Approaches: An Interdisciplinary Journal of Music Therapy
12 (1) 2020

ISSN: 2459-3338 | www.approaches.gr

ARTICLE

Interprofessional research in Guided Imagery and Music: Working collaboratively

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ABSTRACT

Interprofessional collaborative research has been gaining momentum as a leading research practice. The challenges posed by the complex nature of the world and healthcare require new and different solutions. These require the diverse skill and collective work of multiple disciplines. As a result, funding agencies are giving priority to interprofessional collaborative research rather than single discipline research. This article focuses on one method of music therapy practice: The Bonny Method of Guided Imagery and Music (GIM), where practitioners typically work alone. It reviews interprofessional collaboration in current GIM research literature and explores how GIM can benefit from this type of research practice. The authors identify and discuss the competencies and skills needed to successfully engage in interprofessional collaborative research and provide an analysis of two case illustrations of interprofessional research practice in GIM.

KEYWORDS

Guided Imagery and Music (GIM), interprofessional, research, collaboration

Publication history:
Submitted 6 Aug 2017
Accepted 30 Oct 2018
First published 19 Nov 2018

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Many professional disciplines work towards improving and increasing research in healthcare, and the Bonny Method of Guided Imagery and Music (GIM) is one such approach. GIM is an exploratory method that involves listening to specifically selected sequenced music in a relaxed state to elicit imagery, memories, experiences, symbols, feelings, creativity, therapeutic intervention, self-understanding, awareness, and spiritual experience (Short, Gibb & Holmes, 2011; Summer, 1988). Listening to therapist-selected music in a relaxed state brings the imagination into conscious awareness, as the imager describes these experiences with the guide as they image simultaneously (Clark & Keiser, 1986; Short, Gibb & Holmes, 2011). The supported process of listening to the

programmed music in this relaxed state allows GIM to reach the deep layers of the unconscious and bring latent, blocked and repressed information and material to conscious awareness to be processed, to develop awareness and find resolution (Pickett, 2002).

Practitioners using the specialised method of the Bonny Method of Guided Imagery and Music (GIM) (Bruscia & Grocke, 2002) frequently work alone in private practice, and opportunities for engagement with other professionals may be limited. However, increasingly across the broad healthcare spectrum, practitioners are expected to engage in interprofessional collaborative practice in order to improve client care (Strober, 2011; Tracy & Chlan, 2014; Green & Johnson, 2015). In the context of increasing the evidence base for best practice in GIM, such interprofessional collaboration also applies to research practices and how this further informs and advances clinical practice (Clarke et al., 2012; Remedios & Gummesson, 2018). This article seeks to identify and explore the role of interprofessional collaboration in research activities related to GIM, for example, in supporting research development and implementing research studies. In order to address this, 1) we provide an analysis of interprofessional collaborative research in GIM; 2) we provide a rationale for engaging and increasing collaborative practices in GIM clinical practice and research; 3) we explore definitions of the different types of collaborative research; 4) we explore competencies for such work; 5) we explore effective interprofessional research teams; 6) we consider the barriers and challenges to interprofessional collaborative research; and 7) we provide advice about the management of interprofessional collaborative research teams. Our framework and understandings are then demonstrated via two separate case studies leading to the conclusion that researching in a collaborative manner strengthens research and its subsequent application to practice. Developing a working nomenclature is critical in order to better understand collaborative work in professional practice, before delving further in.

DEFINING AND DIFFERENTIATING INTERPROFESSIONAL AND MULTIDISCIPLINARY PRACTICE

It is important to understand the terminology, language and meaning of collaborative work in the professional healthcare domain. Two terms requiring definition at this point include: *multidisciplinary* and *interprofessional* practice. *Multidisciplinary practice* focuses on working with the same client group, but with each professional discipline maintaining its own unique contribution to care to help solve a problem (Aboelela et al., 2007). For example, a client recovering from cardiothoracic surgery may visit the cardiac specialist, the family doctor, the dietitian, the physical therapist, the cardiac rehabilitation nurse/program and the GIM therapist. Each modality has its own specialist skills to bring to the client, but outside of the hospital or medical situation there is limited formal communication between the professionals, and collaborative decision-making rarely occurs. In contrast, *interprofessional practice* extends beyond multidisciplinary practice, serving as an integrated approach focusing on collaboration and sharing of information, expertise and decision-making (Caldwell & Atwal, 2003). For example, this can include working with a client who is engaged in trauma work in their therapeutic process. The client has a primary therapist who is a verbal therapist. The primary therapist recognises the client is not able to fully process her trauma through her words alone. The client identifies a desire to utilise creative modalities to help her process her trauma. The primary therapist refers the client to

work with a GIM practitioner and an art therapist. In this process, each clinician brings their unique expertise to the process, and they work and communicate together for the best interests of the client. They make decisions collaboratively and with the client's permission inform each other of the work the client has done within each modality to successfully support the client's therapeutic process. Understanding how interprofessional collaboration is defined provides a basis to explore how it is represented in our literature and how frequently it is a part of research and practice in the Bonny Method of Guided Imagery and Music. The next section explores the GIM literature and reviews interprofessional collaboration in the literature.

