GUIDED IMAGERY AND MUSIC (GIM) FOR PERSONS WITH DEPRESSION

A THREE-PART INVESTIGATION

BY
TIMOTHY J. HONIG

DISSERTATION SUBMITTED 2022

AALBORG UNIVERSITY
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CV

Tim Honig is Assistant Professor in Music Therapy at Westfield State University in Westfield, Massachusetts, USA, where he is the founding director of the Bachelor of Music in Music Therapy degree program. As a board-certified music therapist and *Fellow of the Association for Music and Imagery*, Tim has worked in inpatient and outpatient psychiatric health, oncology, private practice, and general medical settings. Clinically, his practice has centered on improvisation and imagery.

Tim holds a Master of Music Therapy degree and graduate certificate in Expressive Arts Therapy from Appalachian State University. Prior to studying music therapy, Tim earned a Bachelor of Music in trumpet performance from the Lawrence University Conservatory of Music in Appleton, Wisconsin, USA, which afforded him the opportunity to explore music, sound, improvisation, psychology, spirituality, and consciousness that formed his pathway into music therapy.

Tim has taught within the music therapy programs at Rowan University, Drexel University, and Appalachian State University, where he still assists as an instructor in the Appalachian State training program in the Bonny Method of GIM. He has served as a clinical supervisor for undergraduate, graduate, and post-graduate music therapists and was formerly the music therapy internship director at *Rockford Center*, a psychiatric hospital in Delaware, USA.

Tim lives in the hills of western Massachusetts with his wife Anastasia Day and his container garden of fruit trees, ferns, and succulents.

ENGLISH SUMMARY

This project constitutes a systematic investigation of Guided Imagery and Music (GIM) as a therapeutic method for working with persons who have depression. GIM is a music-centered integrative therapeutic method in which specially designed music programs facilitate client imagery experiences in non-ordinary states of consciousness. With the support of the therapist, these experiences provide transformative spaces for growth. Prior research has shown that a series of GIM sessions can lead to positive mood-related outcomes for persons with a variety of physical and mental health concerns. In addition, case studies have documented GIM as a therapeutic method that can be used with persons who have depression. This research project examines GIM as a therapeutic approach specifically for persons who have depression.

This thesis is composed of three articles and this linking text. The central focus was a feasibility randomized controlled trial examining the therapeutic effects of a series of GIM sessions for persons with depression as well as the feasibility of studying these effects within a randomized controlled design. In relation to the feasibility study, this thesis also includes investigations of the therapeutic method itself by designing a tool to describe what occurs in GIM sessions and by exploring similarities and differences between in-person and telehealth formats of GIM sessions.

Article 1 describes the development of the GIM Treatment Fidelity Instrument. A preparatory step for the feasibility study, this instrument was designed as a way to monitor treatment fidelity in GIM sessions in order to establish internal and external validity when investigating this complex and highly individualized therapeutic method. The instrument was created in collaboration with a mixed group of GIM therapists, trainers, and researchers and was piloted in 28 individual GIM sessions that were conducted by two GIM providers. It provides a descriptive rather than prescriptive model for monitoring treatment fidelity within objectivist GIM research.

Article 2 describes a multi-site feasibility randomized controlled trial (RCT) investigating therapeutic outcomes of a series of GIM sessions with persons who have depression. The study was framed within the post-positivist research paradigm and utilized an effectiveness design. The primary research aim was to investigate the feasibility of the research design, and the secondary aim was to examine effects on depression, anxiety, stress, and mental wellbeing. $N = 14$ participants were randomly assigned to receive either a series of 10 biweekly individual GIM sessions, or an equivalent waiting period followed by four group GIM sessions. Data were gathered at four timepoints. Due to the onset of the COVID-19 pandemic midway through the research study, enrollment was terminated early before reaching the targeted sample of $N = 28$. At that time, all research procedures involving in-person contact were suspended for approximately 6 months before resuming sessions online via telehealth

and completing research procedures for all participants who had already enrolled. Feasibility results showed that a series of 10 individual GIM sessions had high safety, acceptability, and tolerability, and that they required minimal variation from the traditional GIM session method when used with persons who have depression.

Results also indicated that GIM sessions could be successfully shifted to a telehealth format. The waitlist control group was suitable as a comparator group. With minor alterations to the data collection instruments and procedures, the design was found to be feasible for a larger-scale trial. Outcome results were limited by the small sample size and numerous confounds that resulted from adaptations to the COVID-19 pandemic.

ART-ANOVA tests revealed no significant effects for depression, anxiety, stress, or mental well-being. Within the GIM group, highly exploratory post-hoc Wilcoxon Signed Rank tests revealed small, medium, and large effect sizes for the dependent variables at midpoint, which attenuated at subsequent timepoints. More research with adequately-sized samples is warranted to further investigate therapeutic outcomes of a series of GIM sessions for persons who have depression. Additionally, future research should explore under what conditions telehealth GIM may be a viable alternative to in-person sessions.

Article 3 followed up on the feasibility RCT by exploring participants' experiences of shifting from in-person to telehealth GIM sessions, an adjustment made in response the COVID-19 pandemic. Utilizing an interpretivist design, the research aims were to examine participants' experiences of shifting from in-person to telehealth sessions during the feasibility RCT and to explore possible similarities and differences between how participants experienced GIM sessions in telehealth versus in-person formats. Two participants from the feasibility RCT were selected using purposive sampling and engaged in interviews on their experiences of shifting to a telehealth format of GIM.". Thematic analysis revealed four emergent themes: Participants experienced telehealth sessions to be effective overall, but generally less powerful than in-person sessions. Their relationship with their GIM provider was important to their experiences; however, the telehealth sessions initially felt less personal. Their experiences were affected by the combined home and virtual setting. Finally, the participants' experiences of telehealth sessions became more positive as they gained familiarity with the format. More research is needed to better understand indications and contraindications for telehealth GIM, to explore whether a series of GIM sessions can be initiated safely via telehealth, and to gain the perspectives of GIM therapists on telehealth sessions.

This linking text outlines the research framework for this thesis, including the theoretical grounding for Guided Imagery and Music as a therapeutic method. It also includes a discussion of the pragmatist research approach that undergirds this thesis, which frames the complementary research paradigms employed in each of the three

articles. This discussion provides a space for reflections on the ontological, epistemological, and methodological aspects of each of the articles. These reflections include important methodological considerations and decisions that shaped each of the three articles, including ways in which ethical care of the participants was considered at each stage of this thesis.

After providing summaries of each of the articles, the final chapter of this linking text weaves together the findings of the three articles. Integration of the overall findings leads to a discussion of clinical and methodological implications for GIM practice and research. Then, two case descriptions add detail to the integrated findings and illustrate the methodological complementarity among the three articles. The text closes with conclusions and limitations for this thesis, as well as directions for future research.

This research was funded in part by grants from the Mid-Atlantic Region of the American Music Therapy Association (MAR-AMTA) and the Association for Music and Imagery (AMI) and was supported by a PhD scholarship from Aalborg University.

DANSK RESUME

Dette projekt indeholder en systematisk undersøgelse af Guided Imagery and Music (GIM) som terapeutisk metode til behandling af personer med depression.
GIM er en musikcentreret integrativ terapeutisk metode, hvor specielt designede musikprogrammer faciliterer klienters evne til billeddannelse i ikke-ordinære bevidsthedstilstande. Med støtte fra GIM-terapeuten skaber disse oplevelser et transformativt rum for vækst. Tidligere forskning har vist, at klienter med forskellige fysiske og mentale helbredsproblemer kan få et positivt stemningsrelateret udbytte af at få behandling med en serie af GIM-sessioner. Desuden har casestudier dokumenteret GIM som en egnet metode for personer med depression. Dette forskningsprojekt undersøger GIM som en terapeutisk tilgang til personer, der specifikt har depression.

Afhandlingen består samlet af tre artikler og en kappe i skikkelse af denne tekst. Centralt står et feasibility-studie, et gennemførlighedsstudie, i form af en randomiseret kontrolleret undersøgelse (RCT). Den undersøger dels den terapeutiske af effekt af en række GIM-sessioner for personer med depression, dels muligheden for overhovedet at undersøge disse effekter indenfor et RCT-design. I forbindelse med feasibility-studiet undersøges også, om behandling med GIM som metode kan gennemføres. Dette er såvel gjort ved at designe et værktøj til at beskrive dét, som foregår i løbet af en GIM-session, som ved at undersøge forskelle og ligheder mellem GIM-sessioner udført ansigt til ansigt og virtuelt, dvs. som telebehandling.

Artikel 1 beskriver, hvordan et instrument til at monitorere behandlings-fidelity i GIM-terapien er blevet udviklet. Som forberedelse til feasibility-studiet blev instrumentet designet som en måde at monitorere fidelity i GIM-sessionerne på. Formålet var at styrke både intern og ekstern validitet i undersøgelsen af denne komplekse og stærkt individualiserede terapeutiske metode. Instrumentet blev skabt i et samarbejde mellem GIM-terapeuter, -studerende og forskere gennem 28 individuelle GIM-sessioner under ledelse af to GIM-udbydere. Instrumentet udgøres af en beskrivende frem for en præskriptiv model til overvågning af behandlings-fidelity inden for kvantitativ GIM-forskning.

Artikel 2 beskriver et multi-site feasibility randomiseret kontrolstudie (RCT), hvor det terapeutiske udbytte af en serie a GIM-sessioner undersøges for en række personer med depression. Studiet foregik inden for et post-positivistisk forskningsparadigme og benyttede sig af et effektivitetsdesign. Dets primære mål var at undersøge forskningsdesignets feasibility (gennemførlighed). Dets sekundære mål at undersøge metodens effekt på depression, angst og mentalt velbefindende. $N = 14$ deltagere blev randomiseret til enten at modtage en serie på 10 sessioner fordelt på én session hver 14'ende dag eller at skulle vente i en tilsvarende periode efterfulgt af fire GIM-gruppesessioner. Data blev indsamlet på fire forskellige tidspunkter. Som følge af

COVID-19-pandemiens fremkomst midtvejs i studiet blev indskrivning af nye deltagere afbrudt, før det ønskede antal deltagere på $N = 28$ var indskrevet. På dette tidspunkt blev alle aktiviteter, der involverede ansigt til ansigt-kontakt, suspenderet i 6 måneder. Efter denne periode blev behandlingsforløbet genoptaget som online telebehandling for de klienter, der allerede var indskrevet i studiet. Resultaterne viste, at en serie på 10 individuelle sessioner tilbød en høj grad af sikkerhed, accept og tolerance for deltagerne. Desuden viste det, at GIM-sessioner anvendt på personer med depression kun krævede minimal justering i forhold til anvendelse af den traditionelle GIM-metode.

Resultaterne indikerer også, at skiftet til teleformatet fungerede. Personerne på venteliste til behandling viste sig at kunne fungere som en egnet kontrolgruppe. Med kun mindre ændringer i dataindsamlingsinstrumenterne blev proceduren også fundet egnet til at lave en storskalaundersøgelse. Udbyttet af resultaterne blev begrænset af det indskrænkede datagrundlag samt en række nødvendige tilpasninger som følge af COVID-19-pandemien.

ART-ANOVA-analysen viste ikke signifikante fund for depression, angst, stress eller mentalt velbefindende. Inden for GIM-gruppen viste en eksplorativ post hoc-analyse med Wilcoxon Signed Rank test dog små, medium og stor effekt for de afhængige variable ved datapunktet midtvejs, mens effektstørrelsen blev mindre ved de efterfølgende målinger. Skal depressionsramtes udbytte af GIM-behandling undersøges er det derfor nødvendigt at have adgang til en tilstrækkelig undersøgelsespopulation. Desuden bør fremtidig forskning undersøge, under hvilke betingelser, telehealth GIM kan være et egnet alternativ til ansigt til ansigt-sessioner.

Artikel nummer tre følger op på feasibility RCT-studiet ved at undersøge deltageres oplevelse af skiftet fra sessioner ansigt til ansigt til sessioner med telebehandling online som følge af COVID-19-pandemien. Der anvendtes et kvalitativt design, hvor målet var at undersøge deltagernes oplevelse af forskelle og ligheder mellem at få sessioner ansigt til ansigt og som telebehandling.

To deltagere fra feasibility RCT-studiet blev udvalgt gennem målrettet sampling og efterfølgende interviewet om deres oplevelse af skiftet til GIM som telebehandlingsformat. Tematisk analyse afslørede fire temaer: Deltagerne oplevede generelt telesessionerne som effektive, men mindre kraftfulde end sessionerne ansigt til ansigt. Deres relation til deres GIM-behandler var vigtig for deres oplevelser; dog føltes telesessionerne i begyndelsen mindre personlige. Deltagernes oplevelse blev endvidere påvirket af den kombinerede hjemme- og virtuelle ramme. Endelig oplevede deltagerne telesessionerne mere positivt, i takt med de blev fortrolige med formatet. Der er brug for mere forskning for bedre at kunne forstå indikationer og kontra-indikationer for telebehandling med GIM, dels for at kunne undersøge om en serie af GIM-sessioner kan indledes sikkert som telebehandling, dels for at undersøge GIM-terapeuternes oplevelse af teleformatet.

Denne kappe skitserer de forskningsmæssige rammer for denne ph.d.-afhandling og inkluderer det teoretiske grundlag for Guided Imagery and Music som terapeutisk metode. Kappen inkluderer også en diskussion af den pragmatiske tilgang til forskning, der danner grundlag for afhandlingen, og som berammer de komplementære forskningsparadigmer, som er anvendt i hver af de tre artikler. Diskussionen giver endvidere rum til refleksion over ontologiske, epistemologiske og metodologiske aspekter for hver artikel, herunder metodologiske overvejelser og beslutninger, som har formet hver enkelt af de tre artikler, samt hvordan der indgik etiske overvejelser om deltagernes medvirken i hver af projektets faser.

Efter en opsamling af hver artikel væver det afsluttende kapitel af kappen fund fra de forskellige tre artikler sammen. En integration af de overordnede fund leder til en diskussion af kliniske og metodologiske implikationer af GIM-praksis og -forskning. Derefter er to case-beskrivelser tilføjet med det formål dels at integrere fund, dels at illustrere den metodologiske komplementaritet artiklerne imellem. Teksten lukkes med et afsnit om projektets konklusioner og begrænsninger foruden at angive retning for fremtidig forskning.

Denne forskning er fondsstøttet af følgende: The Mid-Atlantic Region of the American Music Therapy Association (MAR-AMTA), The Association for Music and Imagery (AMI) samt et ph.d.-stipendium fra Aalborg Universitet.

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Thanks also to you, the reader, for your curiosity that leads you to read this text. May you find what you seek.

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Article 1

Honig, T. J., & McKinney, C. H. (2021) Monitoring variation to Guided Imagery and Music (GIM): Development of the GIM Treatment Fidelity Instrument. *Nordic Journal of Music Therapy, 30*(5), 440–459. https://doi.org/10.1080/08098131.2021.1888781

Article 2

Honig, T. J., McKinney, C. H., & Hannibal, N. (2021). The Bonny Method of Guided Imagery and Music (GIM) in the treatment of depression: A multi-site randomized controlled feasibility study. *Journal of the Association for Music and Imagery, 18*, 27–54.

Article 3

Honig, T. J., & Hannibal, N. (2022). Client experiences of shifting from in-person to telehealth formats of Guided Imagery and Music (GIM). [Manuscript submitted for publication]. Department of Communication and Psychology, Aalborg University.

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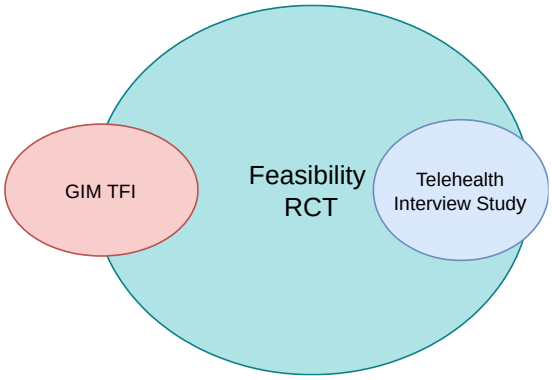
CHAPTER 1. INTRODUCTION

1.1. STRUCTURE OF THE THESIS

This article-based thesis is composed of three interrelated research studies that constitute a systematic investigation of the Guided Imagery and Music (GIM) for persons with depression. The first involved development of a tool for objectivist research, the GIM Treatment Fidelity Instrument (TFI). The second was a randomized controlled feasibility trial, and the third an interview-based interpretivist study. Article summaries are provided in Chapter 4.

Midway through this thesis project, we experienced the onset of the COVID-19 pandemic. By necessity, the research process took on a flexible dimension to adapt to the rapidly changing situation. While the thesis research was initially centered on a fixed postpositivist design with a focus on quantitative therapeutic outcomes, adaptations to rapidly shifting circumstances created space for a more flexible approach to the research process. Those adaptations offered an opportunity to examine new questions and build meaning in unexpected places. Figure 1 shows each of the three articles in this thesis and how their relationships among each other can be conceptualized.

Figure 1: Overview of the Thesis Studies



The overarching research question that guided this research was whether a series of GIM sessions leads to positive therapeutic outcomes for persons with depression. As the thesis evolved, there emerged an additional focus on the thesis as a methodological inquiry. The present text provides context for the article-based thesis as a whole and summarizes the findings of each research study. In addition, it includes discussion of the methodological considerations that emerged from the research during the planning stages, implementation stages, and in the stages after completing each of the three

articles. In discussing the overall findings, a particular emphasis is placed on the findings related to methodological inquiry.

Chapter 1 includes background for the article-based thesis. This background information includes a review of literature relevant to GIM and persons with depression, as well as reflections on personal motivations that formed the conditions in which I undertook this research.

Chapter 2 outlines the theory of science that formed the research foundation for this thesis. It includes a discussion of an integrated research perspective using complementary research paradigms that undergird the postpositivist and interpretivist approaches utilized in the three articles.

Chapter 3 includes a discussion of the methodological considerations that emerged in the process of planning and implementing each of the three studies, as well as a discussion of the ethical considerations that guided decisions in the research process.

Chapter 4 provides summaries of each article, including the major findings.

Chapter 5 integrates the findings of each of the three articles. It includes a discussion of the implications each article has for the others, as well as a discussion of the methodological considerations that emerged from the thesis as a whole. Two case descriptions also illustrate the complementary nature of the participant data gathered in each of the three articles.

1.2. PERSONAL REFLECTION

Recognizing that a researcher's positionality has an impact on the types of questions that are asked and how those questions are investigated, this section includes a set of reflections on some of my personal and professional motivations for undertaking this research. While brief, this provides context for the overall research aims and the perspectives that shaped this thesis.

1.2.1. PERSONAL MOTIVATIONS

This PhD grew out of several interests and needs. Guided Imagery and Music formed my initial bridge from the study of music performance and musicology into the field of music therapy. Since that time, I have been deeply interested in GIM as a therapeutic approach and a way of understanding the complexities of being human in the world. I have used GIM as a therapeutic approach both as a therapist and as a client and I always find it to be a place full of questions and curiosities. From the perspectives of both a therapist and client, I have curiosities about its therapeutic potential: Are clients benefiting from GIM? If so, how are they benefiting, and what

do those benefits look or feel like? These curiosities were one part of my motivation for engaging in the research that comprises this thesis.

Depression is an insidious disease that has impacted me in my personal and professional spheres. As a music therapist, my practice has focused on mental health and mood disorders in particular. I have worked with clients with mood disorders including major depression in a wide spectrum of settings—private practice, outpatient clinics, and inpatient hospital; a wide range of time frames—long term psychotherapy, multi-month treatment programs, and short-term hospitalizations lasting only days; and a wide range of acuity—from crises of suicidality to chronic low-level mood dysthymia. These clinical experiences have guided my curiosities about GIM towards questions that are relevant to persons with mood disorders, particularly depression, and this focus is reflected in my PhD research.

As a GIM therapist, I have witnessed meaningful and persistent change for the better in the clients with whom I have worked. I have also been witness to moments where clients feel stuck or confused in the GIM process. I come to the work with a set of pre-understandings that GIM leads to growth even during periods where that growth is not apparent. Consistent with theoretical framing put forth by Carolyn Kenny (Kenny, 2006), therapeutic change sometimes requires that one first takes time to build up energy. These experiences, along with my own experiences of change in GIM, bias me towards understanding GIM as a powerful therapeutic approach. I undertook this research with an understanding of this bias and worked to mitigate vulnerabilities to this bias in ways that are described throughout this project. In part, this was one motivation to investigate GIM through an objectivist lens.

As a researcher, my social location has an impact on the questions I ask and the ways that I seek to answer them (Jacobson & Mustafa, 2019), and therefore they are important to set the context for this thesis. I am a US American citizen, white, of northern European heritage, cisgender male, from a middle-class economic and social background. My educational background is in the study and performance of Western art music, which led me into the field of music therapy. The majority of my professional music therapy practice has been in highly diverse but racially, ethnically, and economically segregated areas. As such, I occupy positions of dominance within US American society. In a way that may be reflective of my dominant social positionality, I chose to conduct my PhD research situated largely within the dominant scientific paradigm of objectivist research. Acknowledging this, I found it important to qualify this research as one perspective on GIM for persons with depression and that different ways of knowing can lead to complementary truths. In addition, this research involved working with persons who were in more precarious situations than my own in terms of health, social, and/or economic status. As researcher and therapist, this had the potential to set up problematic power imbalances between me and the participants. With this in mind, I took care throughout the research process to

foreground ethical considerations. These are discussed in more detail in Ch. 3.4 of this linking text.

1.2.2. PROFESSIONAL MOTIVATIONS

This research was conducted as a PhD thesis and therefore can be understood, in part, as a set of learning experiences. When I planned my PhD proposal, I developed it with an aim to build expertise in a range of research methodologies as a way of grounding a lifetime of research where I have the skills and knowledge to flexibly adapt methodologies to new research questions that emerge. Aalborg University provided a space to develop this knowledge, with its grounding in the Problem-Based Learning model (Askehave et al., 2015).

Similarly, I entered the PhD process in order to develop an academic career within the teacher-researcher-practitioner model. Music therapy pedagogy is a central focus for me, and I began my doctoral work with the intention of building skills that would allow me to work with music therapy students at the undergraduate and graduate levels pursuing research interests of their own that would require varied methodological standpoints.

This thesis served both these professional purposes by providing a methodologically coherent way of deepening my understandings of three different types of research approaches in a mentored context; developing a research tool, conducting a complex quantitative outcome study, and performing qualitative, process-oriented interview research.

Finally, this research provided me an opportunity to explore my own ambivalence about objectivist research methodologies. On one hand, objectivist research provides a way of estimating cause-and-effect relationships and allows us to make useful predictions about therapies and the clients with whom we work. On the other, I am critical about reductionistic ways of knowing and being (e.g., Abrams, 2010; Aigen, 2015). In part, I set out on this PhD journey to learn more about objectivist methodologies, or more specifically, post-positivist research, in order to dive deeper into this tension that I held.

1.3. BACKGROUND

1.3.1. DEPRESSION

The World Health Organization (2016) estimated that over 300 million people around the world had experienced depression and found that the global prevalence of depression was increasing. In the US, 17.3 million, or 7.1% of the population, had a major depressive episode in 2017, up from 16.2 million in 2016 (SAMHSA, 2019). In 2019, the Centers for Disease Control and Prevention reported that 18.5% of adults

in the US experienced symptoms of mild, moderate, or severe depression (Villarroel & Terlizzi, 2020). In the US, people with depression or anxiety were found to have a 60% higher mortality rate and had a life expectancy that was 7.9 years lower than those without depression or anxiety (Pratt et al., 2016). Annually, depressive and anxiety disorders together account for a cost of $1 trillion USD.

A recent study found rates of depressive symptoms have increased significantly during the COVID-19 pandemic (Vahratian et al., 2021). Between August 2020 and February 2021, more than 40% of adults in the US reported symptoms of depression or anxiety within the past week, with the most substantial increases among young adults aged 18-29. Importantly, 25% of persons reporting symptoms of anxiety or depressive disorders felt they needed treatment but did not access it, an increase of 2.8% from August 2020.

Depression is characterized by feeling sad or depressed most of the day nearly every day, along with feelings of hopelessness, helplessness, worthlessness, or guilt; anhedonia, lack of motivation, fatigue, or low energy; difficulty with concentration; significant change in weight; hypersomnia or insomnia; and recurrent thoughts about death (American Psychiatric Association, 2013; World Health Organization, 2016). Over 50% of individuals with depression will also have comorbid anxiety (Mineka et al., 1998). While depression and anxiety are clinically distinct, the majority of individuals seeking treatment for depression will also have anxiety as a therapeutic focus.

In the treatment of depression, both pharmacological and psychosocial treatments have been found to decrease symptoms (Wolf & Hopko, 2008). For mild to moderate depression, pharmacological treatments are most frequently used and most highly recommended (APA, 2000), and have comparable efficacy to psychotherapy. However, psychotherapeutic treatments have had higher rates of patient satisfaction than pharmacological treatment (Wolf & Hopko, 2008). While more resource-intensive, the combination of psychotherapy and pharmacotherapy has been shown to be more efficacious than either approach alone (Halverson et al., 2016). The choice between pharmacological and psychotherapeutic treatment, or a combination of the two, is recommended to be left to the patient's preference (APA, 2000). Cognitive-behavioral therapy is the most researched psychotherapy for depression, and other examples with a strong evidence base include interpersonal therapy, problem-solving therapy, behavioral therapy, and psychodynamic therapy (APA, 2000; Halverson et al., 2016). While psychodynamic psychotherapy has less well-documented efficacy, it has been shown to be associated with symptom reduction in addition to more pervasive, long-term improvement (APA, 2000). Again, a patient's preference should be strongly considered in deciding which type of psychotherapeutic approach to utilize. In the case of pharmacological treatment, improvement should be seen within 6-8 weeks of beginning treatment (APA, 2000). Otherwise, treatment should be

adjusted due to failure to respond. For psychotherapeutic work, reassessment is indicated if no improvement is observed within 4-8 weeks.

1.3.2. GUIDED IMAGERY AND MUSIC (GIM)

The Bonny Method of Guided Imagery and Music (GIM) is an integrative method of music psychotherapy centered on the specialized use of recorded music to facilitate transformative imagery experiences (AMI, 2017). With the support of the therapist, referred to as the guide, these experiences of music and imagery allow the client, or traveler, direct contact with aspects of their conscious and unconscious self (Clark, 2014) that provide opportunities for greater understanding, meaning-making, and improving mental, physical, psychological, and spiritual wellbeing (Abbott, 2019). The method is named for its developer, Helen Bonny (Clark, 2019).

