GROUP MUSIC THERAPY WITH HEALTHY ADULT WOMEN: AN APPROACH FOR WELL-BEING

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Tiivistelmä – Abstract

Research shows that music therapy is often utilized to improve the quality of life of individuals with specified diagnoses; however, the documented information regarding clinical work with healthy adults is limited.

The following case study aims to investigate a group music therapy process with healthy adult women. The main objective is to identify implications group music therapy could hold for healthy adult women, such as for the purpose of quality of life improvement and the stimulation of self-actualizing experiences.

The study was conducted within a clinical setting where the participants consisted of 4 intentionally selected adult women. The participants attended 12 music therapy sessions that were audio and video recorded. The recordings were utilized for the data analysis, which was qualitative content analysis.

The results revealed that group music therapy supports the development of self-actualizing experiences and the improvement of quality of life for healthy adult women. The results also suggest that group music therapy can support the evolution of interpersonal relationships, which can then be related to behaviors, patterns, and beliefs concerning relationships outside of the therapy.

Asiasanat – Keywords Music Therapy, Well-being, Quality of Life, Self-Actualization, Group Therapy, Interpersonal Relationships	
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Personal Motivation

Prior to attending the University of Jyväskylä, my experience as a young professional had mostly been working in group music therapy settings with people who have various illnesses and disabilities. Over time, I began to take an interest in observing the group process. I became interested in observing how behavioral roles formed and conflicts and resolutions occurred. Therefore, when beginning my clinical training at the University of Jyväskylä, I was eager to facilitate group music therapy in order to continue honing my skill set, knowledge, and understanding regarding the inner workings of group therapy.

The music therapy group I conducted consisted of healthy adult women, due to the community of applicants. It has been an unusual experience to work with cognitively capable healthy adult women. Throughout our sessions, I have intensely investigated the group and thought quite carefully about how to proceed each week. Now as a researcher, I have followed my interests and conducted a qualitative case study. As the process began to blossom, it seemed to become increasingly important for me to write a case study to share the learning experience and challenges I have worked through.

CONTENTS

1 INTRODUCTION

Music therapy has been defined as "a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as a dynamic force of change" (Bruscia, 1998). When practicing, there are many possibilities for working as a music therapist including various specialized techniques, methods, and theoretical approaches. One can work with children, adults, and/or the elderly by means of individual sessions or group sessions. Generally, past and present practices of music therapy focus on individuals with specific conditions and pathologies. However, the road less travelled is one when working with the healthy individual.

1.1 Research Aim

The aim of my study is to analyze the outcome of group music therapy in order to provide understanding and share findings, regarding an appropriate manner music therapy could benefit healthy adult women.

Music therapy is currently utilized to aid individuals in decreasing symptomology and improving their quality of life. There are several research studies related to music therapy's effect on quality of life; such as a study conducted by Grocke (2009a) where group music therapy was used to determine its effect on the quality of life for people with severe mental illness. There have also been studies that aimed to investigate the effects of music therapy on people's quality of life after receiving transplants or before undergoing surgery (Walworth, Rumana, Nguyen, & Jarred, 2008; Ghetti, 2011), along with terminal cancer (Hillard, 2003), the elderly (Vanderark, Newman, & Bell, 1983; Laukka, 2007), Alzheimer's Dementia (Lipe, 1991), and people with difficulty verbally communicating (Cohen, 1994; O'Callaghan, 1999). Conclusively, there seems to be numerous research studies and articles regarding the use of music therapy for the purpose of well-being for people with specific pathologies, however, according to Bruscia's definition, there is no mention of only working with people whom have specific needs, but rather to work with any client to "promote health."

1.2 Rationale

Music therapy can provide individuals with an opportunity to promote health, well-being, and self-actualization by exploring personal creativity. Laukka (2007), stresses the importance of examining the possibilities music holds in terms of improving one's psychological well-being in his study concerning the elderly. Laukka reports that there is minimal research about aspects of well-being such as "life-satisfaction or aspects related to the realization of personal potential," (2007, pp. 217). However, there seems to be disconnection in bridging the capabilities of music therapy to improve the quality of life for individuals who are seen as healthy. Therefore, I feel this is an important bridge to begin strengthening and it seems appropriate to conduct this qualitative case study in order to fill the knowledge gap in this area.

In my music therapy work thus far, it has already become apparent how music therapy can hold these valuable properties, among others, for all individuals and how people gain new understandings about themselves through the music therapy process. Ruud (1997; 1998) agrees that engaging in music can connect individuals to awareness of feelings, expression, personal mastery of a task, and social communication. Ruud (1998) further suggests that making music involves many functions including cognitive, emotive, motor, social, and perceptive skills. Therefore, the act of engaging in music is complex, utilizing numerous aspects of the mind and if health is viewed in a holistic sense, then music could be used preventatively.