INTERPROFESSIONAL COLLABORATIVE RESEARCH IN GIM: AN ANALYSIS

We sought to understand the current status of interprofessional collaborative research in relation to practice in the field of GIM, since practitioners of the specialist GIM technique typically work alone. Journal articles typically provide good examples of research and investigative practices relating to improvements and understanding in any given profession (Lukka & Kasanen, 1996; Peighambari, Sattari, Kordestani & Oghazi, 2016; Vessey, Ramesh & Glass, 2002). In order to explore collaborative practices in GIM literature, we reviewed articles from the *Journal of the Association for Music and Imagery* (JAMI) as examples of thinking and practice in GIM literature and used this as a proxy to indicate collaborative research approaches. JAMI is the official and sole journal dedicated to the GIM method. Our assessment was completed by reviewing the index of each published journal edition (Association for Music and Imagery, 2016-2018) and coding the number of authors for each article, in terms of whether single or multiple authors were listed for the manuscript and their respective disciplines. This data was then processed and analysed using descriptive statistics. Results of our analysis showed that during the time span 1992-2016, there were 15 editions of JAMI, comprising a total of 101 published articles. Few papers (9) listed multiple authors, suggesting that only 9% of published papers were collaborative in nature (see Figure 1), appearing in only five of the editions of the journal. Based on the only data available, our analysis suggests that GIM practitioners are not typically collaborative in their thinking, practice and research.

In order to create a comparison, we analysed publications from 2000-2016. Peer-reviewed journals were analysed. Articles that included multiple authors from more than one discipline were identified as interprofessional, while those that included multiple authors from the same discipline were not. Additionally, data regarding the disciplines represented in these publications was also gathered. For this analysis, book reviews, editorials and letters to the editor were excluded, as our focus is on collaborative research.

For this analysis, two leading music therapy journals (*Journal of Music Therapy* and *Nordic Journal of Music Therapy*) were included, in addition to the *Journal of the Association of Music and Imagery*. Table 1 illustrates the total number of articles reviewed from each journal as well as the percentage of single discipline articles, meaning only one discipline was represented by the author or authors. Table 1 also indicates the percentage of articles with authors that represented two or more disciplines, indicating an interprofessional approach.