GIM can be used in individual and group therapy formats. In the individual form, sessions typically follow a session structure that begins with a preliminary conversation to discuss the client's present-centered awarenesses such as important themes or emotions to find a focus for the session (Abbott, 2019). The therapist then helps the client move into a non-ordinary state of consciousness, typically through a relaxation induction, before beginning the therapist-selected music. During the music, the client reports their spontaneously-generated internal imagery while listening to the music, while the therapist helps the client deepen their engagement with the music and imagery by providing verbal interventions. After the music ends, typically 10-50 minutes, the therapist helps the client return to a more ordinary state of consciousness and assists the client in processing their experiences through discussion and often visual artwork. The group form of GIM typically follows the same general structure of the individual form but usually involves a shorter music-listening period and no dialogue with the therapist during the music (Grocke, 2019). This thesis research focuses primarily on the individual from of GIM.

1.3.2.1 Theoretical Underpinnings of GIM

Key aspects of GIM include characteristics and functions of the music, shifts through non-ordinary states of consciousness, and a broad understanding of imagery and its uses or representations. In addition, its roots in humanistic psychology form the basis of a theoretical framework for GIM.

Music

Music is a central and essential element of GIM (AMI, 2017). It can be considered a co-therapist (Clark, 2019), or indeed at times, the primary therapist. It is a prime agent of focus, transformation, and aesthetic meaningfulness (Bonny, 2002), and its functions and intentional use form the foundation for GIM.

The music used in GIM is predominantly from the Western art music tradition, often termed *classical* music, although music from other styles and cultures are seeing increased use (e.g., Ng, 2019). GIM programs consist of multiple pieces of music and usually range from 10–50 minutes (Bruscia, 2019a). Shorter programs typically provide more containment or safety, while longer programs allow a more in-depth or open process of unfolding. The music can be considered expert-selected since programs for each session are chosen by the GIM therapist to meet the specific and individualized characteristics of the client in a given session.

Pre-designed GIM programs are developed by trained and experienced GIM practitioners based on extensive listening and cataloging of individual pieces, sequencing them together into programs of several pieces, followed by testing and researching them with self, colleagues, and eventually clients. Helen Bonny developed 18 original GIM programs by 1989 (Bonny, 1978/2002; Grocke, 2002). In collaboration with Linda Keiser Mardis, 12 of these programs were designated core GIM programs in 1994 (Bruscia, 2019a). There are now over 100 GIM programs that appear in books (e.g., Grocke, 2019), journals (e.g., *Journal of the Association for Music and Imagery*), and conference presentations. In addition to pre-designed programs, GIM therapists sometimes use improvisatory programming in which they tailor music choices to the client and their emerging imagery process in the moment, creating a new program for the client during the session in real time (Muller, 2014; Ventre, 2002).

The music in GIM serves myriad functions (Bruscia, 2019c). Western art music, as well as other musics used successfully in GIM, support transformative processes in non-ordinary states and elicit strong emotional experiences (McKinney, 2021). It also helps the imager sustain and deepen their imagery development (McKinney, Tims, et al., 1997), and provides a balance of structure and openness (Bonny, 2002b) to give the client the opportunity to safely explore deep, ecstatic, or difficult content. Music also contains multiple times and spaces in a nonlinear way, sometimes concurrently (Bonny, 2002b; Honig, 2017). This can provide unique opportunities for regression, reprocessing (Körlin, 2019), or metaphorical meaning-making (Bonde, 2000). Lawes (2017) discussed the tension/release process and the rhythmic and tonal dynamics within the music used in GIM as embodying cycles of "opening-closing or breathing" (p. 281) within multiple superimposed layers. For example, the tension/release cycle occurs moment-to-moment, but also at progressively larger scales such as within phrase structures and within a piece of music as a whole. Each cycle contains an experience of wholeness or completion, and this quality imbues the music with superimposed layers of wholeness. Since the music is the primary structuring element in GIM, this quality brings implicit structures of wholeness or completeness to clients' imagery experiences.

According to a taxonomy of music for therapeutic approaches using music and imagery that are closely related to GIM, individual pieces of music within a GIM

program can be categorized as supportive, mixed supportive and challenging, or challenging (Wärja & Bonde, 2014). Supportive music can be characterized by predictability, clarity, steadiness, simplicity of instrumentation and timbre, and lighter moods. The supportive category has three subtypes: secure and holding, which describes music that is the most stable, simple, and reliable; secure and opening, which is has slightly more variability; and secure and exploratory, which contains small gestures towards tension or change. Mixed supportive-challenging music is characterized by changes in dynamics or rhythms, more complex melodic and harmonic content, moments of higher intensity, and darker moods. While music in the supportive category is holding, music in the mixed supportive and challenging category stimulates exploration. Three subtypes of mixed supportive and challenging music include music that is explorative and contains surprises and contrasts; music that is explorative and deepening, which evokes more complex, difficult, or challenging emotions; and music that is explorative and challenging, which includes more tension, surprises, contrasts, and challenging emotions balanced by other supportive musical characteristics. Finally, music within the challenging category contains complex music with a high degree of variation in melodic, harmonic, rhythmic, timbral, and emotional content. Three subtypes of challenging music include rhapsodic, characterized by wide variation among musical content; metamorphosis, characterized by highly complex development of more limited musical gestures; and mystery and transformation, characterized by solemn or dark music that evokes mystic or spiritual states. GIM programs contain music from all categories within this taxonomy. When carefully woven together into a program, multiple pieces within a program create a contour of dynamic change that can be understood in terms of a profile of affective or energy dynamics (Bonny, 1978/2002).

At a larger-scale level, GIM programs can be considered to be preparatory, beginning, working, or transpersonal programs (Bruscia, 2015). These categories correspond to the therapeutic readiness of a client who is most likely to benefit form a given program; these categories loosely parallel the client's stage in therapy, which can unfold in nonlinear or cyclical patterns. Preparatory programs are most likely to be appropriate for new GIM clients, as well as for more experienced clients who are at a point of rest (McKinney, 2021). Beginning programs support deeper work for short periods, while retaining supportive characteristics; these programs tend to be used most with clients who are ready to explore difficult content with the support of safe, reliable music (Bruscia, 2015). Working programs support intense imagery that can bring strong, difficult emotions, and are appropriate for clients with strong ego boundaries and inner resources and have a high degree of therapeutic readiness. Transpersonal programs support and sustain spiritual/transpersonal experiences.

Programs can also be categorized according to the types of challenges they offer (Bruscia, 2015). Some offer physical challenges, emotional challenges, spiritual challenges, and musical challenges; many offer a balance of different types of challenges. Finally, GIM programs can be further described by the level of mood

consistency they offer within and between the pieces that make up the program (Bruscia, 2015). These levels—high, medium, or low mood constancy—categorize both the frequency with which moods change and the duration of moods within single pieces and between different successive pieces in the program.

It should be noted that these ways of understanding GIM programs—the degree of constancy, level of work, or type of challenge—do not offer discrete categories; rather, these categories represent clusters of characteristics along multiple continua. These categories provide GIM therapists with a framework for understanding a client's therapeutic process and aiding therapists in selecting music that best matches the client in a given session, and they should not be understood as prescriptive categories.

Imagery

In GIM, imagery is defined broadly as any awareness in one's imagination. It can include content from any of the five senses, in addition to emotional, somatic, and kinesthetic awarenesses. Imagery content may include memories, archetypes, or spiritual experiences. Based on the writings of Ricour, Bonde (2000) proposed a three-level model for understanding images as metaphor in GIM. First-level metaphors are represented by images containing a client's problem, conflict, or issue, while second-level metaphors contain parts of the client themselves. First- and second-level metaphors combine in a narrative to form third-level metaphors. While it is beyond the scope of this text to detail a full range of conceptualizations of imagery in GIM, other ways that imagery can be understood are as varied as representations of the pathway towards individuation from a Jungian perspective (Stokes-Stearns, 2019), symbolic contact with repressed parts of the self for integration repair (Bruscia, 2019); development of positive inner resources through deep emotional responses to the music (Goldberg, 2019), or transformative metaphors that aid in emotion regulation (Perilli, 2019)

Non-ordinary states of consciousness

Non-ordinary states of consciousness (NOSC) are essential to GIM experiences, and as such they are defined as one of the core elements of GIM (AMI, 2017; Bruscia, 2019c). These states have also been referred to in GIM literature as expanded states of consciousness (Bonny, 1976; Bruscia, 2015) and altered states of consciousness (Bonny & Tansill, 1977/2002). These terms gesture towards slight differences but are largely used interchangeably; NOSC is the current term adopted by the AMI for the states of consciousness accessed, utilized, and explored in GIM, and therefore the term used in the present text.

NOSCs serve a variety of functions in GIM, a few of which are listed here. They allow clients to become more open to the stimulus of the music and to their evolving imagery process (Bonny, 1975/2002) They also increase one's level of awareness and deepen the aesthetic experiences of the music and imagery. NOSCs provide access to

symbolic language or metaphors, aid in contact with and integration of unconscious material, open one up to peak or transpersonal experiences,

The GIM therapist helps the client transition to NOSCs using techniques for relaxation and/or focusing (Bruscia, 2015), and these states are deepened by the music. Non-ordinary states of consciousness are not discrete states but rather constellations of awareness and modes of perception and processing (Honig, as cited in McKinney, 2021).

Theoretical Orientation: Flexibility and Individualization

Rooted in humanistic and transpersonal frameworks (Bonny, 2002a; Bruscia, 2015), GIM is built upon the belief that a person can be more than they are and that we have contact with wisdom and potential for growth or healing (Clark, 2019). GIM is a way to access these places or cultivate these resources (Bonny, 1975/2002), whether they are conceptualized as springing forth from the within the psyche or from some external source (Clark, 2014). With the development of GIM theory and practice, GIM also draws on knowledge from areas as diverse as psychodynamic (Bruscia, 2019) and Jungian theory (Stokes-Stearns, 2019), neuropsychology (Körlin, 2019), gestalt therapy (Clarkson, 2019), narrative frameworks (Perilli, 2017), and spirituality (Kasayka, 2002).

Aligned with the humanistic orientation, GIM practice is by necessity adaptable, flexible, and individualized; it must be tailored to a client's unique situation and emerging states. This includes attunement to the client's

- Current presentation, such as energy, affect, themes, resources, and defenses (Bruscia, 2015)
- Current issues
- Background, such as spirituality, history of depth work, experience in NOSCs, family and social histories, histories of illnesses or traumas, associations with music (particularly Western art music)
- Shifts in the client's imagery process
- Shifts in the client's *space* of consciousness (Clark, 2014; Honig, 2017)

The guide is crucial to this process. Through dialoguing with the client, their role is to help the client deepen and more fully explore their experiences as the imagery develops spontaneously through the music. In addition to their tasks of selecting the music, providing appropriately nondirective guiding interventions during the music, and facilitating the preliminary conversation and post-music processing periods, the guide's experienced presence provides the client with a degree of psychological safety to let go into their experiences, surrendering into the music and their imagery (Mårtensson-Blom, 2011). According to GIM principles, the therapist maintains a non-directive attitude. This seems to be a transcultural aspect of GIM, experienced as

an essential aspect of engaging in GIM by clients from a range of cultures (Yoshihara et al., 2022).

1.3.2.2 Definitions of GIM

Since its development by Helen Bonny, experimentation and adaptation have been integral to GIM research and practice (Bonny, 1995; Summer, 2015) in order to best meet the widely varied characteristics of the client and the therapeutic setting and to develop new possibilities of exploring consciousness through music. A broad array of modifications and adaptations to the Bonny Method appear in the literature (Grocke & Moe, 2015; Muller, 2014), bound together by their specialized use of music to support imagery experiences in non-ordinary states of consciousness within a therapeutic relationship.

In GIM literature, modifications and adaptations refer to different types of variations to the GIM method (Grocke & Moe, 2015). Modifications are substantial pre-planned changes to GIM, while adaptations are changes to GIM that are done "in the moment" (p. 21) in response to specific circumstances. For the purposes of this thesis, I will use *variations* of GIM as an umbrella term that encompasses any alteration to the GIM approach including both modifications and adaptations of GIM.

In the context of these developments to Bonny's original method, GIM authors have used a variety of different terms to describe their approaches, some of which draw different boundaries around what can be considered GIM and what can be considered a related but separate approach (Grocke & Moe, 2015). Three primary ways defining the Bonny Method and GIM practices have emerged, each described in more detail below.

One, developed by Bruscia (2002b, 2015), utilizes a narrow definition of the Bonny Method paired with a broad understanding of the term Guided Imagery and Music or GIM. In Bruscia's (2015) conceptualization, the Bonny Method refers specifically to Bonny's original work (sometimes referred to as BMGIM), including the specific individual and group formats of Bonny's original method (as described in Bonny, 1976). Bruscia's definition of the Bonny Method includes the following nine characteristics:

1. a one-on-one form
2. of exploring consciousness (e.g., in healing, psychotherapy, self-development, spiritual work),
3. which involves the client in spontaneous imaging
4. in an expanded state of consciousness
5. to predesigned programs of classical music,
6. while dialoguing with a specially trained and qualified, therapist,

7. who uses nondirective, supportive, nonanalytical, music-based interventions,
8. within a client-centered orientation,
9. all within a session that has the following components:
    - preliminary conversation
    - induction
    - guided music-imaging experience
    - return, and
    - postlude discussion

(Bruscia, 2015, pp. 1–2)

GIM, on the other hand, refers to any approach using music and imagery in a non-ordinary state of consciousness related to or inspired by the Bonny Method. According to Bruscia's definition, some practices that qualify as GIM but not the Bonny Method include contained spontaneous imaging, directed music imaging, re-imaging, and interactive music imaging. Absent from this definition is a discussion of *music and imagery* approaches, for example those developed by Lisa Summer (2015) and Frances Goldberg (1994). This omission is noteworthy, since these approaches are directly inspired by the Bonny Method and appear extensively in GIM literature (e.g., Grocke & Moe, 2015) and current research (e.g., Story, 2018). According to Bruscia's category descriptions, these approaches would seem to fall under the umbrella term GIM, since they involve music and imagery in a non-ordinary state of consciousness and are closely related to and inspired by the Bonny Method. Practices that do not qualify as GIM within this definition but still involve some combination of music, imagery, and/or non-ordinary states of consciousness include projective listening and music-assisted relaxation approaches, as well as approaches like Guided Affective Imagery and Holotropic Breathwork.

Bruscia's (2015) definition of the Bonny Method is highly specific, while the category GIM includes a broad range of practices, from ones that are only minimally varied from GIM (e.g., a session that follows a Bonny Method session format in which the therapist creates a new program improvisationally by using music selections from Bonny programs in order to meet the client's emerging imagery process) to practices that have substantial differences in therapeutic intent and format (e.g., supportive music and imagery; Summer, 2011). In effect, this definition means that the term Bonny Method has limited clinical relevance since when even minor variations are used, the term Bonny Method would no longer apply. At the same time, this definition of GIM has little descriptive precision since it incorporates such a wide variety of approaches and theoretical frameworks.

Grocke and Moe (2015) describe another approach to defining GIM, the Bonny Method, and related therapies. Their conceptualization utilizes the same highly specific definition of the Bonny Method as Bruscia (2015), writing that the Bonny Method is the specific form of GIM that Bonny developed and practiced. However,

Grocke and Moe (2015) do not elaborate on the precise boundaries between GIM and the Bonny Method of GIM. GIM is used as a term that encompasses the Bonny Method and closely related approaches that

a) follow the same session format (preliminary conversation, relaxation/focus, music imaging, and processing/integration conversation),
b) utilize a music program that is either pre-designed or improvised and has an "affective-intensity contour" (p. 20),
c) involve the client imaging spontaneously to the music in a non-ordinary state of consciousness, and
d) involve dialogue between the therapist and client during the music listening period.

Importantly, this definition of GIM includes the use of Helen Bonny's original music programs, in addition to programs created by other GIM practitioners and improvised music programs.

The four criteria listed above differentiate GIM from other modifications and adaptations like music and imagery (MI) or Focused Music Imagery (Grocke & Moe, 2015; Dimiceli-Mitran, 2020; Summer, 2015). Two central differences between GIM and MI are that GIM involves dialogue between the client and therapist while the client listens to the music while MI typically does not, and GIM utilizes music programs while MI typically uses single pieces of music (Summer, 2015; see below for more detail).

A third model, proposed by Summer (2015), sheds additional light on how GIM can be defined. Her model draws distinctions between GIM and MI approaches that were developed as adaptations of GIM for clinical populations, rather than focusing on distinguishing the Bonny Method from GIM. For MI, each part of the GIM approach is simplified or shortened in order to provide an experience of a single image with greater containment, stability, or comprehensibility for the client's imagery experience than GIM would provide.

> […] whereas the Bonny Method is an exploratory method that utilizes a deeply altered state of consciousness and sequenced, evocative music programs to stimulate many images, music and imagery is a directed method that utilizes brief relaxation and simple, repeated music to stimulate a single image. (p. 341)

According to Summer's (2015) model, GIM and MI differ in three primary areas. (1) GIM involves helping clients enter a deeply altered non-ordinary state of consciousness, while MI involves experiences in lightly altered states accessed through brief relaxation or focusing techniques. (2) Clients engage in the music-imaging portion of GIM sessions with eyes closed, while they experience MI with

eyes open while drawing or writing, as described by Goldberg (1994). (3) GIM involves programs of multiple pieces of music, while MI uses single pieces of music that are sometimes repeated. MI provides clients with condensed, contained experiences, while GIM provides clients with expansive and exploratory experiences.

Both GIM and MI can function at supportive, re-educative, and reconstructive levels (Summer. 2015; Wheeler, 1983), and GIM and MI lie on two separate but related continua that range from supportive to reconstructive levels. According to Summer's writing, GIM sessions in which the therapist uses Bonny's GIM programs will facilitate work at the reconstructive level. But, adaptations in the ways of accessing NOSCs, the music, and guiding techniques can allow GIM to facilitate work at supportive or re-educative levels as well. This understanding of the therapeutic levels at which GIM and other music and imagery approaches can function aligns loosely with the categories proposed by Wärja and Bonde (2014) in their taxonomy of music for therapeutic practices using music and imagery (described above). For example, an approach using music from the *supportive* category would be more likely to facilitate therapeutic work at the supportive level due to its high degree of predictability, containment, and constancy. At the opposite end of the continuum, music from the *challenging* category would be more likely to support work at the reconstructive level due musical elements like high degree of musical elaboration and evocative mood. A GIM program might be made of up individual pieces of music that can be considered supportive, mixed supportive-challenging, and challenging (Wärja & Bonde, 2014) that would each facilitate work at different therapeutic levels, or, one program might facilitate supportive level work in one session, and intense reconstructive work in another. Along these lines, it is important to note that these musical categories and therapeutic levels are fluid descriptors of complex processes and are not always clearly delineated categories.

In Summer's (2015) conceptualization, GIM is understood in terms of a continuum across supportive, re-educative, and reconstructive levels with shared theoretical and procedural commonalities unique to GIM, rather than discrete therapeutic methods with differentiated terms like the Bonny Method vs. GIM. In part, this third model seems to gesture towards removing the distinction between GIM and the Bonny Method. Instead, Summer's definition places both on the GIM continuum rather than separating the Bonny Method from GIM.

Terminology for the Present Research

While there is merit to each approach to defining GIM, the present text will use the term GIM according to Grocke and Moe's (2015) definition, with borrowings from Summer's (2015). Grocke and Moe's (2015) definition has precision in delineating GIM from other more substantially varied approaches, which lends it utility in research. At the same time, it retains more flexibility than Bruscia's (2015) rather restrictive definition of the Bonny Method of GIM that may not reflect the client-centered flexibility so crucial to GIM from its initial development (Summer, 2015).

Summer's (2015) definition of GIM aligns with Grocke & Moe (2015), except that Grocke and Moe separate the Bonny Method as a specific subset of GIM. Drawing on Summer's conceptualization, this thesis will not distinguish the Bonny Method of GIM from GIM. Instead, the present research uses GIM as a term that encompasses the Bonny Method and closely related approaches that follow the same session format, involve dialogue between the therapist and client while listening to the music in a NOSC, and utilize specialized music programs. The term GIM is differentiated from other modifications and adaptations like MI or Focused Music Imagery (Grocke & Moe, 2015).

The term Bonny Method appears occasionally throughout this text and the three articles, for example in the title of Article 2. This is to signal that the research focuses on approaches closely tied to Helen Bonny's work as it is recognized internationally. It also acknowledges that the therapeutic model under investigation here is known by many as the Bonny Method of Guided Imagery and Music.[1]

Importance of Clarifying Terminology in GIM

In the initial stages of this research, I intended to avoid the task of defining specific boundaries of GIM and the Bonny Method since the topic has been, at times, contentious. However, three sets of practical reasons make it important to have a clear understanding of how one uses the term GIM.

First, clarity about therapeutic approach is important for transparent communication with consumers. It is an ethical imperative that consumers are reasonably informed about the therapeutic work they are being offered, and clear terminology aids in communicating this information (Muller, 2014). Additionally, a consumer who is seeking to do work using a specific approach like GIM or MI should be confident that the practitioner actually provides the approach they seek. Again, clarity about terminology is essential in order for this to occur. Since there are strong rationales for using various definitions of the terms Bonny Method or GIM, it may be neither reasonable nor desirable for there to be consistency within the field regarding terminology. Given that variability, however, transparency and clarity about how individuals use terms like GIM or the Bonny Method becomes all the more important.

A second set of reasons concerns training in GIM. As highlighted by Goldberg (2015) and Summer (2015), different levels of practice within GIM and related approaches

[1] GIM therapists who define the Bonny Method of GIM as the specific form of GIM utilized by Helen Bonny, including use of only her music programs, according to the narrow definition proposed by Bruscia (2015) may disagree and recognize the therapeutic model under investigation in this research as GIM and not just the Bonny Method. Such a position would be valid, and explanation of terminology has been included in this linking text in order to be transparent about *what* is under investigation regardless of how the reader defines GIM or the Bonny Method.

like MI require different competencies and involve different scopes of practice. It is essential that there is clarity about how trainers—and prospective trainees—use the terms GIM, Bonny Method, and music and imagery so that trainees can obtain the training they seek and so that there is a clear understanding of what therapeutic practices and models fall within their scope of competence (Muller, 2014).

A third set of reasons for clearly defining terms relates to research methodology. With various definitions of the Bonny Method and of GIM in addition to a wide range of adaptations and modifications to GIM that may or may not fall under the general term GIM (Bruscia, 2015; Grocke & Moe, 2015, Muller, 2014), it is essential to have a clear understanding of how researchers—and therapists—use these terms in order to actually know what therapeutic approach is being investigated. In quantitative or objectivist research, this can be understood in terms of validity (Borrelli, 2011). Internal validity involves establishing whether any outcomes are actually attributable to the therapy or intervention under investigation. This requires that the researchers are clear and transparent about what the therapy or intervention consisted of, and to what degree there was consistency in how the therapy or intervention was provided within a research study. External validity involves knowing to what degree a therapy or intervention under investigation can be compared with other research or clinical practice external to that research study. Both are essential to monitor in objectivist research. For either to be monitored or assessed, there must be a clear understanding of what the therapy or intervention entails. In the case of GIM research, researchers must provide a clear and precise description of how they use terms like GIM or the Bonny Method. Otherwise, there would be a nebulous understanding of what the therapeutic encounters actually entailed, and compromised ability to replicate the research or to make comparisons with the findings of other studies.

Given this methodological need for clarifying the terms GIM and the Bonny Method, we realized that there needed to be a way to monitor whether the sessions in our GIM study were indeed GIM or another related approach so that any conclusions from the research or comparisons with other research could be made appropriately. One possible approach to ensure validity in a research study on GIM would be to require all participants are provided with a specific manualized version of GIM sessions. Given the humanistic foundations and flexible orientation central to GIM, this rigid approach would not have aligned with GIM principles. Another approach would be to create a descriptive tool that would gather data about sessions as they occur. This would allow researchers to monitor and later present what the sessions under investigation actually consisted of. Additionally, this descriptive approach could allow for clarity and transparency about session content *regardless* of the reader's definition of Bonny Method, GIM, and related approaches since it could provide descriptive data about sessions instead of relying solely on labels like Bonny Method. At the outset of this research, there was not an established tool or process of this kind that would allow researchers to describe sessions in which GIM or GIM-derived

approaches are used. In order to monitor treatment fidelity in quantitative GIM research (Borrelli, 2011), such a tool or process needed to be created.

1.3.3. GIM AND DEPRESSION

Case studies and clinical practice have provided preliminary evidence that GIM is a safe and effective therapeutic approach for persons seeking treatment for depression. A 1999 survey of GIM clients found that 28% of clients sought GIM sessions for depression and that 40% experienced change in mood as one outcome of their GIM sessions (Maack & Nolan).

Case studies have also described GIM as a relevant therapeutic approach with persons for whom depression or sadness is a primary therapeutic focus (Bush, 1992; Lewis, 1998–1999; Pickett, 1992; Summer, 2011; Trondalen, 2009–2010; Walker, 1993; Weiss, 1994). Further, case studies describe work with clients who experience depression as an area of focus secondary to other physical or psychological conditions like cancer (Bonde, 2005; Hale, 1992); abuse, domestic abuse, PTSD, and C-PTSD (Borling, 1992; Hearns, 2009-2010; Moffitt & Hall, 2004; Pickett, 1992); eating disorders (Heiderscheidt, 2015); and addictions (Pickett, 1995).

No objectivist outcome research has specifically examined treatment effects of GIM for persons with depression. However, a systematic review of the psychological and physiological health outcomes of a series of GIM sessions in other clinical and non-clinical populations revealed a cluster of positive mood-related outcomes: depression, depressed mood, mood disturbance, and anxiety. These treatment outcomes are described in more detail in Article 2 (Honig et al., 2021).

Existing research also provides evidence for positive treatment outcomes related to stress, which might be a key factor contributing to depression. A group of individuals on leave from work-related stress experienced decreased perceived stress after a series of GIM sessions in comparison to wait-list, as well as decreased levels of salivary cortisol with a small effect size (d = 0.43) in comparison to treatment as usual (Beck, Hansen, & Gold, 2015). Similarly, McKinney et al. (1997) found that healthy adults had decreased plasma cortisol with a small effect size at posttest (d = 0.3), which increased to medium at follow-up (d = 0.7). McDonald (1990) detected a decrease in systolic and diastolic blood pressure from pretest to follow-up with large effect sizes (d = 1.5 and d = 1.2, respectively). This evidence for treatment effects related to stress has relevance to depressive symptomatology and demonstrates physiological change associated with improved psychological wellbeing.

GIM supports varied therapeutic work (Grocke, 2019) and aligns with a multiaxial understanding of human growth and development (Bonny, 2002b; Wilber, 2000). There are numerous theories about how GIM leads to meaningful change for clients experiences of music-imagery as embodied metaphor (Bonde, 2005; Perilli, 2002),

engagement in transpersonal processes (e.g. Clark, 2014), contact with parts of self for psychodynamic work (e.g. Bruscia, 2002), and music-imagery as a vehicle for neurological reprocessing of traumatic events (Körlin, 2002); it is likely that each holds some explanatory power. Bonny wrote that the GIM process is so fully interconnected that it cannot be broken down into therapeutic agents or mechanisms (Bruscia, 2019c). More research is needed to shed more light on the processes of transformation in GIM.