1.3 Terminology

When arguing the case that music therapy could be used to improve well-being and self-actualization, it is essential to understand my interpretation of these terms.

1.3.1 Well-being

Well-being is a concept that people are constantly working toward. Well-being can be seen as a spectrum that comprises numerous aspects of one's life including physical, social, career, financial, and community well-being. Reaching these states of health is a process that can be

non-linear and is forever changing, as people are changing. One cannot simply achieve wellness and then be well forever. Life is constantly throwing challenges and obstacles in our way, which in turn can hinder our well-being. Therefore, this idea of health is something we are endlessly striving to improve and enhance.

Brandalise (2004) has described health as a "way of being," (para. 1). Brandalise suggests, "we, as music therapists, work with clients who search to reach, from their creative experiences, better comprehension about themselves," (2004, para. 1). Creativity can be a stimulating experience that activates one's self in ways that he or she never knew possible. The idea of creativity being a key component in discovering new things about oneself is discussed in Maslow's (1943) concept of self-actualization and the hierarchy of needs.

1.3.2 Self-Actualization

The concept of self-actualization describes several stages of human growth, which Maslow (1943) identifies as a hierarchy of needs. At the most basic level, it is imperative to meet physiological needs such as breathing, eating, drinking, and, sleeping. The next level in the hierarchy is safety, which is described as security of body, employment, resources, morality, family, health, and property. The following stage in the hierarchy is family, friendship, love, and intimacy. The subsequent level is esteem, which is characterized by confidence, achievement, and respect. Lastly, at the top of this hierarchy, there is self-actualization. Self-actualization is described as morality, creativity, spontaneity, problem solving, lack of prejudice, and acceptance of others. The term self-actualization is defined as a person's ability to recognize full potential and strive to be the best a person they can. In order to reach this potential, one must have the most basic needs met and is then able to climb the levels until achieving self-actualization.

1.3.3 Self-Actualization in Music Therapy

Research by Ahonen and Houde (2009) supports the idea of self-actualization and its connection to improvisational music experiences. Ahonen and Houde (2009) discuss several components of Maslow's theory related to the path that leads to self-actualization including making choices, developing self-awareness, taking responsibility, and encountering peak experiences ("We Have Arrived Somewhere" section, para. 2). Through the creative

expression of music making, individuals are afforded an opportunity to concentrate personal energies on exploring aspects of self in relation to music, fellow group members, the outside world, and the inner being.

Group music therapy can be an ideal way to work with people whom have difficulty developing and maintaining interpersonal relationships because the relationship between the group members is not just developing by being in a room together, undergoing therapy, but rather by making music together. Shoemark (2009) suggests that music therapy can be considered a "moment of shared humanity," (pp. 33). When people experience something together, there is a "powerful sense of being a part of a greater whole" (Pavlicevic, 2003, pp. 104). This type of shared experience is one that compliments the development of positive relationships.

As expressed by Pavlicevic (2003):

> "The act of singing or playing together can also be collectively focusing in the moment, which experience can irresistibly impact our sense of identity: here and now, in this moment, together with others. In this sense group musicking provides deeply personal, private, as well as collective musical and emotional experiences. It is the depth and power of these personal experiences within the collective act that can be powerfully bonding socially as well as musically." (pp. 104)

By engaging in music making with others, multiple processes are being activated at one time. The individuals are being communicative, interactive, and expressive of what lies within their own being. Aigen (2005) states, "Music is more than an art form, a means for communication, or even a vehicle for therapy. It is a way of being with other people that embodies particular values that form the foundation for music therapy practice." In this way, music therapy is a way of contacting what is inside of oneself, expressing and exposing it to others in order to connect with the outside world.

Katsh & Merle-Fisherman (1995) state:

> "…contact is made whenever the music process is fully experienced…contact is essential in our lives, and when true contact occurs, we can feel joyous, vibrant, and appreciative of both ourselves and others… By contacting the other person through the music you raise the level of communication between you, enhancing both your connectedness and your separateness as individuals" (pp. 107).

Group music therapy can be a powerful way to create this contact because it can be “a safe way to identify with others” (Katsh & Merle-Fishman, 1995, pp. 94). For individuals whom have difficulty trusting others, music therapy can especially be a less intrusive way to build relationships and begin to relate to others. This concept of safety within a therapy context is one that I continue to discuss and refer to in this case study.