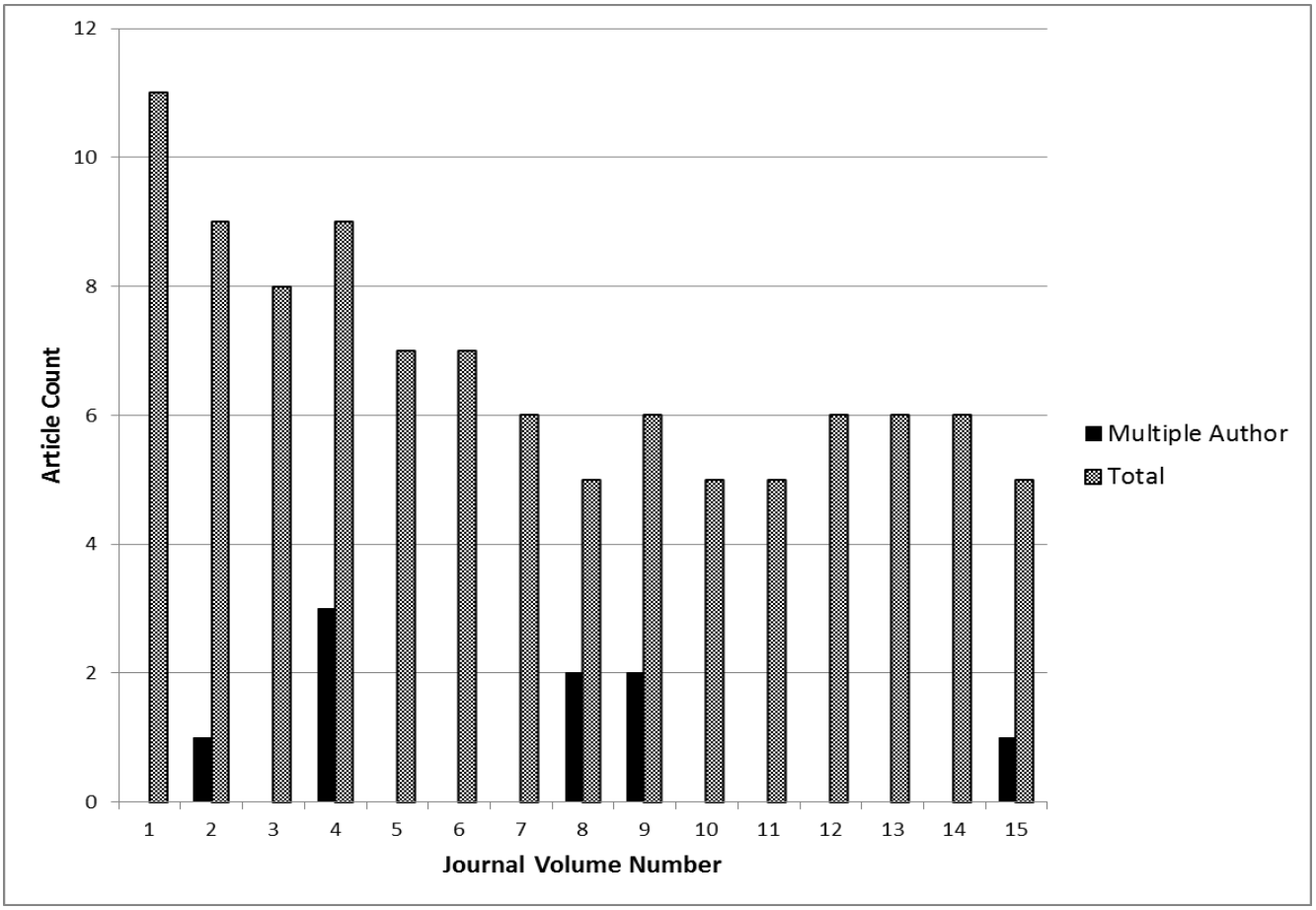

Figure 1: Review of JAMI volumes for articles by multiple authors

Journal	Total articles reviewed	Percentage of single discipline articles	Percentage of interdisciplinary articles	Number of disciplines represented	Disciplines represented in interdisciplinary articles
Journal Association of Music and Imagery	101	91%	9%	4	Psychology, Psychiatry, Physical Medicine, Public Health
Journal of Music Therapy	106	88%	12%	7	Biology, Physiotherapy, Psychology, Occupational Therapy, Speech Therapy, Statistics
Nordic Journal of Music Therapy	256	89%	11%	15	Psychoacoustics, Musicology, General Practice Medicine, Psychiatry, Psychology, Statistician, Audiology, Neurology, Neonatology, Public Health, Social Services, Otolaryngology, Pediatrics, Social Work, Physical Therapy

Table 1: Interprofessional journal analysis

Journal	Total articles reviewed	Percentage of single discipline articles	Percentage of interdisciplinary articles	Disciplines represented in interdisciplinary articles
Journal of the American Medical Association	189	33%	67%	Law, Nursing, Public Health, Psychology, Biomedical Engineering, Health Sciences, Healthcare Administration, Statistics, Medicine, Osteopathic Medicine, Biology, Respiratory Therapy, Veterinary Medicine, Dietetics, Pharmacy, Addictions, Business Administration, Mindfulness-Based Stress Reduction
Critical Care Medicine	513	35%	65%	Nursing, Public Health, Psychology, Biomedical Engineering, Health Sciences, Healthcare Administration, Statistics, Medicine, Osteopathic Medicine, Biology, Respiratory Therapy, Dietetics, Pharmacy, Social Work, Infection Control, Economics
Health Services Research	335	22%	78%	Nursing, Public Health, Psychology, Biomedical Engineering, Business Administration, Health Sciences, Healthcare Administration, Statistics, Medicine, Osteopathic Medicine, Biology, Respiratory Therapy, Dietetics, Pharmacy, Social Work

Table 2: Related healthcare journal analysis

The data indicates that the percentage of interprofessional publications varies significantly. The healthcare-related journals analysed included *Journal of the American Medical Association, Critical Care Medicine,* and *Health Sciences Research.* Table 2 illustrates there is a much higher percentage of interprofessional publications (65-78%) in these journals, while in the leading music therapy journals this is around 11-12% and in the *Journal of the Association for Music and Imagery,* 9%. While this analysis provides a glimpse into interprofessional publication practices, further understanding of the nature of differing collaborative practices is vital for recognising the innate benefits and challenges of implementing interprofessional research.

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The analysis of related healthcare journals in Table 2 suggests a higher percentage of interprofessional collaboration outside of the GIM field. In fact, the positive effects of such interprofessional collaboration in the health sector have been studied by various authors. O'Sullivan, Stoddard and Kalishman (2010) identify six benefits of collaborative practice. These include: 1) identifying and determining solutions to complex societal issues; 2) addressing the complex issues that a single discipline is not able to; 3) increasing productivity; 4) greater flexibility and responsivity

with multiple disciplines; 5) fostering innovation and enhanced use of technologies; and 6) being given priority by funding agencies. Remedios and Gummesson (2018) explore how interprofessional collaboration allows clinicians and researchers to learn from each other, thus fostering new knowledge, new technology, and new solutions.