1.3.3.1 Indications, Contraindications, and Adjustments to GIM

Because GIM allows contact with issues in the conscious and unconscious self, clients can rapidly and unexpectedly move into therapeutic work that brings up issues, memories, or emotions that had been successfully repressed by the conscious mind (Bruscia, 2015). For some clients, this can be intense and challenging work that requires stamina, resilience, and ego strength. GIM has been described as self-limiting, meaning that the GIM process only brings up content that a client can tolerate (Bruscia, 2015). For persons with significant medical or mental health complications, however, Bruscia (2015) suggests that this may not actually be the case and that these persons may be more vulnerable to overwhelming, dysregulative, or dissociative experiences in GIM. If GIM is not self-limiting for persons with significant mental health complications, it means that additional care must be taken with persons who have severe depressive symptoms to ensure safe and ethical care. This raises an ethical issue when considering research that uses randomized group allocation with persons who have significant mental health complications like depression. For persons who have more severe symptom sets or are more vulnerable, greater care must be taken to ensure that the risk to them is minimal.

Summer (1989) wrote that clients must have the following characteristics for GIM to be an indicated therapy: cognitive capacity for symbolic or metaphoric thinking, ability to differentiate between symbolic thinking and consensual reality, ability to communicate about their imagery experiences with their therapist, and capacity for growth in GIM. In addition, Bruscia (2015) added further characteristics that a client must have in order to engage safely in GIM:

1. The emotional stability needed to undergo the feelings evoked by the music and imagery.
2. The ego strength and boundaries needed to maintain [their] sense of self and personal identity after deep experiences where boundaries between self and other or environment may merge.
3. The intellectual abilities needed to understand [their] own experiences and not be dangerously overwhelmed or confused by them.
4. The verbal abilities needed to dialogue with the guide before during, and after the music-imaging experience.
5. Sufficient reality orientation to distinguish imaginary and real worlds.

6. The medical and physical stamina needed to experience the music and undergo the images that may arise.
7. Any [sic] limitation in the ability to listen to, appreciate, and image to the music best suited to reach the goal.

(p. 98)

In addition, presence of "severely disturbed or psychotic imagery" may mean that the client is contraindicated for the Bonny Method (Bruscia, 2002a, p. 285)

If a client lacks any of these characteristics identified by Summer (1989) or Bruscia (2015), unmodified Bonny Method sessions are contraindicated. It is important to note that these contraindications are framed in terms of Bruscia's (2015) narrow definition of Bonny Method, and it is unclear to what extent these recommendations extend to Grocke & Moe's (2015) definition of GIM.

These characteristics presented by Summer (1989) and Bruscia (2015) are primarily oriented towards positive qualities, characteristics, or strengths that clients need to *have* in order for GIM to be indicated. These resource-based criteria do not align directly with diagnostic criteria for depression, which are framed in terms of symptoms according to a deficit-based medical diagnostic model (APA, 2013). However, a review of criterion symptoms of depression (as described previously in Ch. 1.3.1) can point towards risk factors that persons with depression may be vulnerable to, depending on their symptom clusters and severities. Depression may impair concentration or focus. In cases where impairment of concentration or focus is severe, the client may not meet Summer's (1989) criteria and require adaptations to GIM sessions. Persons with higher severity of mood symptoms may also have insufficient emotional stability to tolerate unmodified GIM. Highly distorted thoughts about self and one's existence, such as severe feelings of hopelessness or worthlessness may also prevent the client from being able to fully engage with the music and imagery process. This effect can be amplified by ruminative and distorted thought patterns, which can also compromise a person's accurate perception of reality. Increasing severity of physical symptoms such as fatigue or insomnia may leave clients with insufficient physical stamina for unmodified GIM sessions, and severity of motivational symptoms such anhedonia will impact the client's capacity for growth and ability and willingness to fully engage with their music and imagery experience.

Apart from criterion symptoms, ego strength and personal identity can be tied to the negative self-attributional style (Nolen-Hoeksema et al., 2008) that is correlated with depression, and heightened severity in these areas may also indicate that adjustments to GIM are needed. Similarly, severe impairment in coping and emotion regulation (Vanderlind et al., 2020) may lead to a client being overwhelmed by upsetting or negative imagery experiences. A symptom closely connected with major depression, rumination is characterized by perseveration on negative thoughts or feelings, particularly with a negative bias towards self-attribution. It is correlated with longer

periods of severe depressive symptoms (Nolan-Hoeksema et al., 2008). In persons with severe rumination, it can interfere with their therapeutic process and reduce the effectiveness of therapeutic interventions, and in addition can prolong physical stress states (Watkins & Roberts, 2020).

In each of these areas, as severity of the symptom increases, so does the likelihood that the GIM method would need to be adjusted. The GIM therapist would need to continually assess the client's readiness and appropriateness for GIM in each of these areas. Symptoms of major depression do not rule out a person's appropriateness for GIM; rather, the GIM therapist needs to pay careful attention to risk factors as they present, and need to approach the GIM sessions with the knowledge that increased symptom severity means it is more likely that adaptations or modifications to GIM will be needed.

When a client displays characteristics that indicate risk factors for GIM, a therapist must adapt their therapeutic strategies, techniques, and/or approach accordingly. A full list of possible adjustments to the Bonny Method is beyond the scope of this text (see, for example, Grocke & Moe, 2015; Muller, 2014); however, each portion of the GIM session can be altered to provide greater stability, safety, or containment for the client's imagery experiences and therapeutic process (Montgomery, 2019). For example, the therapist can take a directive, strengths-oriented approach in the preliminary conversation to orient the session towards supportive-level work (Muller, 2014), or utilize a single piece of supportive music (Wärja & Bonde, 2014) rather than a full GIM program to provide greater safety, stability, and/or containment to the client's imagery experience. While certain adaptations may be more likely to be needed with certain clinical populations, specific recommendations for adaptations/modifications to GIM cannot be tailored to specific clinical populations (Bruscia, 2015). Instead, sessions should be adjusted to meet the specific risk categories—and strengths—of the individual client.

1.3.4. GIM SESSION FORMATS

In the traditional format, GIM occurs in-person in a private therapeutic space where the client may lay or recline while listening to the music. In this traditional format, sessions last approximately 1.5–2 hours. A shortened format has also been described in the literature (Grocke & Moe, 2015; Vaux, 1993), where each portion of the session parallels the traditional format but is abbreviated to fit a 50-minute time slot. The session length appears to lead to differences in the therapeutic approach that are substantial enough for 'full sessions' and "short GIM' to be referred to by different terms (Grocke & Moe, 2015). While procedural elements are held in common between full and shortened GIM sessions, shortened sessions provide more containment and less opportunity for expanded NOSCs and depth of experience.

While GIM can be conducted in a single-session format, the therapeutic approach is more powerful in series than in single sessions. Dosage recommendations state that for persons with sub-clinical therapeutic concerns six sessions may be sufficient for meaningful therapeutic outcomes; however, persons with more severe symptom sets may need a minimum of 10 or more sessions (Grocke, 2010; Maack & Nolan, 1999; McKinney, 2019; McKinney et al., 1997).

Recently, GIM has also been used in a telehealth session format (Dimiceli-Mitran & Moffitt, 2020; Muller et al., 2021; Sanfi, 2019). These sessions occur via virtual teleconferencing software such as Zoom or Skype. Preliminary reports show promising results with few differences from the traditional in-person format, but there has been scant systematic research into the telehealth format and how it aligns with the procedural and theoretical tenets of GIM. Use of the telehealth format increased substantially beginning in 2020 in response to the COVID-19 global pandemic, which in many countries prompted therapists and clients to cease all in-person contact for extended periods of time (Dimiceli-Mitran & Moffitt, 2021). The present research was not immune to these effects. Midway through implementation of a feasibility randomized controlled trial for Article 2, we had to cease in-person sessions and eventually chose to resume using telehealth sessions. It was unclear whether in-person GIM and telehealth GIM constitute different therapeutic approaches, or whether they are simply different types of meeting spaces for the same therapeutic approach. More research was needed to better understand the similarities and differences between in-person and telehealth formats of GIM. GIM via telehealth and telehealth therapy more broadly are discussed in detail in Article 3.

1.4. RESEARCH QUESTIONS

The research question guiding the thesis as a whole was: In persons with depression, is a series of GIM sessions effective in reducing symptoms of depression? Each article addressed a portion of this overarching question.

Article 1. Development of the GIM Treatment Fidelity Instrument

- ***Aim #1****:* To develop a process to monitor treatment fidelity within individual GIM sessions for a feasibility RCT.
- ***Aim #2:*** To develop a tool to gather descriptive data about session content and variations to the traditional GIM session format.

Article 2. Randomized Controlled Feasibility Study of GIM for Depression

- ***Primary research question:*** What is the feasibility of a multisite randomized controlled trial to investigate the treatment effects of a series of GIM sessions for persons with depression?

Secondary research questions: In persons with depression, does a series of GIM sessions (a) reduce severity of depression; (b) reduce severity of anxiety, (c) reduce severity of stress, or (d) improve mental wellbeing in comparison to a control group?

Article 3: Client Experiences of Shifting from In-person to Telehealth GIM

Research Aim #1: To gain an understanding of how GIM clients experience shifting from in-person to telehealth GIM session formats.

Research Aim #2: To explore similarities or differences in how clients experience telehealth GIM sessions in comparison to in-person sessions.

CHAPTER 2. THEORY OF SCIENCE

The overall project followed a pragmatist approach (Robson & McCartan, 2016) in which the questions or aims of interest guided the research methodology (Mertens, 2005). Within the pragmatist research paradigm, there is ontological and epistemological flexibility in what is studied and how it is studied. Given this flexibility, research is evaluated in terms of how well it works to solve a given problem or fill a given knowledge gap, and whether a chosen research approach fulfilled its purpose.

The three research studies composing this thesis each had a different ontological focus and answered different types of questions. In the first article I investigated a treatment model; in the second, outcome variables; and in the third, subjective experiences. Therefore, each article relied on different epistemological paradigms and different research methodologies. These three studies followed a coherent trajectory: it began by developing an instrument to monitor treatment fidelity, continued by testing a research design, and concluded by following up with an investigation into the fidelity of delivering the therapeutic approach as experienced from the participants' perspective. This pragmatist approach of centering questions and then formulating ontological, epistemological, and methodological perspectives appropriate to answering those questions aligns with the Problem-Based Learning model of Aalborg University (Askehave et al., 2015).

2.1. ARTICLE 1: DEVELOPMENT OF THE GIM TREATMENT FIDELITY INSTRUMENT

The aims of Article 1, Development of the GIM Treatment Fidelity Instrument (TFI), were (1) to develop a process to monitor treatment fidelity within individual GIM sessions for a feasibility RCT and (2) to develop a tool to gather descriptive data about session content and variations to the traditional GIM session format. In essence, the focus of the project was to investigate a therapeutic approach, GIM, by creating a way of monitoring what happens in the therapy sessions. At an ontological level, this involved investigation of a construct: GIM sessions. It engaged with theories and concepts about GIM in order to develop a way of monitoring what happens in a session and whether it aligns with the essential characteristics of GIM. At the core of this aim is the question of what constitutes a GIM session, and relatedly, what data is needed in order for a researcher to know whether a session could be considered to be GIM. As described in the previous chapter, definitions of GIM vary within the field and therefore the answers to these questions will depend in part on the researcher performing the investigation. There is not a single true answer for what constitutes a GIM session; rather, many true answers could be developed depending on the researcher's values, experiences, and theoretical framing.

Accordingly, development of the GIM TFI was grounded in a constructivist ontology, which is concerned with aspects of reality that are socially constructed (Wheeler, 2016). There are many realities or truths that depend on subjective experiences, perspectives, and perceptions (Hiller, 2016). The researcher and participants have active roles in shaping what knowledge is generated. The researcher is a participant in the research, rather than simply an observer. The same data can be interpreted different ways, and the research is always shaped, in part, by the researcher's values. It is important to note that this project to develop a process for monitoring treatment fidelity in GIM was undertaken in order to fulfill an epistemological need for a post-positivist research study and therefore the product itself aligns with an objectivist ontology; however, the process of creating the instrument was rooted in constructivism.

This ontological grounding had important implications for the epistemological perspectives that guided the research process. From the constructivist standpoint, knowledge is produced through interactions between the researcher(s) and the topic of investigation (Wheeler, 2016). Therefore, the authors [TJH, CHM] and collaborating researchers had a central role in the creation of knowledge. Since reality is dependent on an individual's values or perspectives, it was important to solicit input from different types of persons with different perspectives for a collaborative approach to knowledge generation (Wheeler, 2016). We accomplished this by inviting collaboration from three expert GIM providers who are also researchers and primary trainers in GIM to investigate the construct of what constitutes GIM sessions (Wheeler, 2016). Apart from professional backgrounds, we also sought collaboration from persons based in different geographic regions in the world in order to gain a wider set of perspectives.

The team was composed of four GIM therapists (present author included), plus an additional GIM therapist who participated in the piloting stage. Characteristics of the team members are described in Article 1. In addition, we consulted with GIM and music therapy researchers who were involved in the research milieu in the Aalborg University Doctoral Programme in Music Therapy. By inviting this group of outside experts to provide feedback and critique, we expanded the range of perspectives beyond those of the four-member research team.

Despite involvement by a team of collaborating and consulting researchers, the present author still had a central role in construction of the items. This role included collating and organizing the participant contributions, creating items based on those contributions, and performing revisions after member-checking, consultation, and pilot-testing stages. To manage this, I sought input at all stages from the supervising research member [CHM], completed two rounds of member-checking as described in Article 1, and sought input from outside experts within the Aalborg University music therapy research milieu. In addition, the pilot stage provided an opportunity to test whether the GIM TFI functioned as it was intended in a real-world context while

implemented by two different GIM providers. This stage ensured that the constructed knowledge had the intended clinical applicability. Finally, the research underwent peer review in the publication process, which provided additional outside expert perspectives.

As discussed in Ch 1, there are several different ways of conceptualizing what is and is not GIM. In order to investigate what constitutes GIM sessions, it was essential to be clear about how we conceptualized GIM. In order to deal with this variation in how the construct under investigation has been defined, we chose to utilize a definition of GIM that fit the needs of the overall research project. This strategy aligns with the pragmatist research paradigm (Robson & McCartan, 2016), and the rationale for which definition we chose is described in Chapter 1. In addition, we based descriptions of GIM sessions upon a consensus definition of GIM that was developed and approved by the Association for Music and Imagery (AMI, 2017)

The data gathering process utilized a flexible design consistent with constructivism (Hiller, 2016). Members of the collaborative research team returned their responses in whatever format they chose, and the research process included as many rounds of member-checking as was needed. The revision process was also flexible during the pilot stage, during which the research team made alterations to the TFI based on discussion about the providers' experiences using the TFI. The revision process is described in more detail in Article 1.

From a constructivist standpoint, findings should have confirmability (Robson & McCartan, 2016). This can be achieved by linking the data to the findings or outcomes and by making the analysis process clear and transparent. In order to achieve confirmability, all steps of the analysis process were recorded, and all revisions that were made according to feedback were subsequently returned to the collaborating team members to confirm that the revisions adequately addressed their feedback.

Concepts of validity typically align more closely with an objectivist epistemology (Cohen, 2016) than constructivism. However, since this research was an investigation of how to monitor aspects of a particular construct, construct validity becomes relevant even within a constructivist design (Robson & McCartan, 2016). Construct validity refers to whether an instrument actually provides information about the construct it was designed to help investigate. In this case, we needed to ensure that we were actually monitoring the intended construct: GIM sessions. To do this, we used foundational theory on GIM as a starting point (e.g., Grocke, 2019), utilized a consensus description of GIM (AMI, 2017), and engaged experienced GIM practitioners/trainers as members of the research team.

Within the pragmatist research paradigm (Robson & McCartan, 2016), research is evaluated in terms of how well it works to achieve the intended purpose. This can be framed in terms of ecological validity: does the process actually work in real life

settings? In other words, did the instrument actually work for capturing descriptive data about the GIM session and was that data adequate to determine whether sessions aligned with a particular definition of GIM sessions? To determine whether the GIM TFI had ecological validity, we pilot tested it after GIM sessions in the initial stages of the feasibility RCT. In this pilot stage, we followed a flexible iterative and collaborative process for receiving feedback from providers who completed the GIM TFI and creating revisions as needed (this process and the resultant revisions are described in Article 1). The pilot stage showed that it worked well, and small revisions were made as needed based on member-checking, feedback from the music therapy research community at Aalborg University, and the providers who piloted the instrument.

In addition to confirmability, credibility is another aspect of trustworthiness in constructivist research (Robson & McCartan, 2016). We worked to achieved credibility (Hiller, 2016) of the process for developing the GIM TFI by situating the instrument in a consensus description of GIM (AMI, 2017), seeking input from multiple sources with different perspectives, and on construct and ecological validity by evaluating and revising the instrument based on feedback during the pilot stage.

2.2. ARTICLE 2: MULTI-SITE RANDOMIZED CONTROLLED FEASIBILITY STUDY OF GIM FOR DEPRESSION

In Article 2, a multi-site randomized controlled feasibility study of GIM for persons with depression, the ontological focus was on therapeutic outcomes and how best to investigate those outcomes. Accordingly, this portion of the thesis was grounded in a post-positivist objectivist ontology (Hiller, 2016; Robson & McCartan, 2016). The objectivist research paradigm is built on the ontological assumption that there exists an objective reality that is independent of the observer (Wheeler & Bruscia, 2016). This reality can be known through observation, and reality or truth exists independent of the observer (Robson & McCartan, 2016). Objectivist research is typically concerned with quantitative data points, since it is concerned with objective realities rather than interpretation of subjective experiences. The present research was focused on quantitative outcomes as well as the feasibility of the objectivist research design, and therefore aligns with an objectivist ontology.

At the epistemological level, the post-positivist perspective acknowledges that knowledge based on observation is fallible and represents researchers' best guess about reality based on the available information (Hiller, 2016). Knowledge is developed and refined through repeated observations. Additionally, this perspective recognizes that reality—including causal and explanatory relationships—are affected by the social contexts of the researcher, participants, and the object of study. In part, this means that the post-positivist perspective reflects the complexities of real-world investigation in which it is not possible to control all variables that might affect an outcome. Recognizing that reality is highly complex and dependent on myriad factors,

causal relationships can be known through repeated observations and by controlling the environment in order to limit the numbers of factors that might affect the outcome of interest (Hiller, 2016).

This research was based on a causal hypothesis that a series of GIM sessions may reduce symptoms of depression when compared to receiving no GIM sessions. Methodologically, this causal hypothesis was tested using analysis of inferential statistics. Operational definitions of concepts, phenomena, and objects are crucial to objectivist research (Cohen, 2016). We began by defining the therapeutic approach under investigation: a series of GIM sessions. This definition was grounded in the description of GIM that appears in Article 1 and is described in Chapter 1.3 of this linking text, based on established GIM literature (AMI, 2017; Grocke, 2019). We operationally defined a series of sessions as 10 sessions, based on dosage recommendations that a series of 10 sessions may be sufficient for persistent change in persons with significant health concerns (Grocke, 2010; McKinney, 2019; McKinney et al., 1997). These precise operational definitions were also crucial to establishing validity, a concept that is discussed in more detail below.

The outcomes of interest were symptoms of depression—depression, anxiety, stress––and the strengths-based construct of mental well-being. To measure these, we selected specific instruments that are described in Ch. 3.2.3 of this linking text and in Article 2. Within this research, we controlled the environment to limit the variables that might have effects on the outcomes of interest (for example, whether or not participants received GIM), to see if it was indeed GIM that produced any observed effects. We repeated the process with multiple participants, aligning with objectivist research principles that by making repeated observations we are more likely to make accurate predictions about reality (Hiller, 2016). Participants were randomly allocated to one condition, again conforming to the objectivist research principle that controlling variables allows one to focus on the relationships between variables of interest. Additionally, we identified potentially confounding factors such as medications or other therapies, as well as stressful life events that occurred while participants were involved in the study. We collected data about these factors at all data collection points. However, we did not control these variables since it would not be ethical to restrict access to a resource that an individual felt they could benefit from. For example, if a participant decided that they would benefit from adding a new antidepressant or beginning work with a counselor, it would have been unethical to restrict them from accessing those supports even though those supports could have a direct impact on the dependent variables for the research study. While this introduced the potential for additional confounding variables, it aligns with the principles of effectiveness research (Singal et al, 2014) and with real-world GIM practice where clients are free to receive any additional therapies that they feel they could benefit from.

Along the same line, within this research I sought to achieve a balance in which there was a controlled environment that would allow examination of causal relationships, while still reflecting real-world circumstances like individual preferences in receiving other therapies and allowing for variation in how GIM sessions were conducted according to therapeutic indications. This approach follows principles of effectiveness research (Singal et al., 2014) and also aligns with a post-positivist ontology (Hiller, 2016) since it recognizes that reality is influenced by one's contexts.

Findings in objectivist research are restricted to specific groups of interest (Cohen, 2016). The research hypothesis guiding Article 2 was focused on the specific population of interest: persons with depression. This population was operationally defined as persons who meet severity thresholds for mild, moderate, or severe depression as measured by the Inventory of Depressive Symptomatology–Self-Report (IDS-SR; IDS/QIDS, 1997; Rush et al., 2005).

The feasibility RCT had initially been planned as a fixed design. However, due to ethical considerations that resulted from the COVID-19 pandemic, the design became flexible by necessity (see Ch 3 for more details about shifts in the research aims that resulted from the coronavirus pandemic). The initial target *N* had been 28, which would have resulted in a small but adequately-powered study (see Ch 3.2.1 *Intended Sample Size*). Since we determined that recruitment and enrollment needed to be terminated after the pandemic's onset, the study was reformulated as a feasibility study. In addition, sessions were converted to a telehealth format. This aligns with a pragmatist approach to research in which the research was adapted to real-world challenges (Robson & McCartan, 2016). This change in design had substantial implications for the statistical analysis. Implications for the statistical analysis were addressed by adjusting to using non-parametric statistical tests and a Yates transformation to account for unbalanced missing data, and reported these as limitations to the outcome findings in Article 2.

Within objectivist research, it is important to establish validity and reliability (Cohen, 2016). One strategy to ensure optimal internal and external validity is to implement a comprehensive process to monitor treatment fidelity (Borrelli, 2011). This would allow us to establish what was actually investigated for the purposes of replication and comparison with other research studies, and to ensure a level of consistency between providers and among sessions. In objectivist research on complex therapies, treatment fidelity has five components: study design, interventionist training, intervention delivery, intervention receipt, and enactment. Each of these were considered in the feasibility RCT.

Monitoring fidelity within the study design included embedding a process to monitor treatment fidelity within study procedures (i.e., providers completed the GIM TFI immediately following each session). Dosage was also carefully monitored: participants allocated to the GIM group were provided with 10 GIM sessions, and

participants allocated to the waitlist control condition were provided with four group GIM sessions. In any case in which participants received fewer sessions (including in the case of withdrawals), we recorded and reported this information. We also tracked participants' timelines of receiving sessions. Within the design, participants were to receive GIM sessions once every two weeks unless therapeutically indicated otherwise. Overall timelines for the participants were recorded and reported in Article 2.

Fidelity within interventionist training involves ensuring that all persons providing the therapeutic intervention in a research study have sufficient training in that intervention (Borrelli, 2021). In order to ensure fidelity within interventionist training for the feasibility RCT, we required that providers were Fellows of the Association for Music and Imagery who had completed GIM an approved GIM training, were master's-level board-certified music therapists, and had clinical experience working with persons with depression.

Fidelity within intervention delivery was monitored through the use of the GIM TFI. As described in more detail in Article 2, providers each completed the GIM TFI immediately following each session and submitted the completed forms to the PI for review. Any time there was substantial variation from the traditional GIM format, the provider discussed those deviations with members of the research team to assess whether bias might have been involved in that deviation. The shift to telehealth sessions due to the coronavirus pandemic had important implications for validity within intervention delivery: Once sessions were converted to telehealth, was the research still studying the same therapeutic approach? This question was answered in part through data gathered with the GIM TFI, as well as n Article 3. Findings related to this question are discussed in greater detail in Ch. 5 of this linking text.

Borrelli (2011) recommended researchers monitor to what extent participants receive the therapy under investigation. For example, if a research study were examining the effects of teaching coping skills, therapy receipt would describe whether the participants understood the coping skills that they were taught. Within the present study, intervention receipt was conceptualized as indistinguishable from intervention delivery since the participant's engagement in the GIM sessions were central to both. Therefore, receipt of GIM was not monitored as a separate construct.

Finally, Borrelli (2011) recommended monitoring enactment, or the degree to which participants apply what they learn in the therapy encounter to their daily lives. The GIM process was defined as receipt of a series of GIM sessions and therefore was limited to in-session therapy encounters. Additionally, enactment was understood to be a reflection of therapeutic outcomes rather than part of therapy. Therefore, enactment was monitored by collecting outcome data rather than as a component of treatment fidelity.

With regard to reliability, we selected outcome measures with established psychometric properties that are discussed in more detail in Article 2. A more complete discussion of strategies to ensure validity and reliability in the feasibility RCT, as well as a discussion of how effective those strategies were, are included in Ch. 3 of this linking text and in Articles 1 and 2.

Objectivist post-positivist research is vulnerable to forms of bias throughout the research process (Cohen, 2016). Two sources of bias of particular importance are group assignment and allocation concealment. In Article 2, all participants were assigned randomly, and the providers were masked to the randomization schedule, which mitigated risk of bias related to group assignment. However, it is still possible that participants had preferences for which group they would be assigned to and that these preferences may have impacted their participation and outcomes. Allocation concealment can be problematic in music therapy research since participants and the provider cannot be masked to the intervention that is being provided. In part, the waitlist control condition allowed for a degree of allocation concealment since all participants could be told that they would receive GIM sessions, either beginning immediately or after 26 weeks. In order to reduce the risk of bias from assessors, participants instead completed quantitative self-report questionnaires at home without an assessor present. Prior to completing these questionnaires independently at home, each participant completed a full battery of questionnaires in the initial screening where they could ask the screener/provider any questions about how to complete questionnaires. This happened prior to group allocation, so the screener/provider was unaware of the potential participant's group allocation.

Objectivist research is also vulnerable to bias when the researcher functions as provider or clinician, since they may alter their approach in the hopes of skewing the outcomes towards the desired response. In Article 2, I functioned as one of the two providers, which may have introduced this type of bias. As described in Article 2, the effects of the researcher acting as one of the two clinicians was mitigated through implementing a process for monitoring treatment fidelity in the GIM sessions.

As a GIM therapist who is also involved in the education and supervision of GIM trainees, I have a bias towards GIM. This could be seen as a conflict of interest in each of the three studies comprising this thesis, but most impactful in the outcome-oriented investigation of Article 2. At each stage, I attempted to mitigate any possible conflict of interest through transparency and implementing strategies like monitoring treatment fidelity and utilizing two GIM providers.