2 METHODOLOGY

2.1 The Case Study

The research design for this study is a qualitative case study method. Grocke supports the implementation of case study designs as she suggests, “case studies are pivotal as breeding groups for research ideas, and that through grounded case study research design, more elaborate research protocols develop,” (2009b, pp. 13).

For this topic case study strategy seems to be the most appropriate method to analyze the data for numerous reasons. I agree with Aldridge (2005) when stating, “music therapy is a social activity. The way people respond in a therapeutic situation is determined by the way in which they understand that situation,” (pp. 13). Therefore, it is important to closely examine real life situations in order to truly understand the nature of people because not every occurrence in a therapeutic setting can be generalized. The music therapy group that will be studied is unique to itself and cannot be replicated. The study will serve to provide further understanding into the phenomenon of group music therapy and to acquire new insight into the benefits and practical uses this type of work holds with healthy adults. The study does not aim to manipulate the behavior of the participants, but rather to examine the participants in the setting as they are naturally.

2.2 The Participants

The participants for this case study have been selected from a pool of applicants interested in obtaining music therapy services. The participants consisted solely of females ranging in age from 24 to 30 years old, who reported a desire to gain greater self-understanding and to improve emotional expression. None of the women had been diagnosed with disabilities or illnesses and all agreed to receive group music therapy services once per week with sessions an hour in length. The total number of sessions the group experienced was 12 sessions.

In the beginning of the process, there were a total of 5 women including 3 native Finnish women and 2 foreigners from Brazil and Colombia. However, after the first 3 sessions, the Colombian woman discontinued the therapy and the following sessions consisted of the remaining 4 women. For the purpose of examining a group process from beginning to end, I will not be including the fifth participant in my description or understanding of the study.

Group Homogeneity vs. Heterogeneity

When selecting the group members, compatibility was highly considered. According to Dies (2003), homogeneity can strengthen the effectiveness and aid in the development of cohesion in group therapy. This homogeneity is observable in several ways including age, gender, diagnosis, or common life experiences. Brabender, Smolar & Fallon (2004) report, "The quintessential criterion for including a member in a therapy group is that the member's goals are compatible with the goals of the group" (p. 61). Therefore, the premeditated goals for the group were to build cohesion, develop positive interpersonal relationships, increase emotional expression, and gain personal insight.

However, the group was also heterogeneous in the fact that the women had opposing ways to manage their emotions. Two of the participants reported that they would like to learn how to better express their emotions as where the other two women reported they would like to learn how to regulate their emotions. The women were intentionally selected based on these similar, yet differing needs. It was felt that having two people with similar needs would provide the support and understanding between peers, but also having people with opposing needs would provide a contrast where people have the potential to learn from each other and contribute new perspectives.

2.3 Clinical Approach

The therapy was co-facilitated by this researcher and a music therapy classmate. Upon beginning the therapy there was no specific predetermined theory or approach that was utilized. We believed it would be beneficial for the group if the therapists provided structure during the beginning of the process. Then, as the group seemed to become comfortable, it appeared that we were drawing upon humanistic and client-centered perspectives to the music

therapy (Tennant, 1997). The humanistic approach to therapy is one that incorporates Maslow's (1943) hierarchy of needs and stresses the importance of growth. The client-centered perspective (Wood & Wood, 2008), which is closely related to humanism and created by Carl Rodgers, is an approach where the clients are trusted to know what they needs during the therapy. In this way of working, the clients identify their own goals and the therapist supports the clients in their own process.

During this case study, we indeed gave the clients an opportunity to identify their own individual and group goals for the therapy and encouraged the group members to be vocal in how they would like to spend the session time. This method seemed to aid in the group taking more of a self-directed approach where they were able to make the decisions and take control over the therapy. This seemed important in developing cohesion between the group members and increasing empowerment in each member. At this stage, the clients were able to handle having a large amount of freedom where they could make decisions together and individually regarding the music they created.

The chart below illustrates my clinical thinking in the beginning of the music therapy. However, the process did not necessarily follow this table strictly. It was my belief in the beginning of therapy that this is how the process would unfold. On the contrary, as the process developed and various topics emerged, my co-therapist and I exhibited flexibility and developed creative therapeutic ideas that would match the clients' needs.

TABLE 1. The anticipated process prior to the therapy.