In addition to understanding the benefits of collaborative clinical work, it is helpful to understand the type of collaborative practice and research development that may be warranted in any situation. Recognising there are different ways that professionals may collaborate and work together can help provide clarity in the overall development, implementation and evaluation process, and provide greater insight into how to best work together. It is likely that many professionals do not learn these collaborative skills within their academic training programmes and are left to informally discover and experiment with how to collaborate. However, we believe that these competencies are vital for interprofessional teams to utilise, leading to successful teams and successful teamwork.

COMPETENCIES AND PRACTICES IN COLLABORATIVE TEAMWORK

Where good and effective teamwork occurs, interprofessional collaborative practice has been shown to improve the quality of client/patient care (World Health Organization, 2010). It is clear that certain competencies are required in order to engage successfully in interprofessional collaborative practice. According to the World Health Organization (WHO), these competencies include 1) interprofessional communication; 2) a patient / client / family / community-centred care approach; 3) role clarification; 4) good team functioning; 5) collaborative leadership; and 6) skills in interprofessional conflict resolution (WHO, 2010). While collaborative work is increasingly valued and revered in research, healthcare and clinical practices, most training programmes do not teach professionals how to work in this manner (Bindler, Richardson, Daratha & Wordell, 2012). To date, clinicians and researchers have typically needed to discover these competencies through informal trial and error experiences.

Applying these competencies in order to achieve interprofessional collaborative practice within a team requires the qualities and skills of respect, trust, shared decision-making and partnerships (World Health Organization, 2010). Hopkins and Spuhler (2009) identify four essential elements for effective interprofessional teams. First, the team needs to have shared goals, providing a reason for their work together. Second, there needs to be a sense of interdependence, and a recognition that individuals can arrive at mutual goals. Third, commitment from each collaborator needs to be demonstrated, as well as a shared understanding that working together leads to more effective decisions. Finally, there needs to be a sense of accountability, with a shared commitment as a functioning unit. Further characteristics determining team effectiveness include that each of the members sees their role as important to the team, that there is open communication, that a sense of autonomy exists, and that there is an equality of resources for team members (Bridges, Davidson, Odegard, Maki & Tomkowiak, 2011). Poor interprofessional collaboration can have a negative impact on the quality of care provided to patients (Bridges et al., 2011). It is important to recognise that, by nature, collaboration contains two key elements: cooperation and assertiveness. Cooperation is evidenced in team members working together to produce a mutual benefit or for common purpose, and assertiveness facilitates the exchange of knowledge and information among professionals

(Hopkins & Spuhler, 2009). We believe that these same competencies, qualities, and skills potentially apply to both interprofessional research and practice.

GIM competencies and training standards

The Competencies, Training Program Standards, and Procedures for The Bonny Method of GIM (AMI, 2018) include several competencies that relate to collaborative practices in GIM. These include seeking supervision and consultation when needed and communicating with other professionals. There are also competencies that relate more specifically to applying emerging knowledge from professional literature and maintaining one's knowledge of relevant current research and literature. These competencies focus on the professional practice of GIM and one's own professional growth and development as a GIM practitioner, and the need to maintain one's understanding of the evidence in order to remain knowledgeable about developments in the field, as well as to be able to communicate with professionals from other disciplines.

The competencies indicate that GIM practitioners should abide by the code of ethics of their primary profession, whether that be counselling, music therapy, psychology or social work. The Association for Music and Imagery (AMI) competencies are focused on the clinical practice of GIM and do not venture into the area of research. Despite the lack of direction in the competencies related to research practice, some practitioners trained in GIM are engaged in research and, as the literature shows, much is undertaken by single researchers and is not collaborative or interprofessional in nature. As a result, we seek to explore the benefits of and rationale behind interprofessional collaboration for GIM in this current article.

WHY IS INTERPROFESSIONAL COLLABORATION IMPORTANT?