2.3. ARTICLE 3: EXPERIENCES OF GIM VIA TELEHEALTH

The ontological focus of Article 3 was subjective experience: how did participants experience their telehealth sessions after shifting from in-person sessions, and how did those experiences align with or differ from their experiences of in-person

sessions? These questions guided the research paradigm towards interpretivism. From an interpretivist ontological perspective, reality is dependent on an individual's subjective experience of phenomena (Hiller, 2016). As such, reality can only be understood through interpretation of experience. This process of interpretation is imbued with the values, beliefs, and social contexts of the persons involved; therefore, truth is variable and relative (Wheeler, 2016). This aligned with the aims of Article 3 since the question interest was participants' own subjective experiences.

From this interpretivist perspective, the epistemological aim is to achieve a greater understanding of the investigative focus. This aim is founded in a constructivist epistemology, which views knowledge as constructed interpretations of experience that increase our understandings of phenomena rather than reveal fixed objective truths (Wheeler, 2016). Data and findings are not discovered or gathered, as in objectivist research, but rather generated as part of the research process (Hiller, 2016). Reality of experience is constructed, and therefore new meanings emerge when one or more persons explore a phenomenon through interpretivist research. Accordingly, I understood the qualitative interview process to be a site of data generation, and that this process of data generation continued through the analysis process (Brinkmann & Kvale, 2015).

The data and object of the research in Article 3 were exploratory. The phenomenon of interest was participants' experiences of their telehealth sessions, and this phenomenon was approached with an open, exploratory approach in which the participants could guide the data generation process towards aspects that were meaningful or important to them. In order to stay true to this exploratory approach, I engaged in the interviews with an open perspective (Wheeler, 2016). I began by systematically reflecting on my pre-understandings of the phenomenon of interest, telehealth GIM, by creating an epoché. This allowed me to shed light on areas in which I might bring bias to the interview process and avoid taking certain pre-understandings as givens.

In interpretivist research, designs are flexible rather than fixed so that the research process can adapt to emerging knowledge (Wheeler, 2016). In Article 3, aspects of the design that were kept flexible included the semi-structured interviews in which the interview itself was adapted to the participants and their responses (Brinkmann & Kvale, 2015), and in the analysis process in which the nature of the emerging codes, categories, and themes influenced how the analytic process would proceed (Ghetti & Keith, 2016). The present research also used purposive sampling (Keith, 2016), since interpretivist research is concerned with specific experiences or phenomena and is not intended to be generalizable (Wheeler, 2016).

In interview-based research investigating past experiences, knowledge is necessarily retrospective; participants discuss their memories of experiences, rather than the experiences themselves (Brinkmann & Kvale, 2015). As interviewees reflect back on

the phenomena of interest, they gain new insights that did not exist before. These retrospective meanings may differ from the realities of the *in vivo* experience itself; yet, from the interpretivist perspective, both are true representations of reality. Further, these retrospective meanings are shaped by the interview process. These meanings are further shaped by the interview process itself: questions, how questions are framed, the interview context, and the quality of relationship between interviewer and interviewee (Brinkmann & Kvale, 2015). In this way, creation of knowledge can be an intersubjective process, particularly in interview-based research. Acknowledging that qualitative interviewing is a skill that is developed with practice over time (Brinkmann & Kvale, 2015) and that the researcher is a crucial participant in data generation, I engaged in a process of workshopping interview questions and interviewing style with a PhD supervisor [NH].

In the interpretivist analysis process, the researcher immerses themselves in the data. I engaged in this by reading the interview transcripts repeatedly and catalogued statements that emerged (Wheeler, 2016). It was an inductive approach where I drew connections between data from individual instances within the interviews as codes and themes emerged (the analysis process is described in more detail in Article 3). It followed a process of thematic analysis where I identified meaning units or codes, condensed those codes, organized them into categories, and then interpreted those categories as themes that emerged from the texts (Ghetti & Keith, 2016).

The quality of interpretivist research can be evaluated in terms of trustworthiness (Ghetti & Keith, 2016; Robson & McCartan, 2016). One aspect of trustworthiness is credibility (Robson & McCartan, 2016), where the research findings are made transparent and can be traced back to the source text. In Article 3, this was accomplished through several strategies. First, I recorded and reported the analytic approach and the process of consolidating codes, categories, and themes (as described in Article 3), which provided a degree of transparency. Findings were confirmed with the participants in a member-checking stage. Additionally, the collaborative process of thematic analysis between the two authors ensured that findings were confirmed by more than one researcher's perspective.

Language is crucial to data generation in qualitative research (Hiller, 2016), and trustworthiness demands that participants' language be carefully considered throughout the analytic process. Therefore, I stayed close to the original text of the interviews throughout the research by reading the transcripts repeatedly during the analysis, by confirming the emergent themes with original text, and by confirming that the findings accurately captured the participants' meanings through member-checking.

2.4. COMPLEMENTARY KNOWLEDGE FRAMEWORKS

In this thesis, I understood the objectivist and interpretivist paradigms as complementary understandings of reality (Robson & McCartan, 2016). On one hand, some aspects of reality exist independent of subjective experience or social construction and can be known through observation (the objectivist perspective). On the other hand, some aspects of reality exist only through subjective or social experiences (constructivist and interpretivist perspectives). Each are useful lenses through which to view reality, and each offer possibilities for investigating different types of questions. Using these complementary understandings of reality to generate knowledge aligns with a pragmatist research perspective in which research questions guide the research approach (Mertens, 2005).

CHAPTER 3. METHODOLOGIAL AND DESIGN CONSIDERATIONS

Each of the three articles includes details about the method and design for the three studies comprising this thesis. This chapter contains additional detail beyond what is included in the articles about methodological considerations that informed each of the studies. These considerations shaped the design for each of the three studies, and in the cases of Articles 1 and 3, they provided a basis for the studies by highlighting an area of need.

3.1. METHODOLOGICAL BASIS FOR DEVELOPING THE GIM TFI

It is clear from clinical practice and research that in a series of GIM sessions, modifications and adaptations are at times necessary (see, for example, Beck, 2012; Maack, 2012; Summer, 2011). As described previously, this reflects the theoretical grounding of GIM that the GIM therapist should tailor each part of the session to the client's unique situation. Yet, how does one study a therapeutic method when adaptations and modifications are therapeutically indicated in the course of an RCT? How does the researcher achieve validity when there must be some flexibility in how the therapy sessions manifest?

These methodological questions emerged as a finding from the process of planning a protocol for the feasibility RCT described in Article 2. As described in Chapter 1, GIM is defined in the literature (AMI, 2017; Grocke, 2019) and its adaptations and modifications are widely described (Grocke & Moe, 2015). However, there needed to be a way to provide a clear picture of what sessions consisted of so that we knew what it could reasonably be compared with and whether we were actually studying what we intended to study. Since GIM therapists practice in such varied and flexible ways, particularly with clients who have high symptom acuity, it was a reasonable possibility that GIM sessions could look very different between therapists, between clients, and even within a single series of sessions with the same client and provider. This might include variations within the GIM approach, for example using more supportive-level music (Wärja & Bonde, 2014) or using guiding interventions that are slightly more directive or containing (Muller, 2014). Or, this could include shifting away from GIM to employing MI or another related approach (Grocke & Moe, 2015) to achieve greater manageability, comprehensibility, or stability.

The first research study in this thesis, Article 1, addressed this issue by developing a way to monitor what happens in a GIM session relative to current essential characteristics of GIM. The intention was to develop an instrument to monitor treatment fidelity that would capture details about any variations in how the session

was conducted, including what was varied, when, and why. It was developed with an eye toward GIM and variations that were likely to be needed for persons with depression, since it was developed for use in the feasibility RCT exploring treatment effects for persons who have depression.

The specific aim of this project was to create a process to monitor treatment fidelity for GIM research. The primary goals were two-fold: to monitor fidelity to the GIM approach within clinical sessions; and to gather descriptive data on type, frequency, and extent to which sessions are adapted or modified as clinically indicated. A secondary aim was to gather the data in a way that allows the researchers to review the extent to which the sessions included in the research study adhered to the GIM approach.

Treatment fidelity can be monitored using manuals, protocols, or guidelines, terms which overlap to a degree. A treatment manual guides practice. The guidelines within a manual might appear specific or broad, and could relate to procedures, techniques, activities, attitudes, or principles. Manuals include guidelines about what should be done, when it should be done, and with whom (Rolvsjord et al., 2005). Like a contextual approach to resource-oriented music therapy (Rolvsjord et al., 2005) or improvisational music therapy (Geretsegger et al., 2015), GIM cannot be reduced to a standardized set of interventions. These complex approaches, however, can still be understood in terms of a set of underlying theoretical principles (Hawe et al., 2004) in which the therapeutic model allows for the creation of certain conditions in which a client can achieve growth or change (Rolsvjord et al, 2005). Protocols involve detailed plans—for treatment or research—so that they can be replicated (Wheeler & Murphy, 2016). Similar to manuals and protocols, guidelines provide recommendations for how to practice, with whom, and under what conditions. All three terms can be understood to be prescriptive.

In considering these prescriptive approaches when designing a process to monitor treatment fidelity for use within GIM research, a second set of methodological questions emerged that centered on an epistemological tension between the need to standardize the therapeutic approach under investigation (according to post-positivist epistemological demands), and the need to individualize GIM to a client and their process (according to the ontological demands of the theoretical underpinnings of GIM). In setting out to detect patterns of change in participants' depressive symptoms, the researcher needed to know what that change could be attributed to—ideally, the therapy under instigation. This is of particular importance when the research is implemented in a naturalistic setting for effectiveness research[2] since there are more potentially confounding variables involved. On one hand, we need to be as precise as possible about what the participants received because this would allow us build

[2] Effectiveness research studies effects within real-world contexts, while efficacy research studies effects within highly controlled environments (Singal et al., 2014).

knowledge about the effects of the therapy they received, an epistemological requirement of postpositivist research. On the other hand, the more limitations that are placed on the therapy, the less it actually adheres to underlying philosophy of GIM, which is to be flexibly individualized to the client. Epistemologically, this means that in specifying an approach by practicing in a more rigid or prescribed way (i.e., through guidelines), knowledge is produced about a therapy that actually deviates from GIM principles. Said another way, the epistemological demands of postpositivist outcome research are in tension with the ontological foundation of GIM as a therapeutic method.

As described by Hawe et al. (2004), complex interventions can be standardized according to a therapy method's foundational principles rather than procedures. According to this recommendation, one approach could have been to ensure that the GIM therapist adhered to the principles or theories underpinning GIM. This approach would have provided limited descriptive data for what the *client* received. Instead, it would have focused on the thoughts, beliefs, or philosophical motivations for the therapist with less emphasis on tracking their actions or decisions they made.

Therefore, GIM Treatment Fidelity Instrument (TFI) emerged using a descriptive approach that tracked procedural elements while staying rooted in the principles of the GIM process (Bruscia, 2015). It was designed to capture descriptive data about the items that can later be used to decide whether a session was GIM—or indeed for other purposes, as became relevant in Articles 2 and 3. This descriptive approach focused on components of a session. It does not guide practice; it *follows* practice, and allows us to track the ways in which a session aligns with the Bonny Method, GIM, and its variations. In a way, this parallels the function of the GIM therapist who guides by following the client wherever the music takes them. In addition, as a descriptive tool the GIM TFI allows one to examine their actions as a GIM therapist. Importantly, the GIM TFI functions as a tool to gather descriptive data regardless of the boundaries one draws between the Bonny Method, GIM, and other related approaches. Details about the process of developing the GIM TFI are included in Article 1 and in Chapter 4 of this linking text.

3.2. METHODOLOGICAL AND DESIGN CONSIDERATIONS FOR THE FEASIBILITY RCT

Article 2 describes the first research study to use a randomized design, a control group, or look at quantitative outcomes of GIM specifically within the population of persons with depression. There is a lack of data on aspects relevant to a larger RCT protocol such as expected screening-to-enrollment ratio, dropout rate, response rates, or population-specific effect sizes, all of which are research milestones that must be reached prior to implementing a full-scale trial to investigate "signal over noise" (Czajkowski et al., 2015). A discussion of the aims for feasibility studies is provided below.

For the purposes of this study, depression was operationally defined as meeting the severity threshold for a minimum of mild depression according to the Inventory of Depressive Symptomatology–Self-Report (IDS-SR; IDS/QIDS, 1997; Rush et al., 2005). Participants with depressive symptoms in the "very severe" range were excluded due to the increased likelihood that the intervention would need to be modified from the original form to meet the client's needs (see Honig et al, 2021). To improve feasibility, this study did not rely on a clinician diagnosis of major depressive disorder for inclusion in the research, but rather the validated severity thresholds of the IDS-SR.

3.2.1. INTENDED SAMPLE SIZE

The intended sample size was for the feasibility RCT was $N = 28$, an estimate based on power calculations size using G*Power's calculator for ANOVA: repeated measures, within-between interaction (Faul et al., 2007). Existing research on a series of GIM sessions has demonstrated effect sizes for depression/depressed mood ranging from $d = 0.2$ to 0.8, and anxiety ranging from $d = 0.4$ to 0.7 (see McKinney & Honig, 2017). Accordingly, the power calculation for this proposal used an effect size estimated at $d = 0.5$. This was transformed to effect size f using the equation $f^2 = \frac{d^2}{2k}$ where k is the number of groups, which produced an estimated effect size $f = 0.25$. Remaining parameters were as follows: alpha = 0.05, Power set at 0.8, two groups, four measurements (pretest, midpoint, posttest, and 6-week follow-up), 0.5 estimate of correlation among repeated measures, and nonsphericity correction = 1. The total sample size was estimated at 24 with actual power estimated at 0.81, critical F = 2.74. This conservative estimate suggested an N of 24 would have sufficient power to detect treatment effects. To account for withdrawal, an additional four participants were added to the targeted sample size. Withdrawal in GIM research has been inconsistent, ranging from less than 5% (Beck, 2012; Maack, 2012) to more than 20% (McKinney et al., 1995; McKinney et al., 1997). A survey of clinical trials estimated withdrawal rates at approximately 10% (Hewitt et al., 2010). For the present proposed study, withdrawal was estimated at 15-20%, with an adjusted minimum N of 28.

3.2.2. INITIAL PLANS AND ADAPTATIONS

This research was initially planned as a small but adequately-powered randomized controlled trial with treatment outcomes as the primary research aim. In the process of beginning that RCT, several issues arose. One was methodological: there emerged many unknowns regarding the details of implementing the RCT. For example, there was little known about participant recruitment and retention, the flexibility with which the GIM process would need to be implemented in an RCT protocol when used in therapy for persons with depression, or whether the chosen instruments would detect the kind of therapeutic growth experienced in GIM. The second issue that arose was related to feasibility: the recruitment sources that were initially targeted did not produce the anticipated response rate and the recruitment process and scope of the

research had to be re-examined in light of funding limitations. These issues were even further amplified after the onset of the COVID-19 pandemic in March 2019. At this point, 14 participants had been enrolled, of the targeted 28. Approximately 1/3 had completed data collection, and the rest were at varied timepoints in their participation. Based on guidance from the Institutional Review Board providing ethics oversight for the research, we were forced to cease all in-person contact with participants. As described in Article 2 and Ch. 3.4.2, we eventually made the decision to close enrollment early with 50% of the targeted sample, and to shift from in-person sessions to telehealth for the participants already enrolled.

These events created substantial threats to the randomized controlled design. Regarding internal validity, sessions were now offered in two different formats, which may or may not have constituted the same therapy approach. In addition, the pause that resulted from stopping all in-person contact meant that participants had vastly different timelines ranging from 29 to 63 weeks. These items also meant that external validity would also be compromised, an issue compounded by the fact that the participants were experiencing stressors related to an unprecedented global health crisis and social uprising in the US. As a response to these issues with the evolving research process, the RCT was reconceptualized as a feasibility study. The main purpose of this feasibility study was to provide knowledge about how best to study GIM as a treatment for persons with depression in a controlled design, and whether such research is feasible.

Feasibility Studies. A feasibility study may be a scaled-down version of a larger research study and provide preliminary support for whether or not that larger study is warranted. It may also provide information regarding small but important aspects of the study such as completion rates, variation in real-world implementation of the study procedures, and whether the measurement tools adequately detect the targeted outcomes (LaGasse, 2013). Feasibility and pilot studies are a critical first step for ensuring a successful RCT (Lancaster et al., 2002; Leon et al., 2011; Thabane et al., 2010). Objectives of a feasibility study include testing the research procedures and intervention protocol; testing recruitment, consent, and randomization procedures; testing and determining the most appropriate data collection tools and outcome measures; and testing timing of the research process, including recruitment and data collection points. Examination of effect sizes may also provide estimates for the requisite sample size to adequately power a larger RCT, though there is debate over to what extent this may produce misleading results (LaGasse, 2013; Lancaster et al., 2011; Leon et al., 2011; Thabane et al., 2010)

Based on recommendations for pilot and feasibility studies (LaGasse, 2013; Lancaster et al., 2002; Leon et al. 2011; Thabane et al., 2010), the primary goals of this feasibility study were to test procedures for recruitment and screening, explore issues related to treatment fidelity and retention, test the logistics of the research procedures, and provide preliminary data on the treatment effects of GIM for persons with depression.

Examination of treatment outcomes were conceptualized as secondary goals. For a more detailed explanation, see Article 2.

Methodological questions. As discussed above, the flexibility with which the feasibility study had to be implemented in the context of the COVID-19 pandemic meant that there were questions about whether the therapy approach could be considered to the same in light of all the new confounds (e.g., session format, timeframe, social and health context). This created a shift towards items of methodological interest that are discussed in greater depth in Ch. 5 of this linking text.

3.2.3. OUTCOMES, SYMPTOMS, AND INSTRUMENTS

A central methodological issue for the feasibility RCT in Article 2 was selecting and defining the therapeutic outcomes of interest. According to the post-positivist research paradigm, this study would focus on therapeutic effects that were observable and more-or-less objective, as demonstrated by psychometric properties of each instrument. From this perspective, the questions were which therapeutic outcomes to measure and which constructs would approximate those outcomes of interest.

The systematic review of health outcomes of a series of individual GIM sessions (McKinney & Honig, 2017) showed a cluster of mood-related outcomes including depression/depressed mood and anxiety–these two symptom sets are of primary relevance to depression, and therefore should be measured. The systematic review also showed positive outcomes related to stress. Research has shown that there is a close relationship between stress and depression (Hammen, 2005), and therefore stress was determined to be a relevant outcome of interest. Given these findings, the symptom constructs of depression, anxiety, and stress were determined to be relevant therapeutic outcomes.

With its roots in humanism and its strong connections with transpersonal psychology, GIM also allows therapeutic growth in positive dimensions of human experience (Young, 2019). With the understanding that mental health and mental wellness are closely related but separate constructs (Simmons & Lehmann, 2013) and given the therapeutic outcomes in mental wellness or well-being that have been demonstrated in GIM research (Jerling & Heyns, 2020), the feasibility RCT needed a way to capture therapeutic outcomes related to mental wellness. Therefore, mental well-being was selected as a relevant therapeutic outcome to complement the deficit-based outcomes of depression, anxiety, and stress.

By focusing on these specific therapeutic outcomes, this feasibility RCT had a limited scope that is consistent with effects studies grounded in post-positivist research (Cohen, 2019). It was designed to focus on only four therapeutic outcomes: depression, anxiety, stress, and mental well-being. This highlights how from the post-positivist perspective, effects studies are meant to detect data related to specific

outcomes that were selected *a priori*. While there may be other therapeutic outcomes that emerge from the participants' GIM process, these were not defined as within the scope of the feasibility RCT.

3.2.3.1 Considerations in Selecting Outcome Instruments

After selecting these therapeutic outcomes of interest, there were subsequent methodological questions related to selecting the most appropriate instruments with which to measure the predefined outcomes. A systematic review of health outcomes of a series of GIM sessions (McKinney & Honig, 2017) found that there was a wide variety in instruments that had been used to measure mood-related outcomes, including the Profile of Mood States, Hospital Anxiety and Depression Scale, Symptom Checklist–90 Revised, Center for Epidemiological Studies–Depression scale, Major Depression Inventory, and Hopkins Symptom Checklist. Given the wide variety of instruments, prior research in GIM did not point to a clear choice in which outcome instrument(s) to select for the feasibility RCT. Rationales for each of the instruments that were selected are provided below.

In selecting the outcome instruments, one question was whether to use self-report or clinician-report assessment. Instruments administered by clinicians are more resource intensive in that they require specially-trained clinicians to administer and interpret them (Uher et al., 2012). Additionally, when used in research studies they require procedures to ensure that each participant's group allocation is concealed from the clinicians performing the assessment. Clinician report instruments may also expose the research to bias through participants exhibiting demand characteristics to the clinician conducting the assessment, although this may also be a factor in self-report assessment. Self-report instruments are standardized and therefore have some advantage over clinician-report assessments since the latter can be conducted with slight variations or omissions based on the clinician's intuition or conversational style (Yigletu et al., 2004). However, clinician-report assessments may provide unique information that cannot be captured through self-report (Uher et al., 2012).

There is some evidence that self-report assessments yield results that are adequately similar to clinician-report assessment and therefore can be interchangeable in research and clinical practice, particularly when using the IDS-SR with persons who have depression (Rush et al., 2006). Another comparison of several self-report and clinician-report instruments for measuring depression found that the two types of assessment yield complementary results (Uher et al., 2012). If only one type of assessment could be used, the authors of this comparison study recommended that self-report assessments be chosen over clinician-report assessments. Given the possible advantages of self-report instruments, resource limitations that would not allow use of both self-report and clinician-report instruments, and recommendations from the literature, the feasibility RCT in Article 2 used only self-report instruments.

Another consideration for the feasibility RCT was the amount of time participants would be asked to dedicate to completing data collection. It was important to limit the number of questionnaires in order to reduce testing fatigue and to minimize the burden paced on participants. This was particularly true for the feasibility RCT in Article 2 as it was initially planned to be a small but adequately-powered RCT before being reformulated as a feasibility study (see Ch. 3.2.1–2 of this linking text). If this research had been initially planned as a feasibility study, one relevant line of investigation could have been testing and comparing relevant outcome instruments. In that case, additional outcome instruments could have been included in the battery of questionnaires. This would have come with a tradeoff, though, in that it would have increased the burden on participants by asking them to complete a more extensive battery of tests. The decision was made to limit the testing burden by using a battery of questionnaires that would be time-efficient for participants. In other words, the research would use as few instruments as possible while still providing adequate assessment of each therapeutic outcome of interest.

3.2.3.2 Instruments for Assessing Therapeutic Outcomes

Given the considerations and decisions described above, the feasibility RCT in Article 2 used three therapeutic outcome instruments: the Inventory of Depressive Symptomatology – Self-Report (IDS-SR; Rush et al., 1996), the Depression Anxiety Stress Scale (DASS; Lovibond & Lovibond, 1995; Lovibond & Lovibond, 1996), and the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS; Tennant et al., 2007). Each of these instruments were self-report. For the purposes of this study, the IDS-SR scores served as primary indicator of severity of depression for inclusion since this instrument corresponds closely to diagnostic criteria for depressive disorders (IDS/QIDS, 2017; Rush et al., 1996). Additional data was gathered using a participant questionnaire that was designed for this research study. This questionnaire gathered data about participants such as age, gender, access to mental health supports, changes to medications and other therapies, and major life events. This questionnaire is described in more detail in Article 2 and included in Appendix A of this linking text. Is not discussed here, since the focus of this section is on instruments for assessing therapeutic outcomes.

Inventory of Depressive Symptomatology – Self-Report

The IDS-SR was designed according to criterion symptoms of depression (Rush et al., 1996). It was created in response to observations that the Hamilton Rating Scale for Depression did not fully account for all criterion symptoms of depression, that it assessed multiple symptoms within single items, and that total scores were representations of several different factors (Rush et al., 1996). Similarly, the Beck Depression Inventory (BDI) is biased towards cognitive symptoms, with 52% of items dedicated to this constellation of symptoms. As a result, the BDI is not adequate in assessing other criterion symptoms such as items related to appetite or weight gain, psychomotor agitation, or insomnia subtypes. The IDS-SR was developed to address

all criterion symptoms so that it can be applicable to work with persons who have various types of depression and whose symptoms present in different clusters.

In comparison to the Hamilton Depression Rating Scale (HAMD) and Beck Depression Inventory (BDI), the IDS-SR is more sensitive to change; this holds true even when depression is at levels below clinical thresholds (Helmreich et al., 2011; Rush et al., 2005). The IDS-SR also detects a wider range of depressive symptoms that manifest in different proportions at different levels of severity. Additionally, the IDS-SR has high internal consistency and very high inter-rater reliability (Cusin et al., 2010), though test-retest reliability measurements were not available. One downside is that at 30 items, the IDS-SR takes longer than the 17-item HAMD (Helmreich et al., 2011). However, the benefits of using this instrument seemed to outweigh the drawbacks.

Depression Anxiety Stress Scale

Given that depression and anxiety have a comorbidity rate of over 50% (Mineka et al., 1998), it was essential to utilize an instrument that would differentiate between depressive symptoms and anxiety symptoms. The DASS (Lovibond & Lovibond, 1995) was designed to differentiate between depression and anxiety symptom constructs, as well as stress. The Hamilton Anxiety Scale (HAM-A) was shown to insufficiently detect anxiety in persons with depression and to lack the capacity to distinguish between treatment effects of anxiolytics and antidepressants. Similarly, the BDI and Beck Anxiety Inventory have insufficient discriminative validity between depression, anxiety, and stress. In contrast, the DASS has strong discriminative validity between the constructs of depression, anxiety, and stress in both clinical (Brown et al., 1997) and nonclinical (Lovibond & Lovibond, 1995) groups. The DASS also has high internal consistency (Lovibond & Lovibond, 1995), particularly with persons who have depression (Page et al., 2007). It has high temporal stability (Lovibond & Lovibond, 1997; Page et al., 2007), yet was found to be sensitive to change in persons who were hospitalized with depression (Page et al., 2007). There may be a ceiling affect for persons with the most severe depression symptom severity, however this was only observed in inpatient psychiatric settings (Page et al., 2007).

In the feasibility RCT described in Article 2 of this thesis, the DASS was used as one measure of determining severity of depression, anxiety, and stress and was not used as a primary indicator of a depression diagnosis for the purposes of inclusion, since it reflects severity of symptoms over time rather than diagnostic criteria (Psychology Foundation of Australia, 2014), and since the three scales of the DASS separate out three sets of symptoms that are related to a depressive symptomatology. With anxiety and stress constructs removed, the depression scale of the DASS (DASS-Depression) actually assesses a much narrower range of depressive symptoms than the IDS-SR, magnifying factors related to mood and cognition. This is supported by research showing that the DASS-Depression has a strong correlation ($r = 0.75$) with the BDI, which is known to be skewed towards mood and cognitive symptoms (Brown et al.,

1997). Yet, the DASS-Depression has a 0.65 correlation with the DSM-IV-TR interview schedule for depression as compared with 0.09 for panic disorders and -0.01 for generalized anxiety disorder. This contrast shows that that despite the stronger correlation with cognitive symptoms of depression, The DASS-Depression does align more closely with depressive symptomatology than with diagnostic criteria for anxiety or panic disorders.

