drew on our subjective knowing and used it to guide us towards the questions we asked, the ways that we gently probed for the deeper descriptions and the ways we approached the analysis of the data. We have been transparent about each step of the process so that these biases are revealed, and the reader is invited to decide for themselves if they remain helpful.

This study was infused with a desire to support GIM therapists by listening to their stories of grappling with an enormous transition in practice whilst simultaneously coping with their own experiences of fear and anxiety in response to the pandemic. Our assumptions were that this would be challenging. We felt the technology could be difficult. We thought that the sense of safety would be hard to achieve. We worried that therapists would not be able to provide care in the way they were used to, and clients might feel abandoned. We also made the transition with our colleagues and met our own challenges, but we felt a responsibility to explore what had happened and to try to make sense of it. Partly this was to validate efforts made by the therapists, partly to reap the potential learnings from what worked and what didn't, and also as a gesture of processing a shared experience of caring.

Participants

Recruitment of participants for the study was made through the MIAA. The invitation to participate was sent out via email by the Administrator of MIAA. The criteria for inclusion were that the GIM therapist had provided both in-person and online GIM sessions and were willing to discuss the benefits and disadvantages of both forms of delivery. The invitation explained that there would be an interview of 1-1.5 hours that would be recorded using Zoom technology. It was further explained that a transcript of the interview and reduction of the themes would be sent to them for verification. They were provided the opportunity to change any aspect of the final essence of their individual experience.

Participants contacted the first author by email if they were interested and a Plain Language Statement and Consent Form was emailed to them. If they wished to proceed a time was arranged for a Zoom interview and a copy of the interview questions sent to them. At the start of the interview the first author reminded the participant that the interview would be recorded and requested permission. The first author also reminded them that the number of GIM therapists in Australia was small and that they should bear that in mind in answering any questions to insure their confidentiality and that of their clients. This was a requirement of the ethics board approval.

Seven female GIM therapists responded to the invitation to be part of the study and they were interviewed in June 2022. Three had been practicing for more than 10 years, and four less than 10 years.

Data collection

In-depth interviewing is a common choice of data collection in qualitative research, and thematic analysis (Braun & Clark, 2006, 2020) is commonly used to analyse the data. The 23 questions designed for this study were a mix of closed and open-ended questions (see Appendix 1). Questions 1-5 focused on how the therapists prepared to transition to online sessions and Questions 13-18 were about technology. These were direct questions (Kvale, 1996) to elicit information, and a deductive analysis was applied by simply creating lists from the answers.

Other questions were designed as open questions (Kvale, 1996) to elicit information that required reflection and description. For example, questions 6-12 were about the elements of the session and whether they were the same or different in the two modes of delivery. The participants reflected on sessions given to clients and often elaborated on their experience as they compared the two forms of delivery. Questions 19-22 were about rapport and therapeutic process, and a final question (#23) asked about their overall experience. For these open questions the interviewer (author 1) drew on her experience in conducting phenomenological studies by providing opportunities for the participant to dwell on the experience by being mindful of creating space through silence. She encouraged elaboration in order to gain a fuller meaning of the experience as described by the participants. An example was participant 2 who struggled to find the right words to describe the absence of the "essence of the person" when providing the relaxation induction online. She said haltingly, (ellipses indicate 2-3 seconds of silence between phrases), that it was "like a dead body... a body with nothing you know, like the soul... there's nothing... the soul or the essence of the person's gone, it's not there."

Data analysis

The length of the interviews varied but were between 1-1.5 hours. They were recorded and transcribed automatically by Zoom. The transcriptions were sometimes inaccurate, for example the word "mandala" was transcribed by Zoom as "Mandela." The transcription of the seven participants interviews generated 79 pages of data, 1.5 spaced.