Previous authors have identified that the expertise to explore problems and questions may not be confined to a single discipline or approach. Further, the complex and changing world we live in requires new methods and approaches to address the scope of these issues (Repko, 2012). Interprofessional research builds on the integrated approach inherent in interprofessional practices, as noted above. Interprofessional research is most closely related to the definition by Aboelela and colleagues (2007) of transdisciplinary research, which includes sharing resources for a common outcome that can be applied across disciplines. Klein (2010) urges that collaborative research holds the answers to our urgent social issues, supporting the discovery of greater solutions. Working in an interprofessional research group can often be more productive than working alone (Aboelela et al., 2007; Short et al., 2009; Short et al., 2015; Strober, 2011; Tracy & Chlan, 2013). Combining ideas within a collaborative group can provide flexibility in thinking and approach, leading to innovative solutions. In addition, research funding agencies typically prioritise and reward interprofessional and collaborative research. For example, the National Institutes of Health (NIH) in the USA (NIH, 2013), and ARC Linkage and NHMRC Partnership grants in Australia strongly encourage researchers to work across disciplines.

An increasing interest in integrative and non-pharmacological approaches is providing momentum for the implementation of collaborative research practices (Heiderscheit & Chlan, 2014). Typically, collaborative healthcare research has the most significant impact and leads to translational

research, embedding the research back into the practical real-world situation to improve healthcare (Bindler et al., 2012; Kilgore & Langford, 2009; O'Sullivan, Stoddard & Kalishman, 2010; Strober, 2011). Additionally, exploring various and diverse perspectives can foster the design of a research trajectory which strives to answer multiple research questions or priorities for a specific clinical population (Magee & Heiderscheit, 2016; Shoemark, 2013). Collaborating across disciplines fosters the sharing of new ideas and sets the stage for disseminating research results to a broader scope of disciplines rather than to a single discipline (Magee & Heiderscheit, 2016).

UNDERTAKING INTERPROFESSIONAL COLLABORATIVE RESEARCH

From our experience, interprofessional collaborative research is hard work. In order to be successful, there is a need for good project management skills, since typically additional time is required to achieve agreement and milestones within a collaborative team. Additionally, within the interprofessional collaborative research team, personal and professional conflicts may arise, and appropriate skills must be used to address and defuse such situations. Although some discipline training programs provide interprofessional educational experiences, typically most practitioners are trained within a uni-disciplinary (single discipline) model, an approach which considers each profession to be an individual silo of knowledge and practice. Typically, governance structures such as health systems, infrastructures and academic expectations reward a uni-disciplinary approach, providing incentives, resources, facilities, and budget policies within a single professional area. Regardless of these challenges, the need for interprofessional translational research with sustainable outcomes remains, in order to provide best practice for patient care.

A successful interprofessional collaborative research team is more than a collection of professionals from various disciplines working together. To be effective, considerable effort and thought needs to be put into the creation and management of the interprofessional research team. Typically, all research studies need a principal investigator (PI) who will lead and manage the study (Magee & Heiderscheit, 2016). Additionally, the PI will determine choices about the potential collaborators for the study.

O'Sullivan, Stoddard, and Kalishman (2010) have looked carefully at the creation of an interprofessional research team. They state that it is important to clarify motives, values, beliefs about science, to define appropriate data and accepted methods for research, to pay attention to group process and leadership variables, and to consider relationships within the team (O'Sullivan, Stoddard & Kalishman, 2010). Their guidelines for the development and management of interprofessional research teams are as follows:

- *Careful selection of team members*: Ensure team members possess the expertise and skill needed for the research project, that they value collaboration and can work collaboratively.
- *Clarification of roles and expectations*: Each member of the team understands their role in the overall scope of the research project and what is expected of them throughout the project.
- *Facilitate regular communication*: Facilitate regular and clear communication to ensure the project is consistent with projected timeline and team members are informed of any updates or changes regarding the project, as this may impact their effort.

- *Develop relationships and trust among team members*: Fostering trust among team members helps to ensure the team will be able to address challenges that occur throughout the research project.
- *Examine effectiveness of team functioning*: Determine if each member of the team is and continues to be effective in their role on the project. If a team member is no longer effective and this is not addressed, it can undermine trust and collaborative efforts of the team.
- *Ensure "home" school/college is tolerant of collaboration*: It supports effective engagement if each discipline can engage with an interprofessional team and this is valued as a part of their own academic or clinical practice. (O'Sullivan, Stoddard & Kalishman, 2010)

Naturally, change can occur over time within the collaborative research team. In the process of the unfolding research project, there needs to be ongoing clarification, trust, and careful feedback. The process might also require culture change (O'Sullivan, Stoddard & Kalishman, 2010). Leadership within research teams on a particular project have been seen as having eight stages of change (Hopkins, Spuhler & Thomsen, 2007; see Table 3):

Stage 1	Establish a sense of urgency
Stage 2	Create a powerful guiding coalition
Stage 3	Create a vision
Stage 4	Communicate the vision
Stage 5	Empower others to act on the vision
Stage 6	Plan for and create short-term wins
Stage 7	Consolidate improvements and produce more change
Stage 8	Institutionalise new approaches

Table 3: Stages of change in leading research teams (Hopkins, Spuhler & Thomsen, 2007)

Understanding each of these stages of changing needs within a collaborative research project provides the GIM practitioner-researcher with guidance as to their leadership tasks in order to support timely and effective research, and provides a theoretical framework which can further inform and support GIM researchers as they work to collaborate interprofessionally.