Warwick-Edinburgh Mental Well-Being Scale

The WEMWBS measures positive aspects of, or changes in, mental wellness rather than mental illness (Stewart-Brown et al., 2009; Tennant, et al., 2007). Research in GIM indicates that in addition to improvements in deficits such as mood disturbance or pain, improvements in strengths-based assessment items such as quality of life or mental well-being are highly relevant (e.g., Jerling & Heyns, 2020). This is congruent with the two-continuum model that conceptualizes mental health and mental illness as related but separate constructs (Westerhof & Keyes, 2010). The WEMWBS was added as a strengths-based assessment to capture any change in positive aspects of mental health, in complement to the IDS-SR and DASS as deficit-based measures of mental illness. The WEMWBS has demonstrated content, criterion, and construct validity (Stewart-Brown et al., 2009; Tennant, et al. 2007). It measures positive constructs relevant for persons with depression including positive affect and functioning, and the degree to which interpersonal relationships are satisfying (Simmons & Lehman, 2013). The WEMWBS assesses qualities such as optimism, feelings of usefulness, confidence, and positive self-regard; energy, social wellbeing, focus, and energy. These qualities align with the types of positive change that have been reported in case studies of persons with depression or chronic sadness who receive GIM (Bush, 1992; Hearns, 2009-2010; Hale, 1992; Pickett, 1992; Trondalen, 2009-2010; Walker, 1993; see Ch. 1.3.3 of this linking text), and therefore the WEMWBS has strong face validity for the present research. An abbreviated 7-item version of the WEMWBS was developed in cases where there is a risk of testing fatigue (Stewart-Brown et al., 2009). While the shortened version was shown to have similar psychometric properties to the full 14-item version, the authors recommended that the full 14-item version would be a better choice in cases where face validity was of particular importance.

3.2.4. REFLECTIONS ON THE SCREENING PROCESS

The screening process for the feasibility study in Article 2 had important methodological implications. The outcomes from these 90–120-minute encounters had a real and meaningful impact on the research and indeed on provision of care to humans seeking help; it was where some participants with depression were excluded and others included. In terms of research philosophy, the screening process and how it was implemented was an important consideration within the post-positivist research paradigm, since it involved selecting a set of humans with complex and varied lives that could be considered to be the same in certain respects: They fit certain inclusion

and exclusion criteria, for example they all reported depressive symptoms that were rated as mild to severe on the IDS-SR.

At the same time, the screening was a time for the volunteer to weigh their decision for whether or not to participate in the research study. The screening was where they met the provider who would potentially be their GIM therapist, where they had their first experience with music and imagery, and where they had their first encounter with the self-report data collection forms (where they found out what they were to report upon, and how). Intersubjectively, it was a dynamic space of new encounters and experiences.

An overview of the screening procedures and a list of the inclusion and exclusion criteria for the feasibility RCT may be found in Article 2, Honig et al. (2021). The screening procedures are described in more detail in Appendix B. The following section of this linking text provides additional detail about the screening procedures, as well as methodological reflections on the process.

At the time of designing the study, there were no formal assessment procedures that were designed specifically for initial screenings in GIM research nor for GIM clients with depression. The GIM Responsiveness Scale can assess a potential client's responsiveness to GIM (Bruscia, 2000; Meadows, 2000; Young, 2011); however, it was designed to assess the therapeutic potential of GIM for a client and to evaluate their progress over time. It did not fit the precise needs of the present feasibility study.

The IDS-SR was the primary depression screening tool used in the feasibility RCT. It was designed according to criterion symptoms of depression and items on the questionnaire correspond to diagnostic categories for major depression (IDS/QIDS, 2017; Rush et al., 1996). Because it is based on the full set of criterion symptoms, IDS-SR provides important information about a person's appropriateness for GIM, but the IDS-SR score is insufficient as a sole indicator of appropriateness for GIM. A participant could report a high total depression severity score on the IDS-SR by scoring high on symptom clusters like physical symptoms (e.g., pain, sex drive, or appetite), but have low symptom severity in cognitive or emotional symptoms (e.g., a positive view of oneself, few panic symptoms, and no thoughts of suicide). This person would likely be able to engage in GIM with minimal risk despite their high depression score. On the other hand, another participant could score relatively low on the IDS-SR by reporting no symptoms except highly significant cognitive or emotional symptoms (e.g., hopelessness, suicidality, or self-critique). This second person would be likely to be at higher risk of harm from unmodified GIM despite their relatively low score. These two hypothetical scenarios illustrate the importance of identifying an individual's relevant depressive symptom clusters and comparing then with indications/contraindications for GIM when screening them for GIM.

A person's symptom severity has a strong impact on whether GIM is an appropriate therapeutic approach (Bruscia, 2015), as discussed in Ch. 1.3.3.1 of this linking text. Perhaps just as important, though, are the presence of protective factors.[3] These protective factors include tangible characteristics like a strong support system, or they could be understood as inner resources or psychological strengths that provide energy, stability, and resilience adequate to engage in GIM. Building on indications and contraindications of GIM that appear in the literature, some of characteristics that are most relevant in assessing appropriateness for GIM include ability to focus, congruent affect, protective factors, lability of mood and affect, rumination, use of cognitive strategies to avoid catastrophizing thought patterns or distorted attribution bias, and suicidality or risk of self-harm. When enrolling persons with depression into this study, these were important to assess and were therefore considered in the screening procedures (see Appendix B for how these were included in the initial screening).

These considerations highlight the complex process of designing a screening procedure that would include persons with depression and would exclude persons who would be at greater risk of requiring substantial modification to GIM or who are inappropriate for GIM altogether. The screening and assessment process was composed of three parts. First, the researcher invited the potential participant to provide informed consent. After providing informed consent, the participant completed pretest assessment materials. Finally, the researcher provided an introductory music and imagery experience and where indicated conducted a brief clinical assessment interview (see Appendix B). The screenings were conducted by the GIM provider assigned to that research site, one of whom was the present author [TJH].

3.3. METHODOLOGICAL UNDERPINNINGS OF THE TELEHEALTH GIM INTERVIEW STUDY

The ways in which the feasibility RCT in Article 2 was adapted and reformulated in response to the COVID-19 pandemic raised critical methodological questions about the research. Most significantly, the format of the GIM sessions was shifted from the traditional in-person format to a telehealth format. This shift happened in tandem with a rapid change in service delivery among music therapists. A survey of music therapists found that by 2021, the percentage of music therapists providing services primarily in a telehealth format had risen from under 3% prior to the COVID-19 pandemic to over 66% (Brunick, 2021). Research on telehealth GIM is scant. A survey of GIM practitioners conducted in 2018 revealed that few GIM therapists had provided GIM by telehealth at the time (Sanfi, 2019). A preliminary exploratory investigation of telehealth GIM found that the telehealth format created challenges like technological issues, but that it also came with significant benefits in terms of

[3] This discussion of protective factors is drawn from my experiences as a GIM therapist and supervisor, and they deserve careful attention in future research.

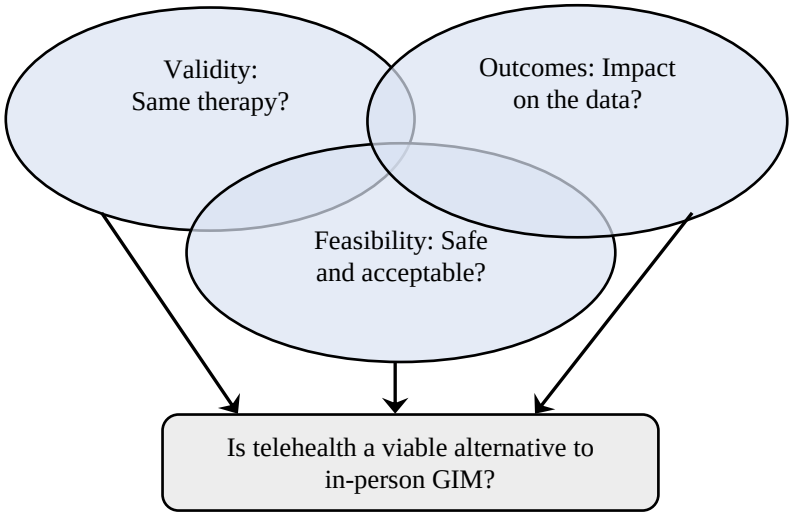
convenience (Bowler, 2012). Importantly, this exploratory study found that the GIM therapist and client were still able to cultivate a meaningful therapeutic connection via telehealth. Other literature has focused on preliminary recommendations for practicing GIM via telehealth (Dimiceli-Mitran & Moffitt, 2020; Sanfi, 2019). A more detailed review of literature on telehealth GIM and other related telehealth therapies is included in Article 3.

Article 3 of this thesis was driven by the methodological questions that arose from this change: Once sessions were provided via telehealth, was it still the same therapy? How meaningful an impact might it have had on the data? Was it safe or acceptable to the participants? The first question relates to validity and treatment fidelity. The second engages with how the change might have had an effect on the therapeutic outcomes of interest. The third question relates to feasibility of the telehealth therapy format for research. Each of these questions points toward a broader question of whether telehealth GIM can be a viable alternative to in-person GIM, or whether it should only be viewed as a last-resort option (see Figure 2).

Article 3 provided a way of exploring these questions through a qualitative investigation of participant experiences transitioning from in-person to telehealth GIM sessions. In this way, Article 3 is based on a methodological focus. It can be framed as a follow-up to both Articles 1 and 2 in which I investigate the fidelity of different ways of delivering GIM, in this case the participants' perspective. Each of the three methodological questions stated above informed the formulation of the two research aims for Article 3:

1. To gain an understanding of how GIM clients experience shifting from in-person to telehealth GIM session formats.
2. To explore similarities or differences in how clients experience telehealth GIM sessions in comparison to in-person sessions.

Figure 2. Methodological Questions Resulting from the Shift to Telehealth GIM Sessions



In order to address these research aims, Article 3 utilized a flexible interview-based design grounded in the interpretivist research paradigm (Wheeler, 2016). Prior to data collection, I engaged in a process of examining my pre-understandings through an epoché (Jackson, 2016), which included reflections on GIM via telehealth both from my perspectives as a GIM therapist and a GIM client. Data were generated in semi-structured interviews designed according to recommendations by Brinkmann & Kvale (2015), with participants who were selected through purposive sampling (Keith, 2016). The semi-structured interview guide is included in Appendix D of this linking text. Data analysis followed a process of thematic coding analysis (Ghetti & Keith, 2016; Robson & McCartan, 2016). Additional details about the methodology and design are included in Article 3.

Because the feasibility RCT in Article 2 focused on the participants' therapeutic outcomes, this interview-based study exploring experiences of telehealth GIM maintained a focus on the participants' perspectives. While it may have been helpful to investigate the GIM therapist's point of view, a decision was ultimately made to keep the focus on the participants' experiences in this small exploratory investigation of telehealth GIM. In the future, it will be important to gain insight about the therapist's perspective on telehealth versus in-person formats.

3.4. ETHICAL CONSIDERATIONS

This thesis is composed of three studies that were each grounded in different research paradigms; each of these paradigms provided a different set of ethical imperatives related to knowledge generation. In Article 1, the constructivist perspective brought the ethical imperative for transparency about the researcher's involvement in the knowledge-generating process. Therefore, I sought to emphasize transparency in creating and testing the GIM TFI so that the research would be trustworthy. In this process, my prior experience as a GIM therapist was viewed as a strength that closely informed the research process (the research design is described in more detail in Article 1). Similarly, in Article 3, as the primary investigator who conducted the interviews and thematic analysis, I was intimately involved in the knowledge-generation process and my prior experiences as a GIM therapist informed that work. However, in Article 3 these prior experiences also had a strong potential to bias my interviewing and analysis. In order to uphold the ethical imperatives for knowledge generation within an interpretivist frame, this potential for bias in conducting the research for Article 3 required that I engage in a process of articulating and examining my pre-understandings about the phenomenon of interest, telehealth GIM. This epoché is described in more detail below and in Article 3. The research conducted for the feasibility RCT in Article 2, however, required a different ethical standpoint that aligned with post-positivist research. The research design followed an objective perspective where the investigators were to have disinterested curiosity in the outcome. The hypotheses and variables of interest were identified a priori, and the research procedures were designed so that once it began, the data and administration of the care provided to participants would be protected from my preunderstandings or biases.

Yet, within the feasibility RCT in Article 2, my positionality as both the primary investigator and one of the providers created an addition set of ethical dilemmas. In one role, I functioned as the lead researcher for a post-positivist randomized controlled trial. In terms of the epistemological requirements of post-positivist research, I was to take a disinterested perspective that was in conflict my other role in which I functioned as a GIM therapist who was invested in participants achieving greater wellbeing. Given my dual role, the ethical principle of beneficence was on one hand directly related to the dependent variables under investigation, and on the other, something that the therapist was meant to maximize the potential for. Because this was a research study that was designed to investigate outcomes, the research design prioritized the former way of approaching beneficence, viewing it as a variable under investigation. Given that this was a research study that was intended to investigate whether GIM has positive therapeutic effects for persons with depression, we could not guarantee that participants would receive benefit from participating. In an effort to be fully transparent, this was made clear in the informed consent stage of the screening (the Informed Consent Form is included in Appendix B). Instead, we prioritized an intention to minimize risk of harm to participants (efforts to this effect are described

below in Ch 3.4.2). During the times in which I occupied my role as GIM provider within the research study, however, I took the alternate perspective in which I sought to maximize the potential for beneficence. For this to be possible, I had to be insulated from my role as researcher. In part, this was managed this through monitoring treatment fidelity, working with a collaborative research team, and using quantitative self-report measures, as described in more detail below.

This research focused on investigating a therapeutic method while working with persons who have depression. Implicit in this work is the understanding that it involved work with persons who are vulnerable and want to make positive change in their lives. With this in mind, principles for ethical care of participants informed each stage of the research (Dileo, 2021). Concepts related to the ethics of GIM in relation to indications/contraindications and variations to the GIM method are discussed in Ch. 1.3.3 of this linking text; for a full review, see Montgomery (2019). The following section describes the ethical considerations related to particiapants that informed decisions about the research studies in each of the three articles. Since the primary contact points with participants occurred during the feasibility RCT, most of the decisions related to ethics that are discussed here pertain to Article 2.

3.4.1. ETHICAL DECISIONS FOR THE GIM TFI

While the primary aim of developing the GIM TFI was to ensure validity through monitoring treatment fidelity in the feasibility RCT, ethical care of participants provided a secondary motivation. Developing and utilizing the GIM TFI as a descriptive rather than prescriptive tool meant that we would be able to monitor validity without restricting the ways in which the GIM providers individualize the GIM sessions according to emerging clinical indications. This allowed us to provide care that was aligned to the participants' needs rather than to a specific session format prescribed by the research protocol. In creating the GIM TFI, it was important that we avoided language that would convey implicit value judgments about what GIM providers should or should not do. This was because the provider's choices should be guided by the client/participant and not the requirements of the research study.

3.4.2. ETHICAL DECISIONS FOR THE FEASIBILITY RCT

Ethical considerations for the feasibility RCT in Article 2 began with the underlying rationale for the study. GIM literature shows that GIM is being practiced with persons who have depression (see Chapter 1.3.3 for a review). Yet, there has been no systematic research into GIM for persons with depression. This poses a potential ethical dilemma, since a therapy is being provided in the clinical world without a systematic research base for that clinical work. In part, this research was motivated by the need to investigate a therapy that is already being provided for persons with depression so that GIM therapists can provide high-quality care informed by research.

3.4.2.1 Overall Design Elements

With regard to the research design, ethics were considered in planning the overall design as well as in formulating strategies for recruitment/enrollment and planning the screening process. Within the operational definition of the independent variable of interest—a series of GIM sessions—it was important to retain the foundational principle of GIM that the therapeutic approach would be tailored to the client's (in this case, participant's) individuality. We did not want to standardize the approach, since sometimes it is in the client's best interest for the therapy approach to be varied. This introduced greater potential for heterogeneity within the therapy approach, but it was worth the tradeoff because it allowed for greater ethical care of participants and reflected a real-world GIM therapeutic process.

According to objectivist research principles, controlling ancillary variables allows for greater accuracy when examining relationships between specified variables of interest. In investigating whether GIM can lead to positive psychological outcomes in persons with depression, one could argue that the investigation would have greater accuracy if we controlled access to other therapies, thereby ruling out a set of important confounding factors. However, in this research it was important not to restrict access to therapies that participants felt could be beneficial. Instead of restricting access, we elected to collect data at all data collection points on participants' receipt of other therapies and medications during the course of their enrollment.

Designing and implementing a process for monitoring treatment fidelity was, in part, meant to ensure consistently high-quality care for the participants. Strategies to ensure treatment fidelity included specifying requirements for provider training (master's-level board-certified music therapists who completed an approved training in GIM and maintain status as *Fellow of the Association for Music and Imagery*) and treatment delivery, the process for which centered on gathering data using the GIM TFI and is described in Article 2. This allowed us to ensure that participants were indeed receiving high-quality GIM therapy. Importantly, the GIM providers in the feasibility RCT were directed to vary GIM sessions according to client need, aligning with ethical provision of care.

Planning the experimental and control conditions raised a number of important ethical dilemmas. According to the randomized controlled design, there needed to be a comparison group. Yet, participants enrolled in this study because they were interested in receiving GIM sessions. I felt it important to honor each of the participants' interest in receiving this therapy, and the comparison group was designed with this in mind. The waitlist control group was essentially treatment as usual, since

it was a waitlist in which their access to any other care was unrestricted.[4] followed by group GIM. This way, every participant was provided with a series of GIM sessions (either in individual or group format) at some point during their participation. As described above, no participant was restricted from receiving other mediations or therapies that they felt could be beneficial.

3.4.2.2 Recruitment and Enrollment

In recognizing the power imbalances that can between care providers and care recipients and between researchers and volunteers (Dileo, 2021), the flow of recruitment and enrollment was designed to minimize the possibility that individuals could feel pressured to participate. In all cases, potential participants were provided with information about the research study and were invited to contact the PI to follow-up. This gave potential participants agency in deciding whether to follow up about participating and minimized the potential that individuals might feel pressured by the researcher to enroll.

Recruitment materials were distributed through community organizations and outpatient mental health clinics. Materials were not distributed to inpatient clinics, since it was more likely that recent discharges from inpatient clinics would be more vulnerable to risk of suicidality or decompensation.

3.4.2.3 Screening

Once inquirers came to the screening, there were additional procedures put in place to ensure ethical care of participants. See Appendix C for a full description of the screening and assessment procedures used in the feasibility RCT. At the screening, the screener/provider collected names and contact information of current mental healthcare provider in case the potential participant needed more support during the study. In cases in which the potential participant did not have a preexisting relationship with a mental healthcare provider, we provided those persons with contact information for mental health resources.

The informed consent form was written at a 5th grade reading level to help ensure that all inquirers fully understood the content of the form. Additionally, inquirers were given multiple opportunities to ask questions about the research and what would be asked of them if they participated. GIM can be difficult to fully understand without having a first-hand experience of it. Therefore, we provided inquirers with an introductory music-and-imagery experience in the final portion of the screening so

[4] Access to other therapies and medications was unrestricted except for receiving GIM or another similar NOSC-based therapy like hypnosis or holotropic breathwork. See Appendix B for the Informed Consent Form.

that participants had experiential knowledge about what they were going to be provided with during the course of their enrollment.

At the screening, we collected information on exclusion criteria that were specified in order to ensure that participants would be able to meaningfully take part in the research procedures and that risk to the participants would be minimal. We attempted to keep the exclusion criteria as minimal as possible so has to allow persons of diverse backgrounds to participate. However, we limited participation to individuals who speak read English, since the researchers were based in the United States and were only able to practice in English. We recognize that this exclusion criterion introduced a degree of linguistic bias into the research. Additionally, participants were required be able to read English at a 5th grade level or higher because they would be completing self-report instruments.

We asked participants to self-report any history of psychosis or psychotic disorder. Persons with this history were excluded since this is a contraindication for GIM that could result in harm to the person. Additionally, we excluded persons who scored in the *very severe* range of depression (as measured by the IDS-SR (IDS/QIDS, 1997; Rush et al., 2005) because GIM is less likely to be self-limiting for persons with significant mental health concerns (Bruscia, 2015). Inquirers who were excluded were provided with contact information for a GIM therapist with whom they could work privately, as well as contact information for local mental healthcare providers if they were not already connected with one.

3.4.2.4 COVID-19 and the Transition to Telehealth

In March 2019, the COVID-19 pandemic spread to the United States. Because of this, all non-essential in-person contact ceased as required by the local Institutional Review Board for human research ethics. We immediately made the decision that GIM sessions would be paused until we could determine whether or not it was safe to proceed with telehealth sessions. Recruitment and enrollment were also paused, since any new participant who enrolled could not be guaranteed that they would receive sessions. During the time that GIM sessions were discontinued, participants were offered individual phone support from their GIM provider. None of the participants availed themselves of this option.

As the pandemic continued to unfold, we waited to make any decisions about how to move forward until there was sufficient evidence upon which to base a decision. After approximately 5 months, more guidance on telehealth GIM emerged (Dimiceli-Mitran & Moffitt, 2020) showing that for clients who had already experienced GIM in-person, telehealth GIM could be a safe option. At this time, participants were given information about the telehealth format and invited to choose whether or not to proceed. Since it was still unclear how much risk would be involved in initiating GIM via telehealth without a prior therapeutic relationship that had been established in

person, we made the ethically-informed decision to terminate recruitment and enrollment of new participants.

In conducting telehealth sessions, the GIM provider worked with the participant to ensure that the space in which they accessed their online sessions was private. The provider also followed best-practice for ensuring confidentiality in a telehealth session format, for example using passcode-protected Zoom meetings (Dimiceli-Mitran & Moffitt, 2020).

3.4.3. ETHICAL DECISIONS FOR THE TELEHEALTH GIM INTERVIEW STUDY

By the time the interviews for Article 3 were conducted, all participants had completed the research study procedures for the feasibility RCT. Still, several ethical considerations informed how the interview-based study in Article 3 was conducted. The interviews semi-structured, which allowed participants to direct the interview content in directions that they felt were important. After the analysis process, the findings were returned to participants in a member-checking stage to ensure that we accurately captured the participants' meanings. This step followed the ethical imperative to be true to the participants' intended meanings.

CHAPTER 4. SUMMARY OF THE ARTICLES

Each of the three articles comprising the thesis is summarized below. The central component of the thesis, Article 2, is a feasibility randomized controlled trial examining treatment outcomes of a series of GIM sessions for persons with depression. Article 1 included preparatory work for the Feasibility RCT, addressing a methodological need for post-positivist research in GIM. Article 3 explored an area that emerged unexpectedly from the feasibility study, and can be considered a follow-up study that provides both additional findings that inform the feasibility study as well as new findings germane to GIM and telehealth. The three articles together constitute a coherent project employing multiple research paradigms that provides complementary perspectives on the phenomenon of interest: GIM in the treatment of depression.

See *Figure 1: Overview of the Thesis Studies*.

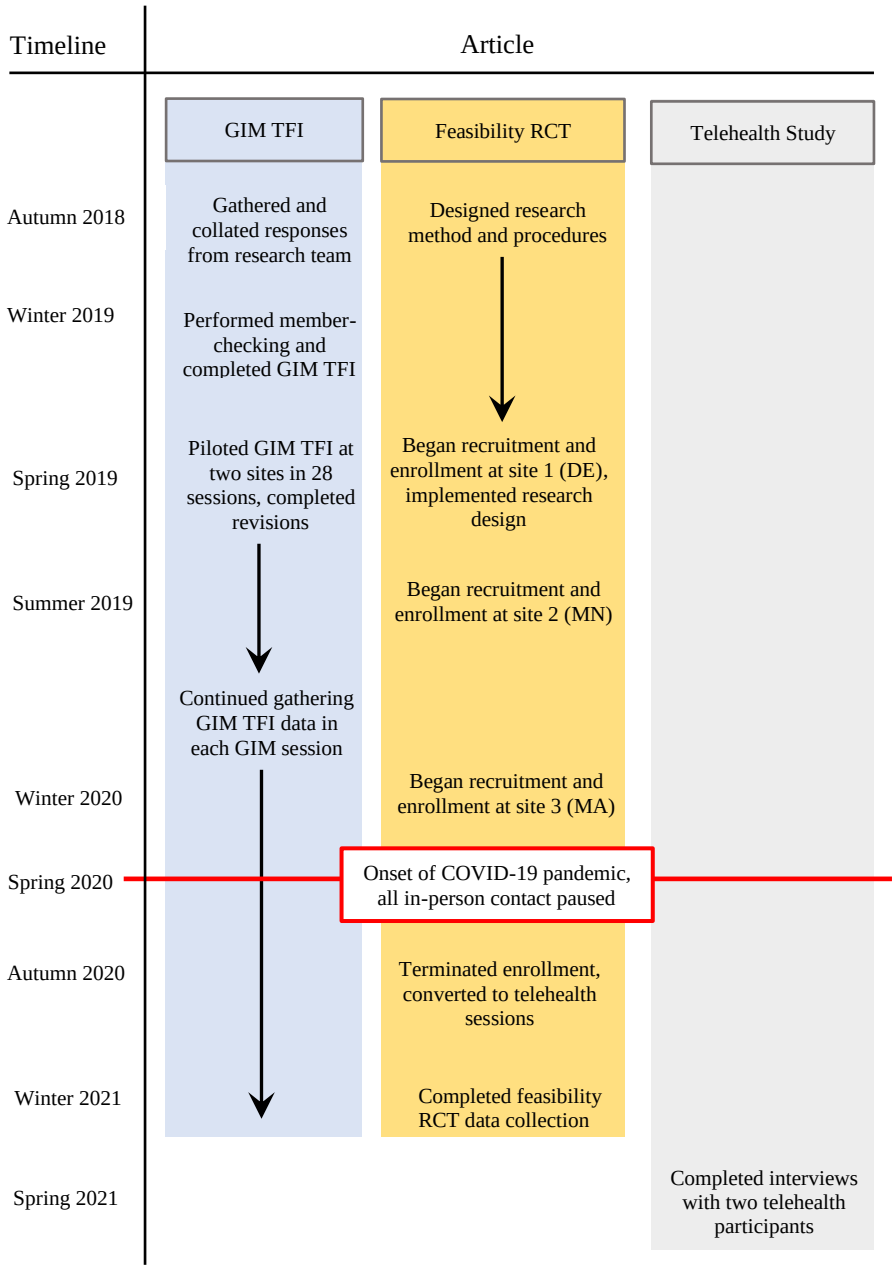
Article 1: Monitoring variation to Guided Imagery and Music (GIM): Development of the GIM Treatment Fidelity Instrument

Article 2: The Bonny Method of Guided Imagery and Music (GIM) in the treatment of depression: A multi-site randomized controlled feasibility study

Article 3: Client experiences of shifting from in-person to telehealth formats of Guided Imagery and Music (GIM)

The research conducted for Articles 1 and 2 was reviewed and approved by the Institutional Review Boards for Human Subjects Research at Appalachian State University and at Westfield State University. The research for Article 3 was reviewed and approved by the Institutional Review Board for Human Subjects Research at Westfield State University. The feasibility RCT (Article 2) was registered with ClinicalTrials.gov (NCT03917979).