The Process

Therapist led	→	Client led	→	Jointly led	→	Closure
↓		↓		↓		↓
Session 1 Session 2 Session 3	→	Session 4 Session 5 Session 6	→	Session 7 Session 8 Session 9	→	Session 10 Session 11 Session 12

2.4 Music Therapy Technique

The music therapy method that was primarily used throughout this case study was improvisational music therapy. Musical improvisation can aid in clients' ability to be self-expressive and communicative in their music making (Erkkilä, 2004; Wigram, Pedersen, & Bonde, 2002). Being given the opportunity to freely make music can make clients feel at ease due to lack of expectations. It was understood that there was no right or wrong way to play an instrument and the group members were free to play as they felt. McFerran and Wigram (2007) investigate the practice of group music therapy improvisation and perceptions of this technique by highly skilled clinicians. It is reported that the freedom provided through group music improvisation encourages spontaneity and interaction with others. This technique can also provide opportunity for self-exploration and "has grown in popularity for those interested in using creative experiential modalities for gaining insight into self, and their relationships with others" (Introduction and Brief Literature Review section, para. 1).

Through this creative experience, there is a possibility to explore different interpersonal roles and an extensive range of feelings and emotional states. Within this particular case study, there were different variations of people engaged in the music making in order to explore different relationships and roles taken within the music. There were sessions that the therapist did not play music in order to only observe the music between the participants and to strengthen cohesion between the group members. Later, it was encouraged that the members play in pairs in order to gain insight into the differences between the ways they behave in a more intimate relationships in comparison with the entire group together. There were also occasions when one single group member was focused on and the other group members obtained a supportive role. The clients were then able to experience both giving and receiving support to their fellow group members and the differences between the experiences.

Keeping mind the possible difficulties in verbalizing the music, a large number of the improvisations were also recorded within the session in order for group members to have the option to listen back to their songs later in the therapy. This receptive experience can be a helpful tool for clients (Wigram, Pedersen, & Bonde, 2002) by taking a step away from the music. When doing so, clients can more easily recognize certain thoughts, emotions, and images that might have been provoked during the active experience.

As the therapy evolved, the relationship between the group members also seemed to evolve through the improvisations. As described by Ahonen and Houde (2009), improvisation in this case involved "searching and waiting for one another, connecting, meeting, taking off, building and releasing, floating in music, and finally feeling and being in music," ("Discussion" section, para. 6). Recognizing the effect of the improvisations on the clients' feelings, thoughts, behaviors, and relationships with each other was made possible by the collected data.

2.5 Data Collection

Upon beginning the therapy, each woman was contacted by phone and thereafter, a common day and time was selected for the sessions. The day of the week and time were consistent throughout the 12 sessions. All participants filled out consent forms agreeing to have each session audio and video recorded for educational and research purposes.

The participants were also given a journal and pen in order to maintain their own personal reflection log. The reflection journal served the purpose of gaining additional understanding and insight from each group member outside of the sessions. The requirements for the journal were established flexibly to provide the clients with an opportunity to write about any and all insights they have gained pertaining to the group music therapy, themselves, or their outside world, and any thoughts or emotions that have been provoked over the course of the music therapy period.

As the therapist, I kept my own journal as well. The journal was an important element that contributed to my growth throughout the process of conducting the therapy and the beginning stages of the research. After each session I wrote an entry pertaining to various topics. Entry topics included reflections on individual group members and the group as an entire unit, along with my thoughts and feelings about facilitating the therapy and my personal process. All of this data was then carefully and meticulously analyzed over the course of several months.

2.6 Data Analysis

My goal, when analyzing the data, was to objectively and precisely describe the phenomenon (Elo & Kyngäs, 2008) of group music therapy with health adult women. Qualitative Content Analysis was used in order to analyze the data. According to Schreier (2012), qualitative content analysis is a systematic way for giving meaning to qualitative information. This form of analysis is generally used for analyzing "written, verbal or visual communication messages" and to "develop an understanding of the meaning of communication" (Elo & Kyngäs, 2008, pp. 107-108). This seemed to be the appropriate method of analysis, due to the fact that I was concerned with analyzing the context of music and discussion excerpts within the therapy and identifying meaning from the process. I wanted to take what happened in the group and determine if there were further implications for this type of music therapy work in future practices.

When beginning the analysis, all video and audio data was transcribed and coded with the help of HyperResearch software. A conventional approach to the content analysis was used as Hsieh & Shannon (2005) describe. This approach is "generally used with a study design whose aim is to describe a phenomenon" and is one where "researchers avoid using preconceived categories, instead allowing the categories and names for categories to flow from the data" (pp. 1279). In order to make the analysis process as clear as possible, I will describe each step taken that has lead to the findings.