CASE ILLUSTRATIONS OF INTER-PROFESSIONAL COLLABORATIVE RESEARCH IN GIM

Below we examine two case studies, which show different levels of interprofessional involvement in collaborative GIM research. These case studies describe our own individual research projects. The review of these cases is contextualised by using applicable elements contained within the guidelines for the development and management of interprofessional research teams by O'Sullivan, Stoddard &

Kalishman (2010). It is important to note that in both of these case illustrations, we were principal investigators and also trained facilitators of the GIM sessions.

Case 1: GIM and cardiac rehabilitation

This case illustration explores how GIM can affect recovery after cardiothoracic surgery (coronary artery bypass grafting and valve replacement) by addressing meaning related to perceptions of the body, and emotional effects related to the recovery process. The initial project was Annie's PhD study, which subsequently developed into further related projects (Short, 2003, 2015; Short, Gibb, Fildes & Holmes, 2013; Short, Gibb & Holmes, 2011). The study was conducted at two major teaching hospitals, recruiting six participants for six weekly GIM sessions which commenced 6-12 weeks post-surgery. Participants were aged 57-72 years, with three female and two from non-English speaking backgrounds as part of a stratified sample approach. Full ethical endorsements were obtained. All GIM sessions were audiotaped and transcribed (total 31 sessions). Within a carefully devised qualitative approach, data were analysed as part of a three-stage process within narrative thematic, semiotic and Jungian frameworks (Short, Gibb & Holmes, 2011). Results suggested a role for GIM in integrating and reflecting on experiences including returning to pre-surgery activity and lifestyle activities (Short, Gibb, Fildes & Holmes, 2013). Subsequent study development focused on additional applications to cardiac care and cardiac rehabilitation.

Collaborative involvement

In Alison's PhD study, collaborators were Alison, her academic supervisor, and academic nurse consultants. There was little engagement from other hospital staff, despite efforts in this regard. Later, Alison found out that one particular hospital cardiac rehabilitation nurse had advocated for the project, which contributed strongly to hospital ethics approvals. This senior nurse was personally interested in psychosocial care, and herself went on to undertake training and registration in clinical psychology. In both study hospitals the cardiac rehabilitation nurses were very supportive, actively involved in recruitment, and enabled access to hospital rooms by managing bookings for the GIM sessions. Networking resources from Alison's previous music therapy work in another part of one of the hospitals were used to enhance credibility with hospital workers for this project. In line with ethics approvals, Alison was not able to access patient notes/charts since she was not regularly employed in cardiac care, relying entirely on patient self-report and verbal communication from the cardiac rehabilitation nurses. These nurses also invited Alison to present her findings at the cardiac rehabilitation conference, leading to a project summary being written and published for the Australian Cardiac Rehabilitation Association Newsletter. Collaborators engaged in recruitment, advice about writing up, co-authorship, further development of related new projects.

Communication and challenges within the team

As an individual PhD project, Alison's initial approach to the team was as a deferential research student negotiating early phases of a project based on no previous existing evidence. She typically only communicated with the cardiac rehabilitation nurses and the patients, with brief presentations to the

cardiac rehabilitation programme for recruitment; no further opportunities for broader collaboration in the team were presented. Initial challenges included gatekeeping, gaining access to activities and room bookings in the clinical environment, recruiting of patients, and regular communication with staff. There was a lack of physical storage space, with all equipment being transported for each session, including blankets and pillows. Finding a suitable quiet room for GIM sessions in a large metropolitan hospital was a challenge; some sessions took place in an oncology teaching area, which, on occasion, led to interruptions and being asked to transfer to another room in the middle of a session, with impacts on patient experiences of the GIM sessions.

This case demonstrates that building relationships with professionals from other disciplines is essential for the implementation of a project in the area of cardiac rehabilitation. The value of collaborating with the cardiac rehabilitation nurses helped to inform subsequent projects which commenced with a broader outlining of the patients' clinical needs and the overall research approach. The team was expanded to involve a cardiologist, another cardiac rehabilitation nurse, the peak body Heart Foundation, other research nurses and community providers. Collaborative team assistance included practical advice about implementation and how to engage aspects of the study within the existing workload, and collaborative team review of the draft proposal before submission.