The procedure for analysis differed according to the nature of the question. The factual questions 1-5 and 13-18 were analysed using deductive analysis that generated lists. Questions 6-12 and 19-23 were analysed using the five steps based on Braun and Clark's (2006) thematic analysis:

1. The transcript was edited for accuracy against the recording. Inaccuracies in the automatic Zoom transcriptions were corrected and duplications and superfluous words removed.
2. A reduction was made of each transcript; emergent themes were identified and labelled. Important quotes from that interview were saved.

3. The reduction, emergent themes and selected quotes were returned to the participant with the questions: "Does the reduction capture everything?"; "Is there anything in the reduction that has been omitted?" A further question required by the Ethics Board was: "Is there anything in the reduction and the quotes that might identify you or your client/s?" Three participants requested material be removed as they, or their client/s may be identified.
4. Returning to the full data set the seven responses were collated according to each question. Questions 1-5 asked about how they prepared for the transition and the responses were collated (see below). No further analysis was needed. Questions 13-18 asked about difficulties with technology. The answers were collated as a list (Appendix 2) and no further analysis was needed. The questions that asked the participants to reflect on the differences between the two modes of delivery (questions 6-12), rapport and therapeutic process (19-22) and the therapist's lived experience (question 23) generated rich descriptions that were analysed using thematic analysis. Analysis was done sequentially, commencing with Participant 1's responses, noting important statements that suggested potential themes. As further transcripts were read similar statements were grouped to form emergent themes that were labelled cumulatively. Grand themes were then identified, and the emergent themes became the subordinate themes (see tables 1, 2, 3 and 4).
5. The second author verified the identification of subordinate and grand themes.

FINDINGS

Preparing for online (Questions 1-5)

To prepare for the transition to online GIM six of the seven participants read Sanfi's (2019) chapter and watched the 14 videos that accompanied that chapter (chapter 32) before they offered sessions to clients. Six participants attended the MIAA webinar, and three trialled with family members and /or GIM colleagues to enhance their skills. One participant prepared by "trial and error" (P7). Three participants purchased new equipment including a new router, a new computer, new headphones and microphones, and a Zoom Pro account for additional support.

All seven participants used the Zoom platform to conduct GIM sessions. Two participants commenced offering online GIM in March 2020, two in April 2020, two in June-July, and one began at the end of 2020.

Comparing the two forms of delivery (Questions 6-12)

In comparing the two forms of delivery (online and in person) for each aspect of the GIM session, participants described a dislocation of space during online sessions (see Table 1).

Grand theme 1: A dislocated space

Grand theme	Subordinate-themes	Example of participant responses
A Dislocated Space	Dislocation of physical space	"During in-person [sessions] you can bend your head to them... and you really couldn't do that online." (P1)
	Dislocation of personal space	"You are so in someone else's face... if you back off it looks like you're not interested and if you sit there looking at them, you look like you're... staring." (P1)
	Dislocated therapy space	"It's their personal space, the separation between personal and therapeutic space is not there." (P7)

Table 1: Grand theme 1: A dislocated space

There were three subordinate themes within this grand theme:

1. A dislocation of physical space
2. A dislocation of personal space
3. A dislocation of therapy space

Dislocation of physical space

Participant 7 described the sense of dislocation of the physical space as

> it's not the same experience… that ritual [for the client] of getting up, going to a clinic space or therapy space, knocking on the door; and for me it was I get up, I sit at my desk, I turn on my computer, I log on …. and now I am waiting. (P7)

There was dislocation of space within the session, for example the clients might be sitting on a chair in the prelude but might go to lay down on the floor for the relaxation (P3). Another client shifted rooms three times in a session due to the shared space with family all being at home (P6).

Finding a comfortable position to lead the GIM session online was difficult and described by P1 and P6. P1 said, "I really struggled where to position my body [online] … it's exhausting really …", and P6 noticed she sat with her neck and shoulders and chin jutting forward, whereas she was more comfortable in-person.

P1 described,

> during in-person [sessions] you can bend your head to them … and you really couldn't do that online. You never really know what the client is hearing online, whereas in person you probably do have a fairly good idea of what they're hearing 'cause you're in the same room.