Initially, I imported all of the videos from each session into the HyperResearch program. Then, I watched each video and took notes on the different phases of the sessions, such as when there were discussions, when there was music, and what type of music interventions were used. Then I watched the videos for the second time and began to transcribe all of the discussion sections in each video. At this point, I also began to highlight and apply codes to different musical situations such as when the music was fast, slow or when someone changed an instrument. After each session was transcribed, I coded all of the discussions for the first time using exact words or phases stated by the participants.

Once all of the sessions were coded, I utilized both quantitative and qualitative ways to determine which codes should belong together, seemed significant, and which should be

eliminated. The quantitative technique I utilized was to recognize the frequency of codes within the data set. I used HyperResearch to filter the codes and analyze the repetition of each individual code name. If there was a code that occurred only once within all 12 sessions, I speculated that it could have limited importance. However, I continued to think qualitatively as well and recognized that although a code appeared once within the data does not necessarily mean it is unimportant. Therefore, I closely investigated the context of the code to identify its reference within the therapy and whether or not it could be combined with another code. I took notes within the software regarding the context of the code and whether it was referring to music or life outside of the therapy. Then I began to combine codes that were similar or related, for example the codes “hard” and “difficult”.

After narrowing down the codes, I began the abstraction phase (Elo & Kyngas, 2008). I started to categorize them into larger group names and develop concept maps using HyperResearch. The concept maps were constructive in providing multiple ways to conceptualize the data and make connections between codes. During this stage, I was able to make inferences in order to address my research aim.

All of the data was coded inductively with the help of HyperResearch software as described above. According to Elo & Kyngäs (2008), qualitative content analysis should be conducted inductively “if there is not enough former knowledge about the phenomenon or if this knowledge is fragmented” (pp. 109). Therefore, I decided to code the data inductively because there had not been a great deal of knowledge obtained regarding the use of music therapy with healthy adult women prior to facilitating the group. Also, there was no pre-selected theoretical framework, approach, or model being consciously used during the therapy or hypothesis as to what would be discovered. It was only after completing the music therapy group that I realized my approach and way of working contained characteristics of humanism, client-centered, and interpersonal approaches to therapy. Therefore, I have utilized these ideas in supporting my findings and understandings of the group process.

2.7 Trustworthiness

There are many factors that contribute to the trustworthiness of this study. According to Elo et al. (2014) trustworthiness is important to distinguish throughout the process including the "preparation" and "organization" of the data (pp.1). Within the preparation phase, Elo et al. (2014) report if the analysis is to be completed inductively, it is more favorable to obtain unstructured data.

Concerning this case study, the data collection was unstructured because it consisted of live video footage from the sessions where anything could happen. It was impossible to be completely structured within this improvisational therapy context because the therapists could not predetermine what the clients would play in music or say during verbal discussion. I entered the therapy having an idea of a possible direction we could go, but was able to stray from the path depending on the clients needs. I also provided the journals, which the members were given no specific instruction on what to write.

Elo et al. (2014) report that the "most commonly used method in content analysis studies is purposive sampling" (p. 4). The sample for this case study was purposeful. All participants were specifically chosen based on their gender, similar age range, similar reasons in their application for music therapy services, and their lack of medical diagnoses. This sample served to help address the research aim at hand and shed light on the topic of group music therapy with healthy adult women.

While in the analysis or organizational phase, Elo et al. (2014) highlight the importance of credibility when analyzing the data and argue that it is imperative that the interpretations made by the researcher are true to the data. Elo et al. (2014) suggest a way to ensure credibility by, "one researcher is responsible for the analysis and others carefully follow-up on the whole analysis process and categorization" (p. 5). Throughout the therapy process, I kept in close contact with my thesis supervisor who was cognizant of everything happening within the sessions and provided guidance to guarantee my objectivity. Then, during my organizational phase, I was the main analyst for the data set and all of my codes, interpretations, and concepts were discussed with my thesis supervisor. Having observed the

group sessions, my supervisor was able to provide a critical eye ensuring the credibility (Hsieh & Shannon, 2005) of my claims.

An additional method that certified my credibility was triangulation. Triangulation (Hussein, 2009; Yeasmin & Rahman, 2012) is recognized as a strategy for improving the validity of research findings, which can occur in numerous ways such as two or more researchers examining the data, incorporating multiple theories, utilizing multiple methods for analyzation, and using numerous data sources. In this case study, "data triangulation" (Hussein, 2009, p. 3) was used. When collecting the data, not only did I use the audio and video recordings, I utilized the clients' journals and observation notes from students who observed the sessions. Utilizing these different "data collection techniques" (Yeasmin & Rahman, 2012, p. 157) helped to increase the credibility in my own observations and interpretations of the sessions.