Figure 3: Timeline of the Thesis Studies



4.1. ARTICLE 1: DEVELOPMENT OF THE GIM TREATMENT FIDELITY INSTRUMENT

Honig, T. J., & McKinney, C. H. (2021) Monitoring variation to Guided Imagery and Music (GIM): Development of the GIM Treatment Fidelity Instrument. *Nordic Journal of Music Therapy*, *30*(5), 440–459. https://doi.org/10.1080/08098131.2021.1888781

This article describes the development of the GIM Treatment Fidelity Instrument (GIM TFI), a form developed to monitor whether and to what extent sessions align with the fundamental principles and process of GIM. Since GIM is a therapeutic process that is individualized and cannot be standardized or manualized, it was necessary to create a novel instrument in order to gather data that would allow us to monitor treatment fidelity in the feasibility study without adhering to a strict prescribed session protocol (Article 2). This was particularly important given that the feasibility RCT would be multi-site and involve more than one provider, thereby increasing the vulnerability to sources of bias in how sessions are conducted that would compromise internal and external validity. Focused on treatment delivery, the instrument needed to capture detail about what occurred in each GIM session, including variations or modifications to GIM, and be efficient enough for the provider to use after each session.

Following the recommendations of Borelli (2011), Feely et al. (2018), Gearing et al. (2011), and Hawe et al. (2004), a team of four researchers contributed to the instrument. Members of the team were all formally trained in GIM and had experience working with persons with depression. They included persons of three nationalities on two continents, three of whom were GIM Primary Trainers. Each member contributed a list of essential features of a GIM session, based on the literature, their own clinical practice, and other GIM-related activities such as research, training, and supervision of GIM therapists. These essential features constituted a set of consensus norms for GIM sessions from which GIM therapists deviate when indicated. The first author compiled the team members' responses to create a preliminary version of the form and a manual[5] that provides additional clarity and instruction for using the form. The first author then performed two rounds of member-checking with the team members. All feedback from the member-checking stages was incorporated into a revised version of the form. The GIM TFI was then piloted in 28 individual GIM sessions by two GIM providers as part of the feasibility RCT (Article 2), during which two items were revised to add additional clarity.

[5] This is a manual for using the GIM Treatment Fidelity Instrument form, not a manual for GIM.

Based on analysis from the pilot stage, findings showed that the 17-item GIM TFI was adequate for monitoring treatment fidelity in GIM sessions and captured sufficient detail about variations to GIM that occurred in the sessions from the pilot stage. The providers also found the instrument to be easy to use immediately after sessions: 14 items were dichotomous, two had three options, and one was scalar with five options. Each item had fields for the provider to include additional detail and/or explanation.

While the GIM TFI was developed for use in the feasibility RCT (Article 2), it also has the potential to be useful for reporting in interpretivist research involving GIM and has applications for clinical practice and training in GIM. Importantly, gathering this detailed descriptive data about GIM sessions may enable GIM therapists—and the GIM community at large—to identify patterns, and perhaps biases, in how GIM is performed with whom. It is important to note that the GIM TFI was not designed as a manual for GIM practice.

4.2. ARTICLE 2: MULTI-SITE RANDOMIZED CONTROLLED FEASIBILITY STUDY OF GIM FOR DEPRESSION

Honig, T. J., McKinney, C. H., & Hannibal, N. (2021). The Bonny Method of Guided Imagery and Music (GIM) in the treatment of depression: A multi-site randomized controlled feasibility study. *Journal of the Association for Music and Imagery, 18,* 27–54.

This article describes the results of a multi-site randomized controlled feasibility study examining effectiveness of a series of GIM sessions with persons who have depression. Grounded in the findings of a systematic review showing that a series of GIM sessions is associated with a cluster of positive mood-related outcomes in a variety of populations (McKinney & Honig, 2017), this research was guided by the following question: Does a series of GIM sessions improve depression, anxiety, stress, and mental well-being in persons with major depression? Initially designed as a small but adequately powered randomized controlled trial (RCT), the study was reformulated as a feasibility study after the onset of the COVID-19 pandemic in response to the rapid shifts to in-person contact procedures.

From two large metropolitan areas of the US, 14 participants enrolled, ages 24–72. After an initial screening for depression symptom severity and appropriateness for GIM, participants were randomly allocated to either a GIM condition or waitlist control group. Persons in the GIM group received a series of 10 individual GIM sessions, scheduled once every 2 weeks unless otherwise indicated. Persons in the waitlist control group received treatment as usual for 26 weeks, equivalent to the length of a 10-session GIM series plus 6-week follow up, and were then offered a series of group GIM sessions after experimental data collection had been completed. Data were collected at pretest, midpoint (approx. week 10), posttest (approx. week 20), 6-week follow-up (approx. week 26), and 12-week follow-up (approx. week 34).

Data were collected at 12-week follow-up so that the WL group completed data collection after their group GIM sessions completed, which provided a degree of masking of their allocation to a control group. Data from the 12-week follow-up were not included in the data analysis. Outcome variables included the following: depression as measured by the Inventory of Depressive Symptomatology – Self-Report (IDS-SR) and the depression scale of the Depression, Anxiety, Stress Scales (DASS); anxiety as measured by the anxiety scale of the DASS; stress as measured by the stress scale of the DASS; and mental well-being as measured by the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). In addition to completing each of these instruments, participants also provided data about other concurrent therapies, medications, and stressful life events. All data collection was self-report.

Feasibility results showed that the GIM condition had high acceptability, as evidenced by enrollment and withdrawal rates, as well as high safety and tolerability. Withdrawal was high overall, but low prior to onset of the COVID-19 pandemic. Immediately following each session, providers completed the GIM Treatment Fidelity Instrument (TFI; Honig & McKinney, 2021) to provide descriptive data about session format. From this data, we observed minimal variation from the traditional GIM format, even after sessions were converted to a telehealth format.

Results showed that the waitlist control group was a suitable control condition. It provided partial masking since all participants received GIM sessions at some timepoint regardless of group allocation. Withdrawal rates were no different from the GIM group, although the WL group had more delays in data collection. No harms or adverse events were reported or observed in either group.

The data collection instruments were adequate to the aims of the research design; however, it is recommended that future research use short version of DASS (Lovibond & Lovibond, 1995) to mitigate the effects of testing fatigue that appeared to result from high degree of redundancy in the 42-item DASS, and to compensate by adding an additional validated anxiety instrument such as the Beck Anxiety Inventory (Beck et al., 1988) or Hamilton Anxiety Rating Scale (Hamilton, 1959). Results also showed that the design could benefit from a more streamlined data collection process with an online tool like REDCap (projectredcap.org) and from gathering information about perceived impact of stressful life events experienced by the participants during the research study. With minor adjustments, the research design was found to be feasible for a full-scale RCT. It struck a balance between standardized procedures and flexible individualization, a necessary part of the therapeutic philosophy of GIM.

Analysis of therapeutic outcomes provides useful description of therapeutic gains for this group of participants, but due to the small sample size, the findings are limited and are not intended to be generalizable. Due to data issues related to the COVID-19 pandemic, 10 participants were included in the final outcome data analysis. Aligned Rank-Transform ANOVA tests (Wobbrock et al., 2011; R package ARTool for

nonparametric factorial ANOVA) revealed no significant differences between groups across timepoints for depression (IDS-SR and DASS), anxiety, stress, or mental well-being. Post-hoc Wilcoxon Signed Rank tests were performed for the GIM group to provide insight into effect sizes for each symptom category:

- Depression (IDS-SR): large effect size between pretest and midpoint
- Anxiety: large effect sizes between pretest and midpoint and between pretest and posttest, and small effect size between pretest and follow-up
- Stress: medium effect sizes between pretest and midpoint and between pretest and posttest, and small effect size between pretest and follow-up
- Mental well-being: small effect sizes between pretest and midpoint, medium effect size between pretest and posttest, and small effect size between pretest and follow-up.

For more details on outcome analysis and effect sizes, see Article 2, Honig et al. (2021).

The results supported findings from the literature that GIM has high safety, tolerability, and acceptability for persons with depression, even with minimal variation from the traditional GIM format. Withdrawal rates were higher than previous GIM research. However, this may have been related to the COVID-19 pandemic. Results showed that medium to large effect sizes may be possible in the initial stages of therapy; given the small sample size and limitations with the outcome data, more research is needed into therapeutic outcomes of a series of GIM sessions for persons with depression. For participants who transitioned to telehealth sessions amid the coronavirus pandemic, telehealth seemed to be a viable alternative to in-person sessions. More research is needed to further explore factors related to telehealth GIM sessions, since a telehealth option may ease recruitment for large-scale RCTs in GIM by providing access to a participant pool that is not limited by geography.

4.3. ARTICLE 3: PARTICIPANT EXPERIENCES OF SHIFTING TO TELEHEALTH GIM

Honig, T. J., & Hannibal, N. (2022). Client experiences of shifting from in-person to telehealth formats of Guided Imagery and Music (GIM). [Manuscript submitted for publication]. Department of Communication and Psychology, Aalborg University.

In this article, we investigated GIM in a telehealth format by exploring participants' experiences of shifting from in-person to telehealth sessions after the onset of the COVID-19 pandemic. In the feasibility study, two participants allocated to the GIM group transitioned to telehealth sessions midway through their GIM series; both agreed to participate in this follow-up interview-based study. This qualitative research

was guided by the following two research aims: 1) to investigate participants' experiences of shifting from in-person to telehealth GIM session formats, and 2) to explore characteristics and possible differences in how a person experiences GIM sessions online versus in person. Each informant engaged in a semi-structured interview with the lead author lasting approximately 1 hour. Importantly, the lead author was not the GIM provider for either informant during the feasibility study. Analysis of the interview transcripts followed recommendations for thematic analysis adapted from Ghetti and Keith (2016), Robson and McCartan (2016), and Brinkmann and Kvale (2016). Participants confirmed the emergent themes and descriptions in a member-checking stage.

Four themes emerged from our analysis of the participants' interview:

1. Participants experienced their online GIM sessions as beneficial and effective, but less powerful than in-person sessions.
2. The relationship with their therapist was strong and important, but online sessions initially felt less personal.
3. The home and virtual setting affected their experiences
4. Their experiences of online sessions improved as they became more familiar with them.

(Honig & Hannibal, 2022)

Points of connection between these themes showed that participants were able to develop inner resources due to inner imagery experiences that were elicited by the music but supported by the strong therapeutic relationship they had developed with their GIM therapist. Points of connection also illustrated that telehealth sessions initially felt less personal because of differences in their perceptions of the therapist's presence, complications or distractions related to the combined home/virtual setting, and minor changes to the session process such as differences in the post-music processing period.

One important finding from this research is that the participants found the 6-month pause in sessions to be more impactful to their therapeutic process than the shift to the telehealth format. Additionally, while the participants initially found the online format to be less beneficial, this effect decreased over a short number of sessions (three to four) as the participants and provider became more familiar with the telehealth format.

The results of this first systematic investigation of client experiences of telehealth GIM lead to several recommendations for GIM practice. First, these results show that telehealth GIM is a feasible option for providing GIM sessions. When possible, GIM should begin in-person to aid development of the therapeutic relationship and so that clients gain familiarity with the GIM process. Client experiences of GIM are likely to become increasingly positive as they and their GIM therapist become more familiar with it. Provider training is important: GIM therapists should engage in training,

supervision, and personal sessions focused on telehealth GIM prior to initiating telehealth sessions with clients. Finally, there are both benefits and drawbacks to GIM via telehealth, and GIM therapists should discuss these potential benefits and drawbacks with clients to inform their decision about which format to use.

CHAPTER 5. INTEGRATION AND DISCUSSION

5.1. PRIMARY RESEARCH QUESTION: ANSWERS AND QUESTIONS

This chapter includes a discussion of implications for GIM research and practice that emerge from the thesis as a whole. The overarching primary research question for this thesis was

> *In persons with depression, is a series of GIM sessions effective in reducing symptoms of depression?*

Each of the three articles in this thesis addressed aspects of this question, as discussed previously in this linking text and in the three articles. New partial answers to this question also emerge from integrating the findings the three articles. In this chapter, I discuss these findings related to the primary research question that emerge when the results of each of the three articles are put into dialogue with each other that would not be possible by examining the results of each study in isolation. This dialogue points to important implications for GIM research and practice. In addition, it leads to a new question of methodological interest: *Is GIM still GIM when it is provided via telehealth?* and reiterates the methodological question of how best to study therapeutic outcomes of GIM. These topics are discussed in the first half of this chapter.

Following the discussion of implications for GIM research and practice and the emerging question about session formats, two case descriptions are provided for more detailed insights into the findings that are described in the first half of this chapter. In part, they help clarify the impact of unexpected shifts to the research procedures. In addition, they illustrate the methodological complementarity within this thesis. While these two case descriptions can provide a deeper understanding of the individual therapeutic processes that were under investigation, their purpose is to highlight methodological findings related to both research and the GIM method itself; they are not intended to be in-depth systematic case studies of the participants' GIM processes.

The flexible adaptations that had to be made while implementing this thesis research provided an opportunity to explore ways that findings could be produced from varied methodological standpoints, and as the thesis evolved, it took an emergent focus on methodological inquiry. The process of integrating the findings described in this chapter illustrates the usefulness of methodological complementarity. This is conceptualized differently from mixed methods research, since the three articles were three separate studies rather than one integrated mixed methods study. Rather, each study had separate research aims. The findings from each can inform the other,

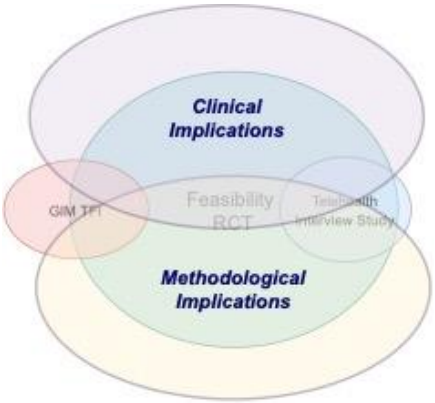
creating complementary understandings of GIM in the therapeutic processes of these participants with depression.

Within this chapter, I refer to descriptive session data that was gathered using the GIM TFI in the process of monitoring treatment fidelity during the feasibility RCT (Article 2). Each GIM provider completed the form for each GIM session immediately after the session ended. All completed forms were returned to and reviewed by the present author. Some data that was gathered using the TFI is presented in Article 2, where relevant to reporting on treatment fidelity. The aggregate data set is unpublished. The GIM TFI is presented in full in Article 1.

5.2. INTEGRATING THE RESULTS OF THE THREE ARTICLES

Two types of findings emerge from integrating the overall results of the three articles: clinical and methodological implications, as illustrated in Figure 6. Clinical implications for GIM practice that emerge from the three articles include insights about potential limitations to therapeutic gains and potential sources of support for therapeutic gains. Methodological implications for GIM research that emerge from the three articles center on the question of whether telehealth GIM can be considered to be the same therapeutic approach as in-person GIM, as well as the impact of contextual factors extrinsic to GIM sessions.

Figure 6: Implications Drawn from Complementary Findings



5.2.1. CLINICAL IMPLICATIONS: POTENTIAL LIMITATIONS TO THERAPEUTIC GAINS

The feasibility RCT showed that there was a substantial drop-off in treatment effects after the onset of the pandemic for the GIM group. The decrease in therapeutic effects for the GIM group is particularly striking in contrast to effect sizes for the control group. This begs the question: why did the GIM group's improvement decrease after

midpoint while the control group continued to improve? Based on the data and findings from Article 2, one possibility that must be considered is that GIM's benefits decreased after midpoint and was less beneficial than not receiving GIM at all. The two participants' reflections in Article 3, however, suggest that they did feel that their later GIM sessions led to positive outcomes although those sessions felt less impactful than their earlier in-person sessions.

Another possibility is that the participants who had been allocated to the GIM condition and participated during the COVID-19 pandemic could have experienced a sense of loss when their GIM sessions were discontinued, and that this may have led to a worsening of symptoms in comparison to the WL group. Like the first possibility, this is speculative, and in addition it does not address outcomes for participants who completed their data collection prior to onset of the pandemic in March 2019.

A third possibility is that participants in the waitlist control group experienced spontaneous remission at higher rates than the GIM group. For persons with depression, spontaneous remission may be as high as 32% within 6 months or 52% within 12 (Whiteford et al., 2013). Since the sample was small, minor differences in spontaneous remission between groups would have an outsized effect on between-group comparisons.

There are other possible explanations, however, that emerge when integrating the findings of the three articles. During the time after midpoint data collection, three significant processes were in motion for all but three of the participants[6] that may have had an impact on their depression and their GIM process. First, participants' contextual experiences were strongly affected by the COVID-19 pandemic. They were on lockdown and highly socially isolated, several out of work, and two reported only rarely leaving their homes during that period. While there is not data to examine the full impact of the pandemic, the two participants in the interview study both stated that it was a benefit of their GIM sessions to have an opportunity to leave the house, suggesting that isolation may have had a detrimental impact on their wellbeing. This may in turn have had an effect on their quantitative outcomes gathered in the feasibility study.

Second, these participants paused their GIM sessions indefinitely and without closure in their therapeutic process[7] before it was determined that the sessions could be continued via telehealth after a period of approximately 6 months. The follow-up interview study showed that the factor of greatest impact for the two participants was

[6] Three participants completed all procedures for the research study prior to the onset of the COVID-19 pandemic in March of 2019, and therefore were not affected by the three significant processes described here.

[7] Due to the pause in their sessions in response to the COVID-19 pandemic

the pause between sessions mid-series. They experienced this as having a greater effect on their therapeutic process than the shift to telehealth or stressors related to the pandemic. This aligns with findings from prior research that a short series of GIM sessions is insufficient for lasting therapeutic gains with persons who have high symptom acuity (Grocke, 2010; McKinney, 2019). In the feasibility RCT article, we hypothesized that either the participants required a longer series of GIM sessions before reaching a point of therapeutic growth that would persist, or that the 6-month pause created a substantial interruption to the participants' GIM process. This latter hypothesis would suggest a cumulative and time-sensitive effect of therapeutic gains, where it is important that clients keep momentum through their series. While more research in this area is needed, this hypothesis points to a recommendation for GIM therapists that if in-person sessions are not possible during continued work with a client, it may be better to shift to a telehealth format than to have an unplanned break in a series of GIM sessions.

Third, when sessions resumed, the participants received their sessions via telehealth,[8] constituting a new mode of therapy delivery. While findings from the interview study and data gathered from the GIM TFI during the feasibility RCT suggest that the two formats were not substantially different in terms of session components, the interview study does show that the participants felt that the online sessions were *experientially* less effective overall, at least initially, a factor which may have had an impact on the participants' therapeutic outcomes after midpoint. A combination of the session data gathered with the TFI (Articles 1 and 2) and the interview study (Article 3) shows that there was an initial transition period for each of the two participants while the participants adjusted to the online format and while the provider gained knowledge and skill necessary for facilitating online sessions through trial and error. For example, TFI data showed that in one session the provider shared music through YouTube; this did not work well because of YouTube's autoplay function, and the provider switched to playing music files on their local device through Zoom's *share computer sound* tool in subsequent sessions. According to the interview study (Article 3), both participants also had minor issues hearing the therapist due to issues with the Zoom audio device. These findings from each of the three articles provide evidence that these transition sessions were lacking in *procedural* effectiveness. According to the TFI descriptive session data (Articles 1 and 2), these transition sessions did not align as closely with the traditional GIM format as later telehealth sessions due to not using a full GIM program and slightly more directive guiding from the provider.

Together, these findings show that the transition sessions were (a) experienced as less effective both *experientially* and *procedurally*, and (b) less aligned with traditional GIM sessions than the participants' final telehealth sessions. This provides insight

[8] In 2020-2021, participants allocated to both the GIM group and the WL control group were provided with telehealth sessions in individual and group forms, respectively.

into the trajectory of therapeutic gains for two participants[9] in the GIM group: In combination with other factors, the effect of these transition sessions may have contributed to an attenuation of quantitative therapeutic outcomes after midpoint for half of the experimental group in comparison with the control group.

In summary, there were three potential limitations to therapeutic gains for participants in the feasibility study who were enrolled during the COVID-19 pandemic. The first applied to participants allocated to both the GIM and waitlist groups, and the second and third applied to participants allocated to the GIM group.

1. Factors resulting from the COVID-19 pandemic may have had a negative impact on the participants' mental illness and mental wellness.[10]
2. There may be a cumulative and time-sensitive effect of therapeutic gains vulnerable to unplanned pauses within a series of sessions.
3. There was an initial phase of transition sessions when participants switched to the telehealth format which were experienced as less effective and may have lessened therapeutic gains.

While these findings cannot generalize beyond the participants in this research study, they may nonetheless provide insight and preliminary guidance for working with clients with similar characteristics and in similar circumstances.

5.2.2. CLINICAL IMPLICATIONS: POTENTIAL SUPPORTS FOR THERAPEUTIC GAINS

Findings from the interview study in Article 3 illustrated two factors that were impactful to the participants' experience of their series of GIM sessions:

1. They developed familiarity with the GIM process over the course of their in-person sessions that made it easier for them to engage in their GIM experiences even when the format shifted to telehealth.
2. They developed a strong personal connection with their GIM provider, to the point where both participants reflected that they were grateful to have the opportunity to finish their sessions with the therapist.

The first factor aligns with findings of Yoshihara et al. (2022) that it takes time for clients to adapt to the process of engaging in GIM. Keeping the procedural aspects of the session consistent had an impact for the participants—they felt that their

[9] Amelia and Betsy, participants in the feasibility RCT (Article 2) and the interview study (Article 3).

[10] Mental illness and mental wellness can be considered two continua that are related but separate (Simmons & Lehmann, 2013).

experience with the GIM process, as captured in detail by TFI session data, helped them transition into this new space of telehealth sessions. More knowledge would be gained through studying clients' processes of learning to engage in GIM (e.g., Yoshihara et al., 2022). The preliminary findings of Yoshihara et al. suggest that for clients across several cultures, there is a unique "GIM culture" that develops outside of certain social norms. Further research should be conducted to explore whether that initial process of learning how to engage in GIM as a client is any different between the in-person and telehealth format.

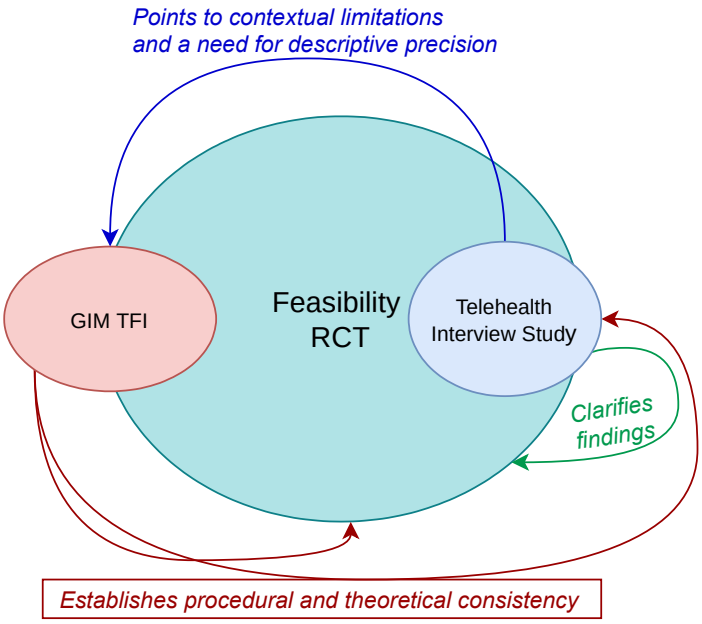
The second factor illustrates a personal dimension to the therapeutic relationship that is developed in GIM. In considering Figure 2 from Article 3, participants reflected that the pause/short series had a detrimental impact on their therapeutic process and on their imagery experiences, but it did not impact their rapport with their therapist. This is a sign that rapport is for GIM a necessary but not sufficient condition, since even when it was intact the participants felt attenuated therapeutic benefits, constituting an important finding for GIM in general. Interestingly, the participants' experiences suggest that rapport was not affected by the pause but other parts of the therapeutic relationship were: ways that they processed the imagery together with their therapist, a feeling that sessions were "personable," and the ease and clarity of verbal communication. The nature and quality of this personal connection in the therapeutic relationship developed in GIM deserves greater attention in future research.

In summary, the three articles highlight two important factors that may have supported the development of therapeutic gains. The first is that participants developed familiarity with GIM that aided their therapeutic process, and the second is that participants developed a strong personal connection with their GIM therapist that was stable over time.

5.2.3. METHODOLOGICAL IMPLICATIONS

While this thesis initially was oriented to investigate therapeutic outcomes, it took a turn towards methodological inquiry centered on two issues: (a) what was the therapy approach, and (b) how best to study its therapeutic outcomes. All three articles already engaged with these questions in different ways. Article 1 provided a way to track what the GIM therapy sessions consisted of through monitoring treatment fidelity, Article 2 tested a design to study therapeutic outcomes of GIM in a feasibility RCT, and Article 3 returned to the question about what the therapy approach was by exploring experiences of telehealth GIM. Each of the three articles informed the other two, as summarized in Figure 7.

Figure 7: Complementary Implications of Each Article



The data gathered using the GIM TFI that was developed in Article 1 allowed us to establish the degree of consistency among GIM sessions, including a comparison of in-person and telehealth sessions. This informed both the feasibility RCT in Article 2 and the interview study on telehealth GIM in Article 3. Second, the feasibility RCT in Article 2 established the need for both the GIM TFI in order to monitor treatment fidelity, and for the interview study in Article 3 as a follow-up to explore the shift in session format. Third, Article 3 helped clarify the findings of the feasibility RCT: It explored how participants experienced the shift in session format from in-person to telehealth, which informed the question of therapy validity in the feasibility RCT. Additionally, it pointed to some of the limitations of the GIM TFI that are described later in this chapter.

When the findings of the three articles are combined, they can provide a different and more nuanced examination of the two methodological issues stated above, (a) what was the therapy approach and (b) how best to study its therapeutic outcomes. These two issues are discussed below.

5.2.4. IS TELEHEALTH GIM STILL GIM?

Adaptations to unforeseen circumstances in the feasibility RCT raised the question: Once sessions were shifted to the telehealth format, were the participants still being provided with GIM? This question can also be asked more generally: Can telehealth

GIM sessions be considered to be the same therapy as traditional in-person GIM sessions? Both questions are crucial in terms of research methodology, since in order to study the effects of a therapeutic approach, we need to know what the approach is. While more research is needed in order to form more conclusive answers to these questions, the findings of the three articles provide some preliminary insight on the topic.