There were various disruptions to the physical space and the progression of the session. These included neighbours and delivery personnel knocking on the front door, barking dogs, and cats clawing at the door wanting access.

Dislocation of personal space

Dislocation was also felt in the personal space, "You are so in someone else's face… if you back off it looks like you're not interested and if you sit there looking at them, you look like you're… staring (P1). And for participant 3, "with the online session, it's straight away in your face, almost the face facing directly, it's just really the… the big face in front. Participant 6 expressed it as, "I always found it more difficult those first few minutes. Just for me getting settled, someone else getting settled."

Changes in personal space were noted during the relaxation induction. Some participants felt the personal space was enhanced, "having the voice straight into their ears really helped centering, was really helpful to get them straight into that space" (P1), and "it's possible the person may be feeling more comfortable in their own space" (P3).

But P3 felt it was a distorted personal space, "it felt like you're scrutinising someone... your face is looking down as they go into this state of altered consciousness" (P1), and "it's kind of distorted because it's skewed in a certain way. There's something about looking at the whole person three dimensionally" (P3).

P5 found that she would turn on an angle, so that she was on the client's level when giving the induction, like a kinaesthetic empathy "I was twisting myself around... I wanted to be on that same [level]."

Dislocated therapy space

The third form of dislocated space was of the therapy space. As P7 expressed,

> it's their personal space, the separation between personal and therapeutic space is not there... They are coming into a therapy session, coming into that waiting room, potentially straight from just having had breakfast... they were in their personal life. (P7)

And for P5,

> in the in-person [sessions], the space is... it becomes a music space. And the client and the therapist and the room is in the music space. Whereas [online] the music is in my ears, and [separately] in the client's ears. (P5)

P3 commented that, "... something is not there. It's less substantial, I suppose... Like we're not sharing the air... [not] looking at the same thing from the same angle... [not] feeling the three-dimensional thing together, this particular reality together."

P2 was cautious in giving the induction: "There were always questions about safety in terms of the depth of the relaxation... people didn't go as deeply as they would if they were in the same room... they had to regulate themselves." P6 felt "they were not in the safety of a therapy space and couldn't go into a deep place knowing the therapist was sitting beside them physically."

When asked about the closure to the session, P3 commented

> we don't share the same space, they are using their everyday space, and it's not a declared therapeutic space... so when you say 'closure' it just becomes a word... how could they differentiate if they're staying in that same room the rest

> of the day because of work. Even if you encourage them to go outside and come back, they'll come back to the same place... I wondered that… if that might have had an effect on the outcome. (P3)

Boundaries were mentioned by P1,

> if someone comes to your house or comes to your room there's a kind of professionality... they're coming to your space, and that impacts the relationship and the boundaries and the therapist-participant roles [but] I don't think that's clear online.

Similarly, P2 said, "there's some transference that happens for the client when they come into a room and for us as well as the therapists. That was different in this space 'cause they were in their space, I was in my space."

Grand theme two: Absent cues and missed caregiving

Participants described aspects that were absent in the online session, including absent cues, and the absence of caregiving (see Table 2).

Grand theme	Subordinate themes	Example of participant responses
Absent cues and missed caregiving	Absent cues	"When a client walks in the room in the face to face [in-person] session, you can pick up what they are like and you can usually sense what their mood is, just from the something that radiates out of them. I couldn't pick up the little nuances online." (P2)
	Missed care giving	"I wasn't able to offer them that little bit of care that you can in an in-person session, in presenting them with the mandala materials, with the pastels, they had to do that themselves... it felt a little bit less generous." (P6)

Table 2: Grand theme 2: Absent cues and missed caregiving

Absent cues

P2 described absent cues as,

> When a client walks in the room in the face to face [in-person] session, you can pick up what they are like and you can usually sense what their mood is, just from the something that radiates out of them. I couldn't pick up the little nuances [online]... I learnt to be more observant.