Case 2: GIM in addictions treatment

This case illustration explores the use of GIM with individuals in addictions treatment (Heiderscheit, 2005, 2017). The initial project was Alison's PhD study which was followed by a subsequent exploration of GIM in eating disorder treatment (Heiderscheit, 2015a, 2015b). The focus of this study utilising GIM was to explore how addressing the underlying issues associated with addiction impacts salutogenesis, physiology and interpersonal problems, including:) impacts on sense of coherence; 2) improvements in clients' ability to cope; 3) improvements in interpersonal relationships; and 4) improvements in clients' health.

The study was conducted in an inpatient addictions treatment program. Nineteen subjects consented and were randomised into either the experimental (n = 10) or control group (n = 9). The clients included four females and fifteen males, ranging in age from 46 to 64. The clients in the experimental group received weekly GIM sessions throughout the course of their treatment, which ranged from 25-60 days. Clients in the control group received the usual care. Pre- and post-tests included the Inventory of Interpersonal Problems, the Sense of Coherence Scale, and Salivary Immunoglobulin A.

The findings from the study suggest that in addictions treatment, GIM can address interpersonal issues, specifically those related to control and being distant in relationships. They also indicate that clients experience a greater sense of comprehension of the events that occur in their life, as well as a trend towards feeling better able to manage life events. Results also demonstrate a trend towards improving health through sIgA measure (Heiderscheit, 2005; Heiderscheit, 2017). Subsequent analysis of this data led to collaboration in analysing imagery themes and content (Heiderscheit & Swanson, 2018) and supported the development of a study utilising GIM with clients in eating disorder treatment.

Collaborative involvement

In this PhD study, (Heiderscheit, 2005; Heiderscheit, 2017) the main collaborators were Annie and her faculty supervisor. Additional collaborators included the treatment facility, a community music therapist, a nurse manager, the treatment coordinator, the health unit coordinator, the patients, a statistician, a laboratory coordinator and laboratory staff. Annie was invited to conduct research at the collaborating facility. Facility staff were engaged in the process prior to recruitment and throughout the study to coordinate patient schedules for GIM sessions. The laboratory was contacted prior to initiating the study to secure space, drop off of saliva samples, and to ensure proper storage and analysis of assays. The statistician was engaged following data collection to conduct statistical analysis. Collaborators were acknowledged in publications.

Communication and challenges within the team

Communication and respect within the team were maintained by recognising the need for each individual's expertise and role in the process. As Primary Investigator, Annie served as the point person for coordination, since most collaborators did not need to interact directly with each other. The PI needed to remain in contact with each collaborator to coordinate study engagement. Given the complex team involved, considerable effort was required to maintain communication. It was important to recognise that each person works differently and to understand how best to interface with each collaborator. It was also important to maintain the leadership role in order to ensure consistency within the project.

DISCUSSION

Effective interprofessional collaborative research requires a unique set of skills from each team member. Not only does this type of research depend on each team member sharing their expertise, but the success of the team is contingent upon how the team members work together and upon their level of commitment towards working together. While this collaborative process is reliant upon strong leadership, it also requires mutual respect within the team. Developing the skills necessary to engage in successful interprofessional collaborative research requires an investment in working with others to accomplish more than that which a single discipline is able to do.

Case study 1 has shown that an interprofessional approach added value to this project via assistance with recruitment and ethics approval. Additionally, there was clinical information sharing and feedback, including learning the technical language to understand concepts and terminology related to cardiac care. Further linkage to other professionals, including conference presentations, was very helpful. Assistance with the writing of articles and a book chapter was valuable to the outcomes of this project (Short, 2015; Short, Gibb, Fildes & Holmes, 2013; Short, Gibb & Holmes, 2011), as was linkage to additional relevant professionals (medical, nursing, Heart Foundation) and advice about further research project development.

Likewise, within case study 2, an inter-professional approach added value by providing collaborative access to patients and support for recruitment. Using this team approach created a positive and quality experience for patients, and decreased disruptions to patient treatment. This

effective interprofessional team also ensured the high quality of research and the proper management of data and assays.

In terms of the stages of change in leading research teams (Hopkins, Spuhler & Thomsen, 2007), each of these case studies established a sense of necessity related to the need for the project, which was supported by staff agreement to run the study. A team committed to addressing patient needs within the research context was established for each project, especially for Case 2. The creation of the project vision began within the academic setting and unfolded with team support via presentations which created investment and interest in the project. The team was empowered according to their different roles, especially within the recruitment process and in data analysis and laboratory testing for Case 2. Milestones were celebrated within the project, with positive feedback to the team related to achieving these goals. For the specific clients, GIM sessions provided additional individual treatment and assessment opportunities which could be conveyed to the broader treatment team. Feedback via presentations and client/participant comments to the team supported the possibility of ongoing institutional change. This led to team and institutional discussions about further research projects which could build on the cases under discussion. In terms of the research cases which have been presented, effective leadership of teams through all stages of project support has led to enhancements which would not have been possible had the research been conducted by a sole researcher. These enhancements provided additional support with 1) design and development of the project; 2) institutional ethics applications; 3) planning towards implementation; 4) recruitment and data collection; 5) assistance with analysis processes; 6) increased interest in dissemination and applications of results; and 7) further development of research themes to encompass new project development.