3 THE PROCESS

In order to present the case study as clearly as possible, I have broken up the group process into sections: (3.1) uncertainty, (3.2) goal setting, (3.3) establishing group cohesion, (3.4) presenting challenges, (3.5) resistance, and (3.6) gaining insight. These sections serve to represent the process and contour of the therapy from beginning to end. Within these sections, I will incorporate excerpts from session dialogues, descriptions of music experiences, and supportive literature that can corroborate these divisions and the process, as it has been understood. It is important to note that these phases were non-linear. Research has shown (Kowalik et al., 1997) that the therapeutic process is one that is non-linear and that "linear 'cause and effect' or 'dose and effect' analogies of psychotherapy may not be appropriate" in a therapeutic context (pp. 211). The same holds true for this case study, as the aforementioned phases did not appear in a linear fashion, but rather different stages of the process may have happened concurrently either for one small moment or for many sessions and each group member may have experiences these stages at different times. Lastly, I have changed the names of the participants for the respect of their anonymity.

3.1 Uncertainty

Broucek (1987) discusses how music therapy could be beneficial for people who are looking to nurture "the life spirit" (pp. 56). This idea, which she pioneers, consists of four areas that music therapy could contribute for people striving to reach self-actualization. The first area she describes is how music therapy can provide a "daring" experience. Broucek (1987) reports that, "it takes daring to try the unknown, to be open to the experience of the unfamiliar" (pp. 56). She continues to state, "music therapy provides exploratory sessions that can help people become familiar with the unknown…these risky musical forays into new expressions may then influence a future choice for daring to risk in other life experiences" (pp. 56). This idea aligns with the way the music therapy process of this case study seemed to unfold.

In the beginning of the process, the clients expressed many questions concerning music therapy. All of the clients reported never having experienced a creative therapy before and communicated intrigue as to what we would be doing. Topics surrounding music therapy

surfaced such as how to define improvisation and whether or not it is important to be a musician. During the music experiences, the participants frequently reported they were *"experimenting"* and *"just trying."* They were observed to test various instruments, try different sounds, and determine their way of expressing themselves with music.

One particular client, Rachel, also discussed her preconception and feelings concerning music therapy after the first session in her journal:

> "I've always had in mind that "therapy"- of any kind- is the sort of practice that requires you to be mostly passive in relation to whatever treatment you're being given. When it comes to "music" therapy, I actually thought of a scenario in which I would be laying down…listening to music and to eventual comments made by the therapist. When I saw myself hitting drums just for the sake of "expressing my emotions" I've found myself to be quite relieved. Relieved from the tension of being in a room with total strangers; relieved from worrying about making a fool of myself; relieved from the very unwanted emotions/feelings I was there to express. I don't know where this is going to take me, but I already feel quite convinced that I'll at least go through a nice journey."

The above excerpt provides a close look at Rachel's inner thoughts. It is clear by this excerpt that Rachel was unsure as to what to except within a music therapy setting. She describes her preconceived idea as to what could happen and then reports feeling *"relieved"* from *"tension"*, *"worry"* and *"unwanted emotions"* after actually experiencing the first session and understanding what engaging in music therapy might mean.

As music therapy is a relatively young profession, it is not uncommon for new clients to have reservations, hesitations, preconceptions, and uncertainty. My co-therapist and I kept this in mind when in the beginning stages of the therapy. We decided the first few sessions of the music therapy process would be geared toward promoting safety for the clients.

Emotional Safety

It was our belief that there was a possibility the clients would be uncertain about what to do, how to behave, and what is acceptable in music therapy. Therefore, we felt it necessary to provide structure within the sessions in order to make the clients feel safe and become comfortable in the setting. Dies (2003) reports that, "research has uniformly demonstrated that patients experience greater tension and feel more critical toward therapists who are viewed as inactive, aloof, distant, and judgmental" (pp. 536). We agreed with Dies' (2003) ideas and

strived to be active and present in order to create an emotionally safe and nurturing environment where the clients felt supported, important, and accepted.

We felt that providing a safe environment for the clients to feel comfortable to make music was of the utmost importance. Brabender, Smolar & Fallon (2004) stress that, "the creation of an emotionally safe environment in which members can begin to trust the therapist and each other" is imperative of the group leader (p. 115). It is natural for clients to enter music therapy being nervous to make music if they have never had music training. Quite often in my previous experience, clients have verbalized that they do not know what to do because they have never played an instrument. Therefore, we wanted the clients to feel that they could be themselves and make music however they desire. We wanted them to understand that knowing how to play instruments was not necessary and it did not matter how the music sounded, but rather the expression it portrayed.