P6 commented, "... online I spend quite a bit of time just getting to know how they are verbally, because I don't have that information as much as I had when they come in the door."

Absent cues during the relaxation induction were described as, "You can't really tell how relaxed they are – you're not there – you're guessing" (P3). P4 missed "not being able to feel the shift of energy

or the warmth or see the skin tingle" and P6 missed seeing the signs of the whole body which you can pick up in an in-person session.

Missed caregiving

Participants reflected on missing the rituals of caregiving in the sessions. P6 said that in-person she "could give them a little bit of care putting the blanket or cover over them... to set the scene and atmosphere for a good session, like a sense of trust they can really let go."

For P1, "I wasn't able to offer them that little bit of care that you can in an in-person session, in presenting them with the mandala materials, with the pastels, they had to do that themselves... it felt a little bit less generous."

Participants also commented that they missed seeing the person out the door at the end of the session, as you would in an in-person setting "[there was no] shepherding out and saying goodbye, that movement process..." (P7)

Rapport, therapeutic process and transition (Questions 13-25)

Questions 13-25 asked about rapport, the therapeutic relationship, the benefits of online vs in-person, and their own experience of the transition (Table 3).

Grand theme three: Rapport and therapeutic process developed

Grand theme	Subordinate themes	Example of participant responses
Rapport and the therapeutic process developed online, but components were not the same, and transition was challenging	Rapport was built and therapeutic process developed	"rapport was enhanced, because of the difficulty we were working under.... I'm inclined to say it might have developed even better... rapport strengthened, it certainly didn't deteriorate." (P6)
	The components of the session were not the same	"GIM online is almost like a slightly different method." (P1) A) Sound checks B) Adaptations C) The depth of the ASC was different D) Providing interventions online was different E) Modifying the Mandala Sharing
	Transition was challenging	"sharing the problem with others... it helped to contain the anxiety about "what do I do... I was still able to offer something... it was good, interesting but also a challenge." (P2)

Table 3: Grand theme 3: Rapport and therapeutic process developed

Rapport and therapeutic process developed.

All seven therapists believed rapport was built through online GIM, and that there was a therapeutic process over time that deepened and was helpful to clients. "There was a sense of 'we are all in this together,' [referring to the COVID-19 restrictions], that a part of rapport building was to share a major experience together" (P4).

Another therapist felt rapport was enhanced, "*because* of the difficulty we were working under... I'm inclined to say it might have developed even better... clients appreciated that... rapport strengthened; it certainly didn't deteriorate" (P6).

P2 and P3 felt that "trust was developed (P2), and... [the] alliance I think is the same, the trust between me and them" (P3). P4 felt "connected with them the same way" (P4).

For P1, she felt closer to her clients online, compared to in-person, "we developed a very close relationship... they're in their own home and you are being invited into their home." P1 felt that the depth that she has reached with one client in particular as "being huge", and way surpassed any depth that she has found with any other client.

P7 felt her clients had more consistency with their sessions. Some had sessions fortnightly that would not have happened when their lives were busier. P3 commented "there is that urgency and immediacy that you are available online, on the spot... you're available for them, when they want, and in that time".

One therapist commented that online "feels almost like a slightly different method" (P1).

> [You are] not giving as much of yourself online... you're asking them to look after themselves in their remote spot, while you sit there at a screen and try to hold the space... But by the same token some people wouldn't have any therapy without it. (P1)

The components of the session were not the same

Participants offered new insights about online sessions and identified aspects that were not the same.

A) Sound-checks

All participants did a sound check with clients before commencing each session. This was difficult for clients who had little computer knowledge and experience. Clients had to check their microphone, device and headphones which put the responsibility back on them to ensure the session was set up in an optimal way. As the session progressed the clients would move and possibly shift the microphone, which then impacted what the therapist heard.