While interprofessional collaborative research requires preparation and consideration of potential collaborators who can contribute to the success of the study, the diverse skills that can be utilised in this type of research hold a higher impact than a uni-disciplinary approach. Inviting people from other disciplines to collaborate on a research study allows for discoveries that are possible through emerging technologies, diverse dissemination of study findings, and the fostering of change in patient care. The community of GIM fellows conducting research is a small community. Implementing interprofessional research around GIM provides opportunities to better understand how GIM impacts healing, health and wellbeing. It broadens the understanding of GIM by various disciplines, and explores the use of GIM in a greater variety of clinical settings. Although it is challenging, there are great benefits to interprofessional collaborative research in GIM. Our initial evaluation of existing interprofessional collaborative behaviour has been limited by the availability of measures of interprofessional collaborative research, and therefore we have used metrics related to authorship as a proxy. This occurs in the broader context where proxy measures related to research development have been used when little information currently exists (see, for example, Cooke, 2005).

Interprofessional collaborative research in GIM has the potential to foster new directions in research as GIM practitioners explore beyond standard clinical practice for GIM. Additionally, through communication and discovery with colleagues from other disciplines, GIM clinicians and researchers can begin to explore new approaches to research knowledge generation (epistemology). Concomitantly, it is expected that interprofessional collaborative research in GIM can explore and

further develop innovative methodology, including new approaches to data collection and analysis processes.

Future directions

While GIM practitioners may be familiar with interprofessional collaborative clinical practices, further education and training about inter-professional collaborative research practice is warranted. It is envisioned that this could be addressed in a variety of ways, for example, with 1) GIM researchers seeking out and applying for fellowships that provide interprofessional training; and 2) the development of professional development modules and workshops for GIM practitioners. Where possible, GIM researchers should be encouraged to present their interprofessional collaborative research experiences, in order to educate others. In doing so, these presentations help to foster conversation and dialogue, engaging GIM practitioners and researchers in information sharing and opportunities to learn from each other, thereby fostering even greater professional collaboration. Finally, incentives towards the submission of more manuscripts for publications focusing on interprofessional collaboration are needed in order to develop the body of literature and information available to GIM researchers. Taken together, these further directions are expected to address the clear need for GIM practitioners to engage in enhanced interprofessional research practice, leading to a more robust, accessible and professionally embedded body of knowledge available for GIM practice.

ACKNOWLEDGEMENTS

Thanks are offered to the collaborators and patients who participated in the cases studies referred to in this article.

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Ελληνική περίληψη | Greek abstract

Διεπαγγελματική έρευνα στη μέθοδο Guided Imagery and Music: Δουλεύοντας συνεργατικά

Alison E. Short | Annie Heiderscheit

ΠΕΡΙΛΗΨΗ

Η διεπαγγελματική συνεργατική έρευνα αποκτά δυναμική ως κορυφαία ερευνητική πρακτική. Οι προκλήσεις που θέτει η πολύπλοκη φύση του κόσμου και η υγειονομική περίθαλψη απαιτούν νέες και διαφορετικές λύσεις. Απαιτούν ποικιλόμορφες δεξιότητες και το συλλογικό έργο πολλαπλών κλάδων. Ως αποτέλεσμα, οι φορείς χρηματοδότησης δίνουν προτεραιότητα στη διεπαγγελματική συνεργατική έρευνα αντί της έρευνας εντός ενός επιστημονικού κλάδου. Αυτό το άρθρο επικεντρώνεται σε μια μέθοδο μουσικοθεραπευτικής πρακτικής: τη μέθοδο Guided Imagery and Music (GIM) της Bonny, όπου οι θεραπευτές συνήθως εργάζονται μόνοι τους. Το άρθρο εξετάζει τη διεπαγγελματική συνεργασία στην τρέχουσα ερευνητική βιβλιογραφία της μεθόδου GIM και ερευνά πώς αυτή η μέθοδος μπορεί να επωφεληθεί από αυτόν τον τύπο ερευνητικής πρακτικής. Οι συγγραφείς εντοπίζουν και συζητούν τις ικανότητες και τις δεξιότητες που απαιτούνται για την επιτυχή συμμετοχή σε διεπαγγελματική συνεργατική έρευνα και παρέχουν μια ανάλυση δύο περιπτώσεων διεπαγγελματικής ερευνητικής πρακτικής στη μέθοδο GIM.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Guided Imagery and Music (GIM), διεπαγγελματική προσέγγιση, έρευνα, συνεργασία