According to the TFI session data, telehealth sessions were conducted in nearly the same way as in-person sessions. Across the seven telehealth sessions, guiding directiveness in the telehealth sessions was rated only 0.1 lower on a 5.0-point scale than the overall average, meaning that the guiding was only marginally more directive in telehealth sessions. Telehealth sessions had a nominally higher rate of variation from the traditional GIM format, but these were all instances in which the therapist used shortened or modified programs for therapeutically indicated reasons that did not appear to be related to the telehealth format. This slightly higher rate of variation from the traditional GIM format in telehealth sessions deserves more research, since Sanfi (2019) found that in 2018 more GIM therapists reported providing music and imagery sessions via telehealth than GIM sessions. Considering the GIM TFI data gathered during the feasibility RCT, the answer to the question raised above would be that the GIM provider conducted the sessions in nearly the same way and therefore the two formats constituted nearly the same approach.

In Article 3, the participants recognized the telehealth sessions as GIM but identified new settings, new competencies, and slight variations that came with the change in format. It was *the same, but a little different*. This aligns with the new competencies and equipment needed for telehealth GIM practice described by Sanfi (2019), Dimiceli-Mitran and Moffitt (2020), and Muller and colleagues (2021). The participants in Article 3 said that telehealth GIM sessions were "still fairly effective" and their experiences improved with the familiarity gained over just three to four sessions, but initially they felt less personal and less effective than in-person sessions. This adds nuance to existing literature on telehealth GIM that suggests the telehealth format can be similarly effective despite challenges unique to the telehealth setting (Dimiceli-Mitran & Moffit, 2020; Sanfi, 2019). It is also in slight contradiction to Bowler's (2012) claim that the personal connection between therapist and client can remain intact in telehealth sessions. For the participants in Article 3 of this thesis, the telehealth sessions were distinguishable from in-person sessions for factors including the limited sensory data inherent to the virtual technology and the complex tripartite setting combining the therapist's office, client's home, and the virtual space, as described in Article 3. These conclusions parallel the findings of research into telehealth formats for verbal psychotherapy (Rogers et al., 2021), showing that GIM is vulnerable to some of the same drawbacks of telehealth as other modalities. But these differences came with other benefits, for example improved convenience and accessibility, again paralleling findings from research on telehealth verbal psychotherapy (Stoll et al., 2020) and telehealth GIM (Bowler, 2012).

Participants found the telehealth format to be *the same but a little different*; at the same time, there were few differences captured by the GIM TFI. This shows that there was a slight discrepancy between the participants' reports and the session data captured by the TFI forms. Whatever factors made telehealth sessions feel slightly different to the participants were not captured by items on the TFI form. There are three possibilities that arise from this discrepancy.

The first possibility is that the factors that made participants' experiences of telehealth sessions feel slightly different from in-person sessions simply were not tracked by the TFI, for example the degree to which the sessions felt personal. In the interview study, both participants reflected that their telehealth sessions initially felt less personal, a quality that does not appear on the TFI form. Since the humanistic orientation of the therapist-client relationship in GIM would suggest that a personal quality to the session would be an essential characteristic of GIM, in this case participants' reflections provided an important assessment of whether telehealth sessions were the same as in-person (*the same but a little different*). These reflections are particularly important given that they contradict the claim by Bowler (2012) that the personal connection remains intact in telehealth GIM.

The second possibility is that the factors that made participants' experiences of telehealth sessions feel slightly different from in-person were unique to the telehealth format (aligning with the findings of Sanfi, 2019) and therefore were beyond the scope of a TFI form that was designed for sessions that follow the in-person format. In other words, the factors that were impactful to the participants were not captured by a tool that was designed to record the mechanics of single in-person sessions. For example, both participants discussed distractions that arose from the combined home/virtual setting such as their domestic pets or audio issues with the teleconference software. These factors would not have been relevant to in-person sessions. Since the TFI was designed for use with the in-person session format, it makes sense that the tool would not track factors like software issues. As with the first possibility, this would suggest that the participants' reflections provided important information about whether in-person sessions and telehealth sessions were the same therapy (*the same but a little different*).

A third possibility is that the factors that made participants' experiences of telehealth sessions feel slightly different from in-person may have been altogether unrelated to the change in session format, but rather arose from other confounding factors extrinsic to their GIM sessions like the unplanned pause or stressors related to the COVID-19 pandemic. In considering the effects of the unplanned pause, the interview study in Article 3 suggests that participants experienced their sessions as two short series instead of one 10-session series because of the unplanned pause of approximately 6 months. Both participants stated that the mid-series pause between the in-person and telehealth sessions was impactful, experiences that are supported in part by their quantitative outcome data from Article 2. This suggests that it is possible that dosage

(Grocke, 2010) and session timing could have been a major source of impact apart from session format. In this case, the question shifts from whether in-person sessions are the same as telehealth sessions, to what constitutes a GIM series (i.e., session timing, dosage, and how telehealth sessions can function within a longer series of GIM sessions). More research is needed to explore this possibility. In considering the possible effects of stressors that resulted from the COVID-19 pandemic, the participants reported factors such as loss of work and social isolation. It is possible that this lived context could have impacted their GIM sessions during the pandemic regardless of the session format, in-person or telehealth. While there are no data that would allow conclusions to be drawn about the impact of these confounding factors, the data do show that the confounds exist and therefore they should be considered. This third possibility, that the factors that made participants' experiences of telehealth sessions feel *a little different* from in-person sessions might have been due to factors totally unrelated to the session format, would suggest that the descriptive session data captured by the TFI provided a limited assessment of whether telehealth sessions were the same as in-person (*nearly the same*). The GIM TFI provided data about factors that were intrinsic to GIM, but the factors discussed here in this third possibility are extrinsic to GIM. Methodologically, it is noteworthy that one possible explanation for why the telehealth format felt different from the in-person format may have been factors extrinsic to the GIM sessions. More research should be done to investigate this possibility by exploring whether and how extrinsic factors that may affect telehealth experiences.

Returning to the question raised above (*Does telehealth GIM constitute the same therapy as in-person GIM?*), the answer also depends on one's definition of GIM. When held up to both the *Core Elements of GIM* as set forth by the AMI (2017) and the definition of GIM proposed by Grocke and Moe (2015) used for this research, telehealth GIM was indistinguishable from in-person GIM: the telehealth sessions involved imagery experiences in a NOSC activated by programs of Western art music[11] in a series of one-on-one sessions that followed a format including a preparatory discussion, transition to a NOSC, interactive music-and-imagery experience with dialogue between the provider and participant, and a time for processing to find closure and integration. Yet, the two participants described meaningful, though minor, differences between the two formats such as vulnerability to new types of distractions like domestic pets and issues with audio, as have GIM practitioners (Dimiceli-Mitran & Moffitt, 2020; Muller et al., 2021). Their experiences were that the telehealth sessions felt a little different and that they were distinguishable from in-person sessions. While the sessions conformed to definitions of GIM, there were elements that made the telehealth sessions different than in-person sessions, obfuscating whether they constituted the same therapy. This highlights a tension within the precision of language that is used to describe therapeutic approaches. On one hand, there is a need for precise descriptions for what therapists

[11] Referred to by the AMI as "classical music" (AMI, 2017)

do and what clients engage in; otherwise, terms can become nebulous. Indeed, this was the underlying aim of Article 1—to gather precise descriptive data about sessions. On the other hand, increasing the precision of language with which we define approaches draws boundaries that can limit practice, scope, and adaptability of therapeutic approaches, and can invoke value judgements about approaches falling within and outside of precise delineations of therapeutic approaches. This tension between precision and inclusion is central to the discussion about what the GIM method is and what GIM sessions entail.

GIM—and its variations—can be effective in myriad forms (Grocke & Moe, 2015). One strategy to prevent restricting the scope of GIM as described above could be to use the term GIM in a broad manner that encompasses the wide range of therapeutic practice related to or inspired by GIM, as proposed by Bruscia (2015). On the other hand, a precise description of GIM with tight boundaries has utility for research because it improves validity and replicability, and has utility in therapeutic practice because it aids in precise and clear communication with the public and other professionals about a particular therapy (Muller, 2014). Yet, the findings of this thesis show that even a narrow, precise delineations between GIM and other related approaches may be insufficient to fully capture meaningful variations between GIM formats. Even within the relatively narrow description of GIM used in developing the TFI, this thesis found two distinct subsets of GIM (in-person and telehealth) that were both confirmed to be sound manifestations of the theoretical and procedural descriptions of GIM.

One possible explanation is that the question of how to *define* a session to be GIM may indeed be the wrong question because definitions come with trade-offs. Either a definition is precise but exclusionary, or inclusive while sacrificing precision. Instead of definitions, more precise *descriptors* are needed that can add detail and nuance to the term GIM, rather than form narrower boundaries around what GIM can be defined as. Adding descriptive texture allows for the benefits of an inclusive definition of GIM while also reaping the benefits of precise description.

The working definition of GIM for this thesis did not have adequate nuance to capture the differences that emerged between in-person and telehealth GIM, many of which were related to the contextual details outside of session observations that were meaningful in the participants' processes (see discussion of extrinsic factors above). These contextual details were outside the realm of focus of the feasibility RCT, the observations for which were limited to the interaction between client and therapist, in other words, to the delivery/receipt of the therapy (Borrelli, 2011). Yet, this contextual perspective may have been needed. This insight is supported by one of the findings of the feasibility study—that the design did not include an adequate way of understanding the impact of significant life events, as well as by a finding of the interview study—that the pause may have had a more substantial impact than the phenomenon we set out to investigate.

A recommendation that stems from this finding is that moving forward, research literature on GIM should include contextual descriptive data on dosage, therapeutic trajectory and timing, setting, therapeutic relationship, and the impact of major life events, since those were shown by the participants' processes to be potentially impactful. This recommendation for contextual descriptive data forms a basis for a discussion of the second methodological issue, *How best to study the therapeutic outcomes of GIM*.

5.2.5. IMPLICATIONS FOR HOW TO INVESTIGATE OUTCOMES IN GIM

Recommendations for designing a full-scale RCT to investigate therapeutic outcomes based on the feasibility findings are discussed in detail in Article 2. This section contains additional methodological reflections on investigating therapeutic outcomes in GIM that emerged from integrating the three articles (see Figures 6 and 7).

The telehealth interview study in Article 3 highlights how useful the TFI can be for gathering descriptive data about how a GIM session instantiates. Gathering descriptive data on the therapeutic environment, the preliminary conversation and induction, the music listening period, and the return and processing portion of the session allowed us to establish what was kept consistent between two session formats––in-person and telehealth—that at first glance may appear vastly different. The GIM TFI allowed us to establish consistency of procedures and principles within the sessions under investigation. In turn, this made it possible to highlight what was actually different between the in-person vs. telehealth format (e.g., slight differences in guiding directiveness and nominally different rates of adaptations, or changes in the participants' experiences of their setting.). Although the TFI was not designed to allow for a comparison of two different GIM formats, it captured enough descriptive data to provide the opportunity to go back and reflect upon a question that emerged in real time: Was it still GIM when offered via telehealth? In terms of methodological considerations, this confirms the TFI's usefulness that was speculated upon in Article 1: If used by clinicians or researchers as a tool to gather descriptive data about what happens in a given set of GIM sessions, it would allow for post-hoc analysis to help answer research questions or address clinical issues that emerge unexpectedly.

On the other hand, the telehealth interview study (Article 3), highlights some of the limitations of a treatment fidelity instrument that is non-contextual; that is, one that only includes descriptive data pertaining to the direct therapeutic encounter. The GIM TFI was designed only to monitor treatment fidelity at the level of treatment delivery (Borrelli, 2011; Honig & McKinney, 2021). It did not allow us to gather data on the clients' experiences, nor contextual information about the client's life outside of the session or other factors extrinsic to the GIM sessions. Indeed, this data would be beyond the scope of monitoring fidelity of treatment delivery. This limitation reflects the sum findings of the three articles discussed throughout this chapter, which signal that nuanced data like changes to the setting, variations in session timeframes, minor

complications within the session like audio or visual issues that impair communication, qualities within the therapeutic relationship, and the client's lived context can have a direct impact on how clients experience the intensity, effectiveness, or beneficence of a GIM session.

An implicit assumption of the feasibility study—and the GIM TFI—is that the therapy that was provided is the carrier of positive outcomes. This claim is supported by the model for how participants developed inner resources that is described in Article 3 (see Figure 3 in Article 3). However, examining contextual or extrinsic factors within the GIM participants' therapeutic processes may weaken that implicit assumption. As a hypothetical example, perhaps the trust and closeness that the participants developed with their GIM provider was a primary source of benefit for two of the RCT participants, and the therapeutic approach itself was ancillary. In other words, it is possible that engaging in the GIM process may have brought about the conditions that were sufficient for the participants to enact change in their lived experience (Rolsvjord et al., 2005). As described in the previous section, it is crucial to know what occurs in the GIM sessions in order to study outcomes. At the same time, the findings from these three articles discussed in this chapter show that it is also important to describe contextual information—what is happening outside of the sessions or outside of the formal procedures under investigation—in order to know what is truly having an impact. The need for examining contextual factors in objectivist research may decrease as the sample size increases. However, objectivist research with larger samples would be bolstered by additional research into contextual perspectives that may point toward mechanisms (or conditions) of change in GIM. This insight was made possible by the complementary nature and scope of the findings from these three articles, and complementary methodologies may provide a useful approach for future research into complex therapeutic methods like GIM.

5.3. INDIVIDUAL CASE DESCRIPTIONS

In the preceding section, integration of the *overall* results of three articles highlighted insights for GIM research and practice. Here, two case descriptions now provide a narrative frame for weaving together data points for *individual participants* that were gathered while conducting each of the three research studies. The purpose of illustrating these two cases is to highlight methodological findings of the three articles in dialogue, rather than to provide detailed systematic case studies about participants' therapeutic work in GIM. Given the limitations in the results of the statistical tests for the feasibility RCT, a closer look at individual cases can be informative. These case descriptions add to the integrated findings by clarifying the impact of the unplanned mid-series pause to their GIM sessions and subsequent shift to telehealth on their therapeutic process and psychological outcomes. They also point to areas where more research is needed.

Data from the two participants allocated to the GIM group in the feasibility RCT who began their sessions in-person and then transitioned to telehealth sessions after the pause for COVID-19 are presented and discussed. These two participants' cases were selected for discussion here because they were involved in each component of this thesis: They were participants in the feasibility RCT and were both allocated to the GIM condition, and data about their sessions were captured using the GIM TFI. They were also the two participants who transitioned to telehealth sessions and who contributed to the interviews for Article 3. Therefore, their cases provide a lens through which to view the entire thesis project as a whole, providing an opportunity to weave together the findings of the GIM TFI (Article 1), the feasibility RCT (Article 2), and the interview study on telehealth GIM (Article 3) in a way that is grounded in two individuals' experiences rather than aggregate results. Both participants are referred to by pseudonyms.

5.3.1. COMBINED IN-PERSON AND TELEHEALTH CASE #1: AMELIA

Table 1 and Figure 4 show quantitative outcome data for this participant, referred to as Amelia.[12] The onset of the COVID-19 pandemic happened after Amelia's seventh session, between midpoint and posttest (as designated by the red line in Figure 4), after which she had three telehealth GIM sessions.

Table 1: Outcome Data for GIM Participant Case #1

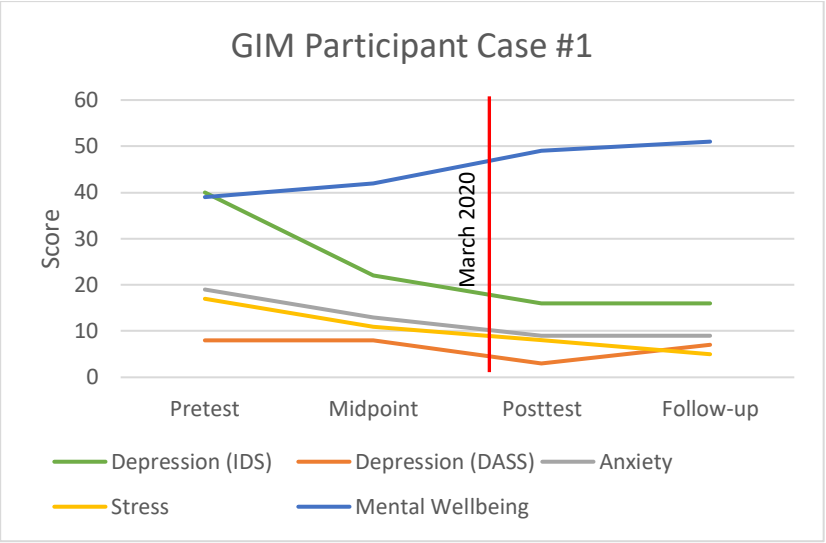
	GIM Participant Case #1			
	Pretest	Midpoint	Posttest	Follow-up
Depression (IDS-SR)	40	22	16	16
Depression (DASS)	8	8	3	7
Anxiety	19	13	9	9
Stress	17	11	8	5
Mental Wellbeing	39	42	49	51

Amelia's quantitative outcome data shows consistent improvement from pretest to midpoint and to posttest in all scores: both depression measures (IDS-SR and DASS-Dep), anxiety, stress, and mental wellbeing. All quantitative outcomes were either stable or continued to improve between posttest and follow-up except for the depression scale of the DASS, which showed a worsening at 6-week follow-up, though still improved in comparison to baseline. In a follow-up interview for Article 3 (Honig & Hannibal, 2022), this participant confirmed her positive quantitative therapeutic outcomes by saying that her series of GIM sessions was "more beneficial than I could have imagined." To her, the most important benefits were related to well-

[12] This participant corresponds to Participant #1 in Article 3 (Honig & Hannibal, 2022).

being such as improved self-image, feelings of confidence and purpose, and hope for the future.

Figure 4: Outcome Trends for GIM Participant Case #1



Session data gathered using the GIM TFI shows that eight of Amelia's GIM sessions can be considered to have been GIM sessions, and two used adaptations where she drew or imaged to single pieces of music. Amelia's GIM provider used GIM programs that were evenly spread between being categorized as beginning programs (n = 3), preparatory (n = 3), beginning-transpersonal (n = 1), working-transpersonal (n = 2), and a single piece (n = 3).[13] The progression of these sessions mirrors Amelia's experience of building therapeutic momentum. She began by traveling to a preparatory program followed by two sessions with beginning programs, then two sessions with working/transpersonal sessions, and then a beginning/transpersonal program before the series was paused for COVID-19. After resuming, the music used in her telehealth sessions included one beginning program and two sessions where a single piece of music was used, each of which can be categorized as *supportive* music according to the taxonomy of GIM music developed by Wärja and Bonde (2014). This progression supports Amelia's statements in the interview study that she built momentum, and then that therapeutic momentum dissipated in the pause before her telehealth sessions. Amelia reported that her telehealth sessions were overall less effective, though still beneficial. These telehealth sessions felt shorter and less in-depth, a reflection supported by TFI data from her sessions described above that show

[13] GIM programs are categorized according to these levels by Bruscia (2015). They describe the stage in therapy and client readiness at which this program is most likely to be indicated.

that the music was indeed shorter in two of the telehealth sessions. She felt that she was replaying images rather than exploring new ideas or new images, which is characteristic of GIM adaptations in which only one piece of music is used. Together, the record of music programs used in Amelia's sessions and her reflections on her therapeutic trajectory suggest an arc to her GIM series where her therapeutic process deepened gradually over seven sessions as she built momentum, and then returned to more supportive-level work that provided her with a chance to review work she had previously done in her series.[14] Methodologically, these two different types of data provide complementary insights about her process. In this case, they align to support similar possible conclusions about her therapeutic process.

Interestingly, Amelia's experience that her telehealth sessions felt less impactful and that she had lost therapeutic momentum during the unplanned pause was not reflected in her quantitative outcomes, since each outcome continued to improve between midpoint and posttest. This suggests that for Amelia, either her perception of session impactfulness referred to a phenomenon separate from the constructs measured by the quantitative outcome instruments, or she still felt the impact but experienced it to a smaller degree than between pretest and midpoint.

Amelia also noted that her benefits from GIM persisted after the series ended, "but sometimes I have to recall it and push myself into it, like with any other skills." This statement is supported by the relative stability of her quantitative outcome scores between posttest and follow-up: the benefits were stable, though perhaps not always as present in her awareness.

5.3.2. COMBINED IN-PERSON AND TELEHEALTH CASE #2: BETSY

Table 2 and Figure 5 show outcome data for this participant, referred to here at Betsy.[15] Onset of the COVID-19 pandemic occurred after her sixth GIM session, between midpoint and posttest (as illustrated by the red line in Figure 5). After the pause of approximately 6 months, she received four telehealth sessions.

[14] The specific music program used in a GIM session does not necessarily suggest a particular level of therapeutic intensity. For example, music categorized as supportive according to Wärja & Bonde's (2014) taxonomy can support deep reconstructive work. However, the music program that the guide chooses to support the client's imagery process can signal the type and affective intensity of the therapeutic work that the client engages in during the session.

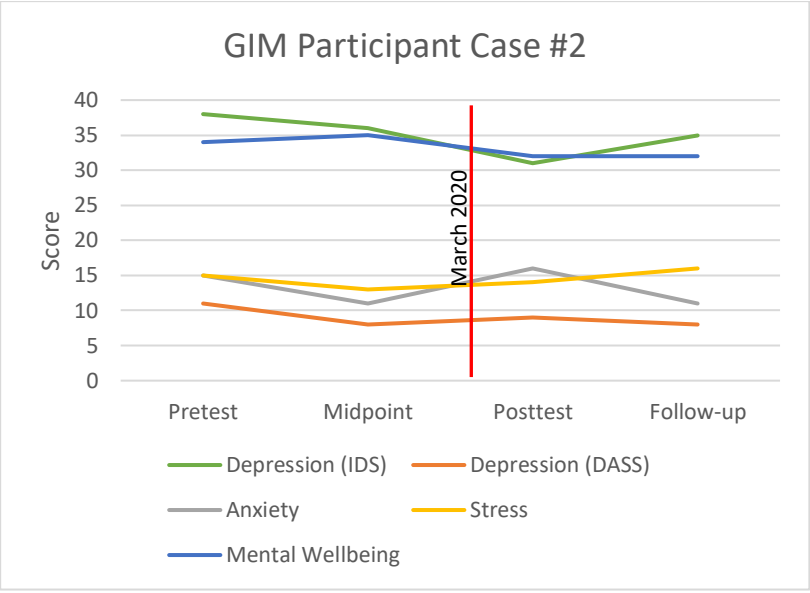
[15] This participant corresponds to Participant #2 in Article 3 (Honig & Hannibal, 2022).

Table 2: Outcome Data for GIM Participant Case #2

GIM Participant Case # 2

	Pretest	Midpoint	Posttest	Follow-up
Depression (IDS-SR)	38	36	31	35
Depression (DASS)	11	8	9	8
Anxiety	15	11	16	11
Stress	15	13	14	16
Mental Wellbeing	34	35	32	32

Figure 5: Outcome Trends for GIM Participant Case #2



Betsy's quantitative outcome data shows modest improvement in all quantitative outcomes between pretest and midpoint. Outcomes trends were more mixed, however, as she progressed through posttest and follow-up. At posttest, she showed continued small improvement in depression as measured by the IDS-SR. Stress and depression as measured by the DASS both showed slight worsening at posttest, each to levels that still showed improvement in comparison to pretest. However, Betsy's anxiety and mental well-being scores at posttest showed worsening to levels slightly more severe than pretest. The mixed outcomes continued at follow-up. In comparing her follow-up scores to pretest, Betsy showed small improvements in depression as measured by both the IDS-SR and DASS, as well as anxiety, but showed slight worsening of stress and mental well-being.

In the interview study, Betsy reflected that by the end of her sessions she had fewer feelings of sadness, particularly in relation to specific parts of her past, supporting the quantitative data that showed slight improvement in depressive symptoms. She noted that GIM "nibbled at the edges" of her depression; she may have worked on her depression in indirect ways and may have decreased it to some respect, but she "didn't really make any big strides" in her depression through GIM. Betsy noted that some of her imagery stayed with her and continued to feel powerful after her series of sessions ended. One possibility is that this impactfulness may not have been captured by her quantitative outcome measures at follow-up, as suggested by her outcome measures show in Table 2. If this were true, it may be partially explained by Betsy's statement that she did not retain a strong memory of most of her imagery from the telehealth sessions, which may have dampened her perception of therapeutic benefits at follow-up. Like Amelia, Betsy felt that she had gained therapeutic momentum in her in-person sessions, momentum that was lost in the 6-month pause due to the pandemic.

Descriptive session data gathered by the GIM TFI show that nine of Betsy's sessions are considered GIM and one was a GIM adaptation where she imaged by drawing to an abbreviated music program. Betsy's GIM provider began the series by using beginning and preparatory level programs in the first three sessions before moving into a working program in Betsy's fourth session. The fifth was an adapted music program in which she imaged through drawn mandala to *mixed supportive-challenging* music (Wärja & Bonde, 2014). Her sixth and seventh sessions had transpersonal programs, followed by a working program and finally ending her series with a beginning program. This progression of GIM programs that the therapist chose through Betsy's series of sessions provides a small glimpse of Betsy's therapeutic process. It suggests that Betsy may have undergone a gradual process of moving in to deeper work, taking a break for reflection and integration, and gradually moving back into deeper work before ending with a more supportive beginning program to help bring closure.

In contrast to Amelia's sessions, the progression of music in each of Betsy's sessions suggests a repeated cycle of moving between supportive and challenging programs. The GIM programs she traveled to can also be considered in terms of mood constancy of the music (Bruscia, 2015).[16] This data suggests that her sessions may have followed a gradual shift from programs with high constancy in her first seven sessions, to two with medium constancy, and a final session with low constancy. One speculative possibility is that over the course of her sessions, Betsy showed greater psychological flexibility that allowed her to tolerate more change within the music.

[16] Constancy refers to changes in mood within single pieces and between different pieces in the program. Programs with higher constancy can be supportive since they have a narrower range of mood variation, but can also be more intense when the moods within that range are difficult for the client to experience. See Bruscia (2015).

As with Amelia's case, juxtaposing these different data points that were gathered for different purposes can enrich possible understandings of her process. These interpretations are largely speculative and warrant more systematic investigation. However, this preliminary level of interweaving the data from each of the three articles shows areas where there is consistency in the findings (e.g., the attenuation of Betsy's quantitative outcomes aligned with her experience that the sessions became generally less powerful after transitioning to telehealth) and where the findings may be contradictory (e.g., Betsy reported feeling that she had lost therapeutic momentum and felt she was starting over in her last four sessions, yet Betsy's final four sessions used music programs with greater levels of intensity that suggests she may have been engaged in deep therapeutic work). Future mixed-methods research in GIM may benefit from considering these varied data sources as a possible means of triangulation.