B) Adaptations

Participants described a number of adaptations they made for online sessions that may not have happened in-person. These included:

- Avoiding the working programs, due to concern about the client going too deeply
- Using shortened music programs
- Verbal sessions with music and drawing at the end of the session
- Supportive Music and Imagery (MI)
- Repeated listening to one piece of music
- Listening to the first piece of the music program without interventions from the therapist, then the therapist pausing the music and checking in with client verbally about the experience, before resuming with next piece of music (P3, 5, 7)

- Music Drawing Narrative (Booth, 2005-2006) worked well online, as the client listens to the music twice (once to draw and second, to write a narrative) (P2, P7).

C) The depth of the Altered State of Consciousness (ASC) was different

P2 felt "people didn't go as deeply as they would if they were in the same room". P4 however thought that "some clients went into the ASC quite deeply, depending on how experienced they were and how much trust they had in me, and in the therapy, and the equipment and settings (P4).

D) Providing interventions online was different

Five of the seven participants described difficulties where the interventions interrupted the flow of the music. P2 said, "Hearing the music was often a problem early on in 2020 where the client would hear the music but couldn't hear my interventions, or when the interventions happened the music stopped, they blocked out the music. But by 2021 that issue was resolved maybe as Zoom improved."

Similarly P5 said, "I learned early not to say "uh-huh" or 'umm" because the music would drop out. Whereas I think that's *more important* online, so that the client knows I haven't left the room, haven't left the space... that was difficult, but it seemed after, perhaps by the end of 2020, the beginning of 2021 this was improving."

Therapists monitored the number of interventions and the timing of interventions more online than in-person. Some made fewer interventions, but P4 made more interventions because she needed to know what was happening for the client. She was conscious of not exploring too deeply unless she knew whether they could handle their emotions. P6 said her interventions were delivered more slowly and close together. "I was cautious because of the distance between us."

P2 described that she used all her senses, being almost hypervigilant in the online sessions. Her inventions were focussed on the body for that reason.

E) Modifying the mandala sharing

Most commonly the clients took a photo of the mandala and shared the screen, but participants commented that the mandala came up rather large and that the client was a little square in the corner of the Zoom screen. Participants (therapists) who had two screens found that was optimal for viewing the mandala and the client's face clearly (P1).

For some clients who didn't have the skill or equipment to share, they held the mandala to the computer camera, and then the therapist asked the client to move it around to see the whole. Sometimes the colours were not clear, and sometimes they were distorted (P7).

A challenging transition

Many participants found the transition challenging. For P2,

> the transition itself was a positive experience – it gave me a sense of purpose and mastery, 'I can manage this,' and sharing the problem with others... it helped to contain the anxiety about "what do I do . . I was still able to offer something... it was good, interesting but also a challenge. (P2)

It was "challenging" for P2, P5, P6, "difficult" and "stressful" (P6) and "there was anxiety" (P2, P4, P6).

Grand theme four: Online provides greater opportunity for clients but in-person GIM may provide greater safety and possibly greater depth of experience

All seven therapists said they would continue to offer online GIM and cited many benefits of online GIM (see Table 4).

Grand theme	Subordinate themes	Participant responses
Online provides greater opportunity for clients but in-person GIM provides greater safety and possibly greater depth of experience.	Benefits of online sessions	"Online sessions are more convenient and more accessible for [busy] people." (P4)
	Benefits of in-person sessions	"in person, the music is filling the room, it's part of the environment and it's part of the therapeutic space." (P1)

Table 4: Grand theme 4: Online provides greater opportunity for clients but in-person GIM provides greater safety and possibly greater depth of experience

Benefits of online sessions

As P1 comments, "some people wouldn't have any therapy without it... It's less of an inconvenience for people to commit themselves", and P2 said,

> They don't have to leave their homes, as long as they have a place of privacy... [However], clients need to be more self-reliant and manage their own emotional space... and this puts more duty of care on the therapist about being aware of the client's emotional capacity before offering them full sessions.