After making this extremely clear to the group members, it seemed that the addition of music in this therapeutic setting promoted and accelerated the development of safety and trust. Broucek (1987) states, "a person's sound can be heard and valued, where the fear of making a mistake can be overcome by the group's acceptance of each person as part of the music-making process" (p. 52). Music can also promote safety with "its complementary relationship with words. It can be used as a defence, or as a place to hide, by avoiding the kind of specific expression that words demand (Shapiro, Turry). Music can contain intense and opposite emotions (Ansdell, Fidelibus) and provide a way of expressing feelings that people are not willing to express verbally because it involves some risk" (McFerran & Wigram, 2007, Music Can Be Safer Than Word section, para. 1).

As the group progressed, we explained to the clients that we would like them to take an active role in guiding the process. We told the members that we encouraged feedback about the music experiences in order to know what is working and not working for them individually and as a group. As I briefly describe when discussing the music therapy technique in chapter 2, we provided variations of music making that incorporated different members of the group including and excluding the therapists. This seemed to enhance the group members' process and contributed to the central theme of relationships discussed later in chapter 4. However,

these variations and the creativity within the music making would have been challenging without establishing safety within the group.

3.2 Goal Setting

Once the group seemed to feel safe and become aware of how the music therapy sessions would work, it seemed necessary for each member to determine individual goals and collectively identify goals for the group without guidance from the therapists. As the group consisted of high-functioning individuals, we felt the group members were fully capable of identifying their own goals for their therapy. This perspective seems to align with Carl Rodger's ideas about client-centered therapy (Barrett-Lennard, 1998) regarding a self-directed approach to therapy where the clients are able to improve themselves by taking personal responsibility for the process.

During session 3, we had each member take time to think about what she would like to work toward within the therapy time frame.
The participants identified the following individual goals:

> Kate: "I want to work towards full acceptance of everything, all processes in life, myself, and also find a creative way of expressing myself and expressing my feelings because sometimes I have problems expressing my feelings."
>
> Tina: "it's hard for me to concentrate on some feeling because I'm reasoning too much and every time I have a feeling I reason myself out of it. And that's something I would like to overcome here, to learn how to express those feelings."
>
> Rachel: "Improving sleep a bit. I sleep very badly. Sometimes my mind in the morning is just a desert and it lasts for the whole day and in the night its just psychedelic and I have all the ideas and brilliant things going on and I have to go to bed…so that's my main goal here, to try to find out what we are doing here can help make it better."
>
> Isabel: "I just want to feel what it's like to play different instruments. If I tell you the truth, that's what I think most. It's good, I don't have such big hopes for that, but if it helps me with this rollercoaster feeling I have that's good. But I'm not waiting for that to happen. If I could learn how to control my feelings, somehow that if I've been bad, I could somehow learn how to change the mood better."

However, as the group progressed, the music experiences elicited thoughts and emotions that led to modifications in the identified goals from session 3. After the music experience during session 8, Isabel reported:

> "I think one of my personal goals was kind of, at least now it is, that I would learn how to listen to others or I would concentrate more on them but still today, I have…because I have so much problems with that, that sometimes I just don't want to listen to anyone, kind of, it came out maybe."

Rachel also identified an addition to her stated goal during session 9 and reported, *"I really would like to have this, to recognize when is something hard."* Isabel and Rachel's newly discovered goals toward the end of the therapy, illustrates how the process of the music therapy was non-linear. Although they had already established individual goals, as the process developed and new experiences were gained, the women discovered additional objectives they wanted to improve.

Aside from individual goals, the group members collectively established goals for the group. The goals they identified were to *"support"* each other and to form a *"band"*, which seemed to lead to the establishment of group cohesion.

3.3 Establishing Group Cohesion

After reading literature regarding group therapy, I have realized that the way of clinically approaching the group possessed components of interpersonal theory. In interpersonal theory, the group begins to represent a micro construct of society and the place each group member holds within the society. "In this microcosm, members' typical ways of seeing themselves in relation to others, and the behaviors that are integrally connected to these perceptions, will be revealed" (Brabender, Smolar, & Fallon, 2004, p. 21). In any type of group therapy the individuals enter the group with individualism, resources, and past experiences, but together the members create the whole, where therapy is able to take place. All group members obtain a unique role within the group setting, which is how group dynamics formulate.