5.3.3. IMPACT OF THE PAUSE, PANDEMIC, AND SHIFT TO TELEHEALTH FOR AMELIA AND BETSY

Both Amelia and Betsy noted that the unplanned pause due to the COVID-19 pandemic had a substantial impact on their therapeutic processes, supporting the finding discussed in Ch 5.2 that factors extrinsic to single sessions were impactful to the participants' experiences. It stands to reason that this, in combination with the change in session format to telehealth, would have had a meaningful impact on the participants' quantitative therapeutic outcomes. Based on the available data, however, these individual cases show that there were not substantial jumps in quantitative outcomes in either direction after going online. Each of the two cases had a different outcome trajectory, one positive and one mixed, after they shifted to telehealth sessions. This suggests that the format in which participants received GIM—in-person or online—may not have had a substantial impact on their therapeutic process since neither showed drastic changes in their quantitative outcome data and both moved in oblique directions. This hypothesis should be investigated in future research.

Another possibility is that the shift may have had a meaningful impact on their experiences of growth or depressive symptoms, but in ways that did not align with the constructs measured by the quantitative instruments. The latter possibility raises questions that deserve more research: If the change in format affected their perception of benefits but not their quantitative measures of depressive symptoms, what were the benefits that they experienced prior to going online and how can we better understand them? Did those benefits manifest in their lived experience of depression? Did changes in their quantitative measures of depressive symptoms manifest in their lived experience depression? Qualitative and mixed-methods research may shed light on these questions.

5.3.4. METHODOLOGICAL INSIGHTS FROM THE CASE DESCRIPTIONS

Shifting to a meta-perspective, these two case descriptions illustrate what may be gained through weaving together individual participants' data from research studies that employ different research aims and methodologies. The GIM TFI allowed us to gather objective data about what was happening in the sessions in order to monitor treatment fidelity, but also provided descriptive data that allowed us to gain a more textured understanding of the participants' therapeutic process in post-hoc analyses that contributed to knowledge gained in Articles 2 and 3. In some cases, it allowed findings to be confirmed and added descriptive nuance. For example, in the interview study both Amelia and Betsy said that they felt they lost therapeutic momentum during the pause between in-person and telehealth sessions. TFI session data about the music programs and modes of imaging (eyes closed vs. drawing) in their sessions added clarity about what losing momentum meant in terms of their therapeutic process, showing that after the pause their sessions moved to a more supportive level. Outcome data linked the participants' statements about losing momentum with the severity of their depressive symptoms, the combination of which suggests that the magnitude of therapeutic benefit had attenuated after that pause but did not halt altogether.

In other instances, weaving together the individual participants' data gathered in each of the three studies highlighted contradictions that point to areas where more research is needed. For example, Amelia reported that her later sessions were less impactful and TFI data showed that she had imagery experiences that were more limited or contained, yet her quantitative outcomes continued to improve. This suggests the possibility that her perception of impactfulness may not have aligned with the quantitative measures of her depressive symptoms.

A follow-up study is planned of the individual cases of all participants allocated to the GIM group, including participants who completed their entire series in-person and the participants who transitioned to telehealth mid-series. This mixed-methods multiple case study may provide additional insight into the therapeutic outcomes experienced by each individual who participated, providing more granular detail about whether, how, and with whom GIM can be an effective therapy for depression. It may also provide additional insight into potential confounding factors, such as the impact of major life events, other therapies, and client-therapist dynamics, all of which may have utility for future objectivist research.

5.4. LIMITATIONS

Limitations for each of the three studies are included in the articles. A few of these limitations are highlighted here, along with a reflection on limitations of the overall research project.

Within this thesis, my positionality as a researcher and therapist constituted a significant potential source of bias. I am a GIM therapist and have pre-understandings about the therapeutic functions and usefulness of GIM in working with persons who have depression. From this perspective, there could be a conflict of interest in that I was investigating therapeutic outcomes for an intervention that I have personal and professional investment in. The research design was intended to mitigate the possible effects of these sources of bias, including the post-positivist design for the feasibility RCT following objectivist research principles, centering a process for monitoring treatment fidelity in order to ensure consistent provision of care, and investigating the participants' own perspectives on their GIM session experiences. Additionally, collaboration with other researchers as well as a peer-review process for the articles provided opportunities to identify instances of bias within the findings. However, this research may still have been vulnerable to bias towards my understandings of the effectiveness of GIM as a therapeutic approach.

Additionally, my role of researcher-as-therapist may have introduced bias into the feasibility RCT since I functioned as one of the two GIM providers. Potential for this bias to affect the research outcomes were mitigated by implementing a process for monitoring treatment fidelity, utilizing self-report data questionnaires that participants completed at home, and by involving an additional GIM provider.

While discussed in more detail in Article 2, the statistical analysis of outcome data in the feasibility RCT was limited by a small sample size and missing data. Given these limitations, the outcome analysis was highly exploratory; conclusions are based on limited data and warrant more research.

The interview-based investigation of telehealth GIM in Article 3 involved the perspectives of two participants. It was intended to capture these two participants' unique experiences of receiving GIM sessions within the feasibility RCT. Further investigation of GIM therapist perspectives as well as an investigation into the experiences of clients who experience GIM telehealth sessions outside of a controlled research study would be informative.

Both Articles 2 and 3 took place within the extraordinary context of the coronavirus pandemic and social uprising within the US. This context is likely to have had an impact on the participants' lived experiences; however, this research did not provide a way of determining this impact. The findings described within this thesis should be understood relative to this extraordinary context.

At a methodological level, this research is limited in that it began as an objectivist (fixed) design but became flexible by necessity. This had two limiting effects: findings from the investigation of *a priori* outcomes within the feasibility RCT should be taken with caution since the outcome aims shifted during the research, and the feasibility

aims of Article 2 may have had a different scope if the study had initially been designed as a feasibility study.

Additionally, there are possible methodological limitations in utilizing multiple research paradigms that were grounded in different epistemological and ontological frameworks. However, these multiple research paradigms within this thesis were viewed as complementary and the approached aligned with pragmatist research practice in which research questions guide towards the research paradigms that are most relevant for investigating those questions. (Mertens, 2005)

5.5. CONCLUSIONS

This research was designed around the primary research question: In persons with depression, is a series of GIM sessions effective in reducing symptoms of depression? Due to adaptations of the research to the COVID-19 pandemic, this thesis was not able provide a clear answer to this question. However, in carrying out this aim, the research also engaged with the questions of how to investigate these treatment effects, and how to determine what constitutes GIM as a therapeutic approach. This latter question was explored by developing a way to monitoring treatment fidelity and by investigating two different formats of GIM sessions, in-person and telehealth. Adaptations to the COVID-19 pandemic placed an even greater emphasis on this second methodological question of what constitutes GIM as a therapeutic approach with persons who have depression. Conclusions from each part of this thesis are included in the three articles, including conclusions about the articles' specific research questions and aims. Some are highlighted here, along with conclusions that can be drawn from the thesis as a whole.

Article 1 centered on the research aims of developing a process to monitor treatment fidelity within individual GIM sessions for a feasibility RCT that would allow one to gather descriptive data about session content and variations to the traditional GIM format. This aim led to the development of the GIM TFI, which was found to be useful as a process for monitoring treatment fidelity that followed a description-based approach rather than definition-based. This finding suggests that firm boundaries defining a therapeutic approach may not be needed when there is a process for gathering descriptive data grounded in a therapeutic framework. This description-based approach may inform processes for monitoring treatment fidelity in other complex music therapy approaches, and use of the GIM TFI may contribute to future GIM research as a therapy monitoring process. The GIM TFI would benefit from further research into its inter-rater reliability.

Article 2 investigated the feasibility of a multisite randomized controlled trial to investigate treatment effects of a series of GIM in persons with depression. Overall, this research demonstrated that GIM can be a safe and acceptable therapeutic method for persons with mild to severe depression, and that it is feasible to investigate using

a multi-site randomized controlled design for objectivist outcome research with a systematic process for monitoring treatment fidelity. The fact that telehealth sessions were provided with high treatment fidelity but also had clear differences from in-person sessions may indicate that there are factors that were not captured by the GIM TFI that were still impactful for the GIM recipients. Therefore, further research into the impactful components of GIM in both in-person and telehealth formats is needed. Additionally, contextual factors extrinsic to GIM sessions should be considered in future GIM outcome research, particularly in objectivist studies with small samples. It is possible that these contextual factors may lead to a better understanding of how clients experience change within their GIM process. It may also aid in creating better understandings of the linkages between GIM and its many variations and between GIM and other telehealth therapies, since they may provide further insights about aspects of these therapies that recipients find impactful.

Analysis of the outcome data on depression, anxiety, stress, and mental wellbeing revealed no significant treatment effects between groups over time. However, these findings are highly exploratory and should be taken with caution. More research is needed to investigate therapeutic outcomes of a series of GIM sessions with persons who have depression.

The aims of Article 3 were to provide a better understanding of participants' experiences of shifting to telehealth as well as the similarities and differences between telehealth and in-person formats of GIM. With the support of a therapeutic relationship that has already been developed in-person, this research provides preliminary evidence that the transition from in-person sessions to telehealth sessions can happen relatively quickly, in as few as three to four sessions. This thesis also indicates that GIM via telehealth may be a viable therapeutic alternative under certain conditions, even with persons who have severe mental health concerns. However, more research is needed in this area.

Participants experienced similarities and differences between telehealth and in-person formats of GIM. Despite the potential benefits of telehealth GIM such as increased accessibility, there also potential drawbacks to the telehealth format such as increased distractions, reduced privacy, and attenuated feelings of the therapist's presence. Since a pre-developed therapeutic relationship was important to the participants' therapeutic gains, a GIM series should begin in person, when possible. More research into the telehealth format of GIM is needed, particularly investigation of therapists' experiences and whether and under what conditions GIM can be initiated with new clients via telehealth.

This research showed that a long pause within a series of GIM sessions was highly impactful. This preliminary finding supports prior research showing that a short series of six or fewer GIM sessions is not sufficient for persistent therapeutic outcomes with persons who have significant health concerns (Grocke, 2010; McKinney, 2019).

Given this finding, a GIM series should have continuity, particularly with persons who have significant mental health concerns.

Importantly, this thesis constitutes systematic research into GIM for persons with depression. Building on case study research, it provides further insight into GIM as a therapeutic modality for persons who have this unique type of mental health concern.

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APPENDICES

Appendix A. Participant Questionnaire for the Feasibility RCT

Participant Information Questionnaire – Pretest

Name: Age:

Gender:

Mailing Address (street, city, state, ZIP code):

Phone number (please include area code):

Email address:

Please list your most recent mental health care provider:

Name: Phone:

Do you have a previous diagnosis of depression? If so, when were you first diagnosed?

Have you ever had any other diagnosed mental illness? If so, please list.

Have you ever been diagnosed with a disorder involving psychosis, such as schizophrenia or schizoaffective disorder? If so, please specify.

Current Treatment

1. Are you currently receiving any treatment for your depression?

Please circle: Yes No

If yes, please specify:

- Medication(s):
    - How long have you been on this medication?
    - Prescribing physician:
- Counselor or psychologist:
- Psychiatrist:
- Other (please specify type, frequency, and how long you have been receiving this care):

2. Besides the treatments described above, have you received mental health care in the last six months?

Please circle: Yes No

If yes, please specify:

- Medication(s):
    - How long have you been on this medication?
    - Prescribing physician:
- Counselor or psychologist:
- Psychiatrist:
- Psychiatric hospitalization:
    - Location
    - Diagnosis at discharge
- Other (please specify type, frequency, and how long you have been receiving this care):

3. In the last six months, have you received Guided Imagery and Music sessions? If so, please specify the therapist.

4. In the last six months, have you participated in any therapy involving altered states of consciousness, such as hypnosis, holotropic breathwork, or drug-assisted psychotherapy? If so, please specify.

Participant Information Questionnaire – Midpoint and Posttest

1. Are you currently you receiving any treatment for your depression other than the procedures of this study?

Please circle: Yes No

If yes, please list the following changes **since the last time you completed a questionnaire packet for this study**:

- **Changes** you made in treatment
- **New treatment** that you started

2. Changes Made to Existing Treatments (list all)

- Medication(s)
    - Please note what medications, and what changes were made:
    - Prescribing physician:
- Counselor or psychologist:
    - What changes did you make?
- Psychiatrist:
    - What changes did you make?
- Other (please specify the changes you made in the treatment):

3. New Treatment(s) Added (list all)

- Medication(s)
    - Please note what medications and when you started:
    - Prescribing physician:
- Counselor or psychologist:
    - When did you start working with them?
- Psychiatrist:
    - When did you start working with them?
- Other (please specify type, frequency, and when you began receiving this care):

4. Has anything significant happened to you in your life since the last time you completed one of these packets?

Participant Information Questionnaire – Follow-Up

1. While participating in this research study, did you receive any treatment for your depression other than the procedures of this study?

Please circle: Yes No

If yes, please list the following:

- Treatment that you were receiving before beginning the study that you **continued** while you participated in this study
- **Changes** you made in treatment that you were receiving before starting this study
- **New treatment** that you started while you were participating in this study

2. Continuation of Existing Treatments (list all)

- Medication(s):
    - How long have you been on this medication?
    - Prescribing physician:
- Counselor or psychologist:
- Psychiatrist:
- Other (please specify type, frequency, and how long you have been receiving this care):

3. Changes Made to Existing Treatments (list all)

- Medication(s)
    - Please note what medications, and what changes were made:
    - Prescribing physician:
- Counselor or psychologist:
    - What changes did you make?
- Psychiatrist:
    - What changes did you make?
- Other (please specify the changes you made in the treatment):

4. New Treatment(s) Added (list all)

- Medication(s)
    - Please note what medications and when you started:
    - Prescribing physician:

- Counselor or psychologist:
    - When did you start working with them?
- Psychiatrist:
    - When did you start working with them?
- Other (please specify type, frequency, and when you began receiving this care):

4. Has anything significant happened to you in your life since the last time you completed one of these packets?

Appendix B. Informed Consent Form for the Feasibility RCT

Consent to Participate in Research
Information to Consider About this Research

Guided Imagery and Music in the Treatment of Depression

Principal Investigators: Timothy Honig, Cathy McKinney
Department: Music Therapy
Contact Information: Tim Honig (302-285-9989, honigtj@appstate.edu), Cathy McKinney (828-262-6444, mckinneych@appstate.edu)

You are being invited to take part in a research study about a music therapy approach called Guided Imagery and Music (GIM) for depression. By doing this study, we hope to learn in what ways Guided Imagery and Music can help people with depression.

You have been invited to take part because you are an adult who is seeking treatment for depression. If you decide to take part, you will receive Guided Imagery and Music therapy sessions. You will receive either group or individual sessions. Some participants will begin right away, and some will begin their sessions after about six months. If you decide to take part in this study, we will assign you to one of these groups.

To be in this study, you must be at least 18 years old and speak and read English. You may not have had psychosis in the past, and may not have had Guided Imagery and Music or a similar therapy within the last six months.

Procedures

You will be asked to take part in a number of Guided Imagery and Music sessions, either in a group or one on one format. You will also be asked to fill out a series of forms five times during the study.

Group GIM

If you are assigned to receive group Guided Imagery and Music sessions, you will receive four sessions, once per week. Sessions will last an hour and a half. They will start with a group discussion about events or feelings from the week and issues related to depression and wellbeing.

Then, the therapist will help you relax and focus as you prepare for a music listening period. Group members will explore a theme or issue related to therapy while focusing on whatever comes to them as the music is played. The music will be chosen to support work relevant for the group on that day.

After the music, there will be a time to work with the imagery that you had during the music. This may be in the form of discussion or other art forms. The session will end

with talking about what the session means in your life and treatment. These sessions will take place in a private group therapy room.

Individual GIM
One on one sessions will follow the same format as the group sessions and will last 90-120 minutes. Sessions will start with a short time to talk about important issues and feelings. This may also include information about you and your life, and will help us bring focus to the session. Then, I will invite you to recline and help you relax and focus to prepare for the music listening portion of the session. You will hear recorded music chosen just for you. Once the music begins, I'll invite you to focus on whatever comes to you. During the music we'll talk about what you experience, and I'll ask questions to help you explore and deepen your experience. Once the music ends, I will help you come back to a more normal state of awareness. We will spend the rest of the session talking about your imagery and if you choose, drawing or making art, to help you process it. This may also include ideas for ways you can use your imagery in your daily life.

All one on one sessions will be audio recorded to help us make sure that the therapy is high quality. When any recordings are transcribed, all data that could identify you will be taken out.

If you decide to take part in this study, your sessions will start either in two weeks or after 6 months. These sessions will take place in the same private office where this screening is taking place.

Data Collection
You will be asked to fill out a packet of questionnaires five times during the study. You can complete the first packet today, if you choose to enter the study. The rest of the packets will be mailed to your home after about 10 weeks, 20 weeks, 26 weeks, and 32 weeks. Your packets will come with a pre-addressed postage-paid envelope. You can use that envelope to return the packet to us within a week after receiving it. If needed, we will send you emails or phone calls, whichever you prefer, to help you remember.

Confidentiality
Your involvement in this study and any data you provide will be kept confidential. If you choose to take part, your data will be identified by a unique number. The key that links your number to your name will be kept in a locked cabinet. Your name and anything that could identify you will not appear in any published data report.

Limits to Confidentiality
The therapist will keep everything that is shared or said during your sessions confidential except when:

- You ask that the therapist inform or refer you to someone else,
- The therapist determines that you harmful or dangerous to yourself or others,

- The therapist determines that you are abusing or neglecting a child, an elder, or an individual with a developmental disability,
- The therapist is ordered by a judge in a court of law to give this information, or
- For the purpose of supervision related to the research. In this case, data that could identify you will be kept confidential and shared only with other researchers involved in this study.

Other Therapies
While you take part in this study, you may not have other Guided Imagery and Music sessions. Apart from that, you are free to add, stop, or change any other therapy. For example, you can see a counselor or join a support group. You may also make changes in your medications as directed by your doctor. We will ask about any changes that you made, but they will have no bearing on your participation.

What are possible harms or discomforts that I might have during the research?
For many people the sessions are relaxing or uplifting. For others, deep emotions or memories could come up that may be distressing. To the best of our knowledge, the risk of harm for taking part in this study is no more than you would have in every day life.

What are the possible costs and benefits of this research?
Taking part in this study will not cost you anything.

If you decide to take part in this study, you will have music therapy sessions **at no cost.** There are no direct benefits to you from taking part in this study. But, we are doing this study because there is evidence that the approach we are studying may reduce depression and anxiety. It is possible that your depression will improve.

Will I be paid for taking part in the research?
You will not be paid for taking part in this research. You will receive music therapy sessions free of charge.

How will you keep my private information confidential?
We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what the information is. On any data that we collect, we will replace all names with numbers. Your data will be kept in a secure place and in encrypted files. We will remove your name and anything that could identify you from any published data report. Your data will be kept safe to the full extent of the law.

Your identifying information and audio recordings of the sessions will be destroyed six months after the end of the study. All other data that could identify you will be taken out so that it can be used in future research. No one will know that it is your information.

Who can I contact if I have questions?

If you have questions about this research now or in the future, you can ask the people doing this study. You can contact:

- Tim Honig, On-site Researcher, 302-285-9989, honigtj@appstate.edu
- Cathy McKinney, PhD, Principal Investigator, 828-262-6444, mckinneych@appstate.edu

You may contact either Tim Honig or Cathy McKinney if you experience adverse or unexpected events during the research study. If you have questions about your rights as someone taking part in research, contact the Appalachian Institutional Review Board Administrator at 828-262-2692 (days), through email at irb@appstate.edu or at Appalachian State University, Office of Research and Sponsored Programs, IRB Administrator, Boone, NC 28608.

Do I have to participate? What else should I know?

It is up to you whether you take part in this research. If you choose not to volunteer, there will be no penalty and you will not lose any benefits or rights you would normally have. If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. There will be no penalty and no loss of benefits or rights if you decide at any time to stop taking part in the study. If you decide to take part in this study, let the researchers know. A copy of this consent form is yours to keep.

If you choose not to take part in this study, you may still have access to music therapy or Guided Imagery and Music for your own personal therapy.

This research project has been approved by the Institutional Review Board (IRB) at Appalachian State University.
This study was approved on: 3/20/2019

I attest that I:

- Am at least 18 years of age
- Am fluent in reading and speaking English
- Have not been diagnosed with a psychotic disorder, for instance schizophrenia, schizoaffective disorder, or depression with psychotic features
- Have not had GIM or another altered-states therapy such as hypnosis within the last six (6) months
- Have had the chance to ask questions, and had my questions answered
- Consent to take part in this research study

_____	_____	_____
Participant's Name (PRINT)	Signature	Date

Appendix C. Screening and Assessment Procedures for the Feasibility RCT

Informed consent phase

In the first part, the researcher provided the potential participant with complete details about the research study, gave time for the inquirer to ask any questions, and then invited the inquirer to give their informed consent to participant. All inquirers who made it to this point provided their informed consent.

Pretest data collection

Then, the researcher invited the participant to complete the first data collection packet. Each item was self-report, but this gave the participant the opportunity to ask the researcher any questions they had about how to complete any item in the questionnaire packet. This was important, since all subsequent data collection packets would be completed by the participant at home. Participants completed the IDS-SR first. This allowed the researcher to total the IDS-SR score while the participant completed the following questionnaires, which was important since a score on the IDS-SR of 14-48 was an inclusion criterion. This way, the researcher was able to notify the participant of whether they would be included in the research study by the end of the screening.

Based on previous GIM literature (e.g., Bruscia, 2015; Grocke & Moe, 2015; Montgomery, 2019), it was likely that as depression symptom severity worsened, persons may become increasingly likely to require adaptations to the GIM process for safety and tolerability However. it was also hypothesized that while certainly relevant, a person's depression severity score may not adequately capture a person's appropriateness for GIM. Therefore, for persons meeting the cutoff for severe depression as measured by the IDS-SR (scoring 39-48), we added an additional interview-based screening process to determine whether they are likely to benefit from GIM. Persons with a depression score passing the threshold for *very severe* (49 or higher) were excluded and referred elsewhere.

Specifically, potential participants who scored between 39-48 on the IDS exhibited clinical characteristics that showed they would be appropriate for unmodified GIM based on interview-based assessment and imagery-based assessment that was occurring in the initial screening, and therefore would be at minimal risk if included in the study.

It was possible that potential participants exhibited demand characteristics when completing the IDS as a screening for depression severity: potential participants may be biased towards providing higher scores for their depression. In other words, they may want to show their depression is worse than it actually is because they want to be

included in this study and know that they must show they have depression in order to be included.

Clinical Interview

Inclusion criteria included individuals scoring in the "mild," "moderate," and "severe" range on the IDS and added an additional 2-part clinical assessment based on the screening interview and response to introductory GIM experience to determine whether a potential participant is appropriate for and may benefit from unmodified GIM as an added measure to ensure safety and appropriateness for inclusion.

When participants scored in the *severe* range of the IDS-SR (39–48), the researcher/provider performed a clinical interview focused on the following areas. Note that this is not a formal psychiatric assessment, but rather an assessment of characteristics that are important in determining whether nor not a person is appropriate for unmodified GIM with minimal risk. These characteristics are based on existing GIM literature (e.g., Bruscia, 2002a).

- Presence of catastrophizing thought patterns
- Negative thought rumination
- Racing thoughts or inability to focus
- Discomfort with positive emotions or inability to accept positive characteristics
- Lability of mood or affect
- Degree of attribution bias of negative events or characteristics
- Degree of attribution bias of positive events or characteristics
- Protective factors, including but not limited to relationships, family, employment
- Thoughts of self-harm or suicidality. In the case of suicidality, assessing plan, access, and lethality

Introductory Music and Imagery Experience

After the participant completed all self-report questionnaires and had a chance to ask any questions, the researcher provided the participant with an introductory music and imagery experience. This experience was to be brief, approximately 5-15 minutes, utilizing a variation of GIM that the provider deemed appropriate to the participant. The intent of this introductory experience was two-fold: first, it gave the participant a clearer understanding of the therapeutic approach they would be exposed to during the research study. GIM can be difficult to understand before a person has a first-hand experience of it, and this introductory experience would provide participants with a better understanding of the therapeutic approach prior to their first session. Second, it gave the researcher an opportunity to perform a music-and-imagery assessment to determine the participant's response to and appropriateness for GIM.

In the introductory music and imagery experience, these characteristics included: presence of images of positive resources; congruence of affective response to the emotional content of the music; lack of images that are bizarre, self-injurious, or

fragmented when those images are associated with negative affect, ability to focus during the music and preparatory relaxation.

Imagery-Based Assessment

In the introductory music and imagery experience, the researcher assessed the presence of:

- Images of positive resources, for example positive emotions or helpers
- Protective and adaptive images (defensive maneuvers)
- Congruence of affective response to emotional content in the music
- Images that are bizarre, self-injurious, or fragmented when those images are associated with negative affect
- Ability to focus during the preparatory relaxation and music-listening portions of the session

When participants scored 39-48 on the IDS-SR at the initial screening, the researcher performing the screening wrote a formal assessment based on the Clinical Interview and Imagery-Based Assessment, along with a final recommendation for whether or not the client is appropriate for GIM and will be included in the research study. They then conveyed this assessment and recommendation to the research team to come to a consensus on whether the participant would be enrolled in the study. When necessary, the therapist will consult with the research team.

Appendix D. Interview Guide for the Telehealth Interview Study

Preliminary outline of the interview: Topics are listed on the left, and sample questions for each topic are included on the right. Follow-up questions would be asked throughout the interview.

Topic	**Question**
Overall experience, in general	What stands out to you about your experience of having GIM sessions? You began receiving your sessions in person, and then switched to telehealth. How was that for you? Did these two ways of doing GIM influence your experiences? Were there similarities or differences between these two ways of receiving sessions?
Closeness and support from the music therapist	What was your connection or relationship with your GIM therapist like in your sessions? Was your connection with the therapist affected by the different settings (in-person vs. online)? If so, in what way? What was your sense of the GIM therapist's presence in each of the two session formats? What was your dialogue with your therapist like in the sessions? Did the settings change your experience of the dialogue?

Closeness and support from the music	What was your experience of the music like in your sessions? What were those experiences? What was your connection with the music like? Were there similarities or differences between these two ways of listening to the music – online and in-person?
Depth of experience	What was your experience of the imagery like during your sessions? Was your experience in the imagery affected by the different session settings?
Return/processing	What was the time after the music ended like for you? What was this time like after you switched to online sessions?
Context/space	What are your thoughts or feelings about the locations where you had your session? Your sessions started out your therapist's office, and then switched to having your sessions in your own home over the computer. What was this like?
Preconceptions going into online sessions	Did you have any thoughts or feelings about the online format going into your online sessions? If so, what were they? Was there anything about the online format you felt anxious about? Relieved?
Therapeutic process	You participated in these sessions to work on issues related to your depression. What was this like for you, in terms of your depression or other parts of your therapeutic process?

	Did you notice this being affected by the shift to online sessions?
Any additional info	Is there anything else that you feel would be important for us to know about your experience of having GIM sessions online?

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