P4 commented that, "I work with busy people... Online sessions are more convenient and more accessible for [busy] people." Similarly for P3, "for in-person sessions the client has to make an appointment and wait, but for online sessions the client might be at 'tipping point'... there is more urgency." P6 reflected on opportunities, "Zoom has made it possible for country people, and people interstate [to have GIM]... all those wonderful possibilities."

Benefits of in-person sessions

Participants were aware of the limitations of the online platform and reflected on their preference for in-person sessions.

> The quality of the music matters, the space matters and I like to have control over the speaker in front of me that the person next to me is listening to. The screen is two dimensional and the virtual spatial presentation mucks around

> with my sense of spatial awareness... [whereas] in-person the place is almost like a sacred place where you meet. (P3)

P1 also reflected on the music, "in person, the music is filling the room, it's part of the environment and it's part of the therapeutic space" (P1).

Other comments focussed on the therapeutic journey of travelling to the therapist. "There's something about the actual journey that begins when they (the clients) decide to come to the session" (P5).

P6 said,

> there is a different quality of presence... the therapist can control the space and know it is uninterrupted, it's safe, and that's not so when the space is in the client's home. Family members might be at home, which is different from getting in your car, going to a therapy session which has that distance from the very thing you might want to be talking about... that because of the situation [the client being at home], *couldn't be talked about...* (P6)

DISCUSSION

Many of the findings of this study are in accord with Sanfi's (2019) survey of optimal conditions for GIM online, including (in part) 1) clear verbal interaction during music listening, 2) good sound quality, 3) ability to control music continuously, 4) safe digital security, and 5) rapport with client"(Sanfi, 2019). Participants in this study unanimously confirmed that rapport could be built online and that a therapeutic process was maintained. One participant went as far as to say that the process was enhanced online. The two client participants in Honig & Hannibal's (2022) study similarly confirmed that the therapeutic relationship was developed and supported their transition.

The findings also confirm Baker and Tamplin's (2021) study of music therapists experience of offering online sessions. They found that telehealth was a viable alternative when circumstances required and that advantages included reduced travel time/costs, increased access for clients in remote areas, and increased engagement for some clients. Respondents in their study identified disadvantages that included technology/latency issues, that it was more tiring to facilitate telehealth sessions, decreased client engagement, and increased support needed for clients – all of which were identified in this present study as affecting GIM therapists.

P1 commented that GIM online was "almost like a slightly different method," which poses the question whether online GIM (Bonny Method) is an adaptation of the original method. Honig (2022) offers a thoughtful argument about this question. The two clients interviewed in his study felt that "the telehealth format was the *same, but a little different*" (p. 90, italics his). He clarifies that the telehealth (online) transition sessions were initially "experienced as less effect both *experientially* and *procedurally*" (p. 85, italics his), suggesting an important distinction relative to the definition of GIM. Definitions often list the elements of the GIM sessions that must be present in order to name it The Bonny Method (Bruscia, 2002). These are the procedural elements that on the whole are the same online as in-person. The difference between the two modes of delivery however lies in the experience, particularly when the client has already received in-person sessions. Honig (2022) discusses the

dilemma further by clarifying that, "... a precise description of GIM with tight boundaries has utility for research because it improves validity and replicability... and in therapeutic practice it aids in precise and clear communication" (p.91). On the other hand Honig argues that "increasing the precision of language with which we define approaches draws boundaries that can limit practice, scope, and adaptability of therapeutic approaches" (Honig, 2022, p. 91).

Implications for the practice of GIM

Numerous themes were identified in this study that have implications for the safe and effective practice of GIM online, including:

1. The readiness of the client. P2 drew attention to the need for clients to regulate themselves. The onus is therefore on the therapist to determine whether online GIM is an appropriate method to use for clients who have difficulty in emotionally regulating themselves. Many of the participants in this study chose to use adaptations for this reason, by shortening the music and imagery component, or adopting Music, Drawing & Narrative (Booth, 2005-2006), or even just drawing to music. It should be remembered that the clients themselves were often distressed during the lockdowns and an in-depth exploration of personal issues was often not appropriate.
2. Safety at home. Several participants recounted situations where the client was not in a safe position at home to freely discuss their concerns. P6 commented that going to a therapy session provides distance from the family and that family issues may be the very thing the client wants to discuss. It was difficult to do that if the family was in the next room. Safety was also paramount in that the therapists insured that the Zoom session was locked immediately when the client entered the session. This aspect was also highlighted by Sanfi (2019) in his explanation of a safe encrypted platform to carry out online GIM.
3. Findings from this study suggest that the two most uncomfortable aspects of the session occur at the very beginning, welcoming the client into the session, and the closure of the session. P1 commented that if you sit too closely it can be too close for personal comfort, yet if the therapist sits back, it gives the impression of disinterest. An initial sitting back when the client joins the meeting, then moving forward to the closer position, might rectify this discomfort. When asked about who ended the Zoom connection, two therapists said they waited for the client to exit first; others said they disconnected at the same time as the client.
4. There is no doubt that technology plays a major part in the smooth running of a GIM session online. Some participants in this study had clients who came to them through a government-supported therapy service, who did not have new technology equipment, nor the skills to effectively use them. In addition, the clients lived in shared housing with poor internet service. Adaptations were often needed for these clients.
5. Five of the seven participants commented that the verbal interventions interrupted the music. It is not clear why this occurred as the instructions in Sanfi's (2019) chapter and in the instruction leaflet produced by MIAA should have worked well. One possible answer is that clients may not have been wearing headphones.

6. Therapists referred to online sessions as being challenging, tiring, stressful and anxiety provoking. P6 commented, “there was always the [doubt] ‘will it work today?’ Will we get through a program, will I have to adapt?” “It was difficult but rewarding.” The implication is that further training is needed and more practice with colleagues before offering online sessions to the public.

Implications for GIM training

Trainees undergoing advanced training in the Bonny Method of GIM were impacted by the COVID-19 pandemic in that there were restrictions on clients being able to attend in-person. Trainees needed to be skilled up to give online sessions, and this happened quickly with little time to prepare. A different study would be needed to determine how the trainees managed the shift from in-person to online, particularly for trainees who were just starting out and transitioned to online immediately. The authors believe the preferred way to proceed is for trainees to be competent with in-person GIM before being encouraged to offer online, particularly with regard to the depth of the induction, choice of music and level of intervention. However, when faced with a catastrophic event, such as a pandemic, this was not possible. Trainees need skills in managing technology for conducting GIM online, and trainers need to be sure that the trainee feels confident enough so that technological issues do not disrupt the smooth running of the session.

Participants in this study mentioned that their clients had to self-regulate, and this has implications for the training of GIM therapists who are working online. An incremental model of introducing the elements of the Bonny Method to new clients may facilitate a process of assessment, by commencing a first session with supportive MI, then in subsequent sessions introducing short pieces of music with interventions and slowly building to a longer music program or full program.

Participants in this study also made changes to the way they intervened. Some made more verbal interventions, one therapist made the interventions more slowly and close together, another held back because the interventions disrupted the flow of the music. These reflections have relevance for training trainees in The Bonny Method.

Limitations of the study

The purpose of the study was to gather information from qualified and experienced GIM therapists about their experience of transitioning from in-person to online GIM during the restrictions caused by the COVID-19 pandemic. The seven participants were all female, living and working in Australia. They were all trained in Australia, and are known to each other through professional development seminars. The findings of this study should be read with this in mind. A more heterogenous sample of gender and diversity would provide a different lens on the experience.

Both authors were impacted by the lockdowns between March 2020 and October 2021. The term “dislocation” for example, first encountered in the Milne and Costa (2020) article, and articulated in the Collins definition, “a way of life is greatly disturbed or prevented from continuing as normal” was chosen for the coding of the themes, as it resonated with the descriptions of the participants’ experience.

An interviewer from a different city and State than Melbourne, Victoria, or from another country may have been less impacted by the pandemic and therefore have coded the responses differently.

On reflection, additional questions that could have been asked in this study would be about transference and countertransference. While some of the quotations hint at the impact of online sessions on both transference and countertransference a more in-depth study could elucidate some interesting outcomes that may impact on the practice of GIM and training of new therapists. In addition it would have been interesting to ask whether participating in the interview itself enhanced their knowledge and understanding of the transition.

CONCLUSION

The study has identified key themes in the practice of GIM online, and the lived experience of GIM therapists who transitioned from in-person to online sessions. Themes identified the differences between online GIM therapy and in-person GIM therapy, as a dislocation of physical, personal and therapy space online, with absent cues and missed opportunities for caregiving. Rapport can be established and there is a development of a therapeutic process online, but the components of the GIM session are not the same and the transition for the therapist may be challenging. Online GIM sessions may provide greater opportunity and immediacy for people to have therapy and experience GIM, but in-person GIM may provide greater safety and greater depth of experience.

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Ελληνική περίληψη | Greek abstract

Αντιλήψεις των θεραπευτών KNAM κατά τη μετάβασή τους από τις δια ζώσης συνεδρίες KNAM σε διαδικτυακές πλατφόρμες κατά τη διάρκεια των περιορισμών του Covid-19

Denise Grocke | Katrina McFerran

ΠΕΡΙΛΗΨΗ

Τον Μάρτιο του 2020, όταν η COVID-19 ανακηρύχθηκε πανδημία, οι θεραπευτές αναγκάστηκαν να μεταβούν από τις δια ζώσης συναντήσεις με τους πελάτες σε διαδικτυακές συνεδρίες τηλεϋγείας. Οι προκλήσεις για τους θεραπευτές που εφαρμόζουν την Μέθοδο Bonny της Καθοδηγούμενης Νοερής Απεικόνισης και Μουσικής (KNAM) ήταν ιδιαίτερα δύσκολες. Αυτή η μελέτη σχεδιάστηκε για να κατανοήσουμε πώς οι θεραπευτές KNAM διαχειρίστηκαν την μετάβαση και πώς αντιλήφθηκαν τις διαφορές των δια ζώσης και

διαδικτυακών συνεδριών. Επτά θεραπεύτριες, όλες γυναίκες, οι οποίες ζουν και εργάζονται στην Αυστραλία, πραγματοποίησαν τον Ιούνιο του 2022 εις βάθος συνεντεύξεις σχετικά με κάθε στοιχείο της συνεδρίας, και η θεματική ανάλυση προσδιόρισε μεγάλες και δευτερεύουσες θεματικές κατηγορίες. Τα αποτελέσματα δείχνουν ότι υπήρξε μια μετατόπιση του φυσικού, προσωπικού και θεραπευτικού χώρου στο διαδίκτυο, με απουσία ενδείξεων και χαμένες ευκαιρίες για φροντίδα. Η σχέση εμπιστοσύνης διαμορφώθηκε διαδικτυακά και η θεραπευτική διαδικασία εξελίχθηκε, αλλά τα συστατικά της συνεδρίας KNAM δεν ήταν τα ίδια, και η μετάβαση για τον θεραπευτή ήταν δύσκολη. Τα ευρήματα υποδηλώνουν ότι οι διαδικτυακές συνεδρίες KNAM μπορεί να προσφέρουν περισσότερες ευκαιρίες και άμεση πρόσβαση στους ανθρώπους για θεραπεία και για εμπειρίες KNAM, αλλά οι δια ζώσης συνεδρίες KNAM μπορεί να παρέχουν μεγαλύτερη αίσθηση ασφάλειας και μεγαλύτερο βάθος εμπειρίας. Παρουσιάζονται περιορισμοί και συστάσεις για μελλοντικές έρευνες.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Καθοδηγούμενη Νοερή Απεικόνιση και Μουσική (KNAM), μέθοδος Bonny, αντιλήψεις των θεραπευτών, δια ζώσης KNAM, διαδικτυακή KNAM