Kate touches upon this concept toward the end of the therapy process during session 8:

> "Yeah I think there is an interesting variety of characters in the room because everyone is their own individual character so I think some how its like were, its creating a diversity and then its easier, even if

> usually you have your own feelings, its also nice to see and hear other peoples feelings because it almost expands what there is to feel."

As Kate describes, being in a group setting can *"expand"* how an individual within the group feels, or furthermore how we see ourselves. When in the group setting, individuals have an opportunity to gain greater self-awareness and hear different perspectives from the peers in the group.

Ahonen-Eerikäinen (2007) expresses:

> "Being a member of a group is a part of our identity. An individual is part of a social network and can only be understood as part of a connected set of relations, a figuration. We are social beings. Being social is so profoundly within the individual that it is difficult to distinguish where the shared social ends and the personal begins" (pp. 5).

Ahonen-Eerikäinen's (2007) argument explains the nature of group therapy because people are always a member of some group, whether it means being a part of your local community, education system, family structure, or national community. If focusing on this depiction of therapy, then one can say humans are inherently social and therefore, group therapy would be beneficial in providing a more realistic representation of the clients' lives outside of the therapy and the way in which they relate to others.

However, in order for group therapy to be beneficial, cohesion must be established through the principles of "acceptance and belonging" (Brabender, Smolar, & Fallon, 2004, pp. 22). Brabender, Smolar, & Fallon (2004) express, "through a process of interpersonal learning, members can obtain feedback," on numerous topics including his or her own "perceptions and behaviors" (pp. 21). Providing and receiving feedback can be motivating in "promoting one another's well-being" for the group members (Brabender, Smolar, & Fallon, 2004, pp. 22). However, these concepts are all intertwined because in order for group members to feel comfortable giving feedback to each other, they must feel accepted and as if they belong to the group. Obtaining a sense of belonging and acceptance cannot happen without cohesion, but cohesion cannot happen without having a sense of universality amongst the members. According to Brabender, Smolar, & Fallon (2004), group members must believe that feelings and thoughts between each other are shared. This universality should then enable the members to feel more inclined to discuss personal issues and become more self-expressive. This is especially important for people whom are in need of developing positive interpersonal relationships because they may have felt isolated from others.

3.3.1 The Beginning

While promoting a safe environment for the clients to feel comfortable and encouraging the identification of group goals, we also encouraged group cohesion. We had been thinking about how to encourage cohesion before beginning the group and felt it was our job to facilitate group experiences that might stimulate unity between the members. Similar to Brabender, Smolar & Fallon (2004), we believed as the therapists, we should be active in encouraging group cohesion, helping members to relate with each other, and supporting them in seeing one another as essential agents in achieving the identified goals of the group.

One way we tried to promote cohesion, was during sessions 1 and 2, by providing tasks for the clients where each member would have to play their feeling on the djembe drum and the others would have to interpret what feeling they might have been playing. This type of music experience could help the group members become more perceptive and aware of each other's expression. Brabender, Smolar & Fallon (2004) state, "the therapist should consider feedback as a cohesion-building factor" (p. 94). Facilitating opportunities for the group members to give each other feedback, converse with each other, and play music together was our goal at this time.

The additional element of playing music together contributed positive factors to the group therapy and its possibilities for cohesion. This was observed in many ways including the way in which the group members interacted with each other in and outside of music. Within the music atmosphere, each group member could select a preferred instrument and play music that was unique to her. By playing music together, the group was able to unite on a different plane. The incorporated aspect of music in therapy, aided the clients to feel more comfortable because it was a less intrusive way of be with another person in therapy.

> Rachel reported in her journal:
>
> "It seems that we've got to actually play more than we talk =). I guess this somewhat nicer way to feel more comfortable among people you don't know that well."

However, this is not to say that the development of cohesion was instantaneous due to the element of active music making. The start of the music therapy group was also a time when the group members exhibited "a politeness and respect for conventionality that leads them to avoid behaviors that are outwardly rejecting of one another" (Brabender, Smolar & Fallon,

2004, p. 89). This was confirmed during session 2 while verbally discussing the music experience.

Kate stated:

> "I think also, the fact that nobody tried to rise above the group. Everybody tried to fit in a bit even if you couldn't really and everyone was still consciously or unconsciously trying to fit in some way."

Even though active music making can expedite the formulation of cohesion, it still takes some time for the individuals to not worry about rising *"above the group"* or how to *"fit in"* as described by Kate above.

However, in order to keep moving forward and strengthen group cohesion, during session 3 the co-leader and I began to provide the clients with choices. The choices included whether or not the music improvisations should be recorded and how to end the session. We continued to provide the group members with different types of choices at least once in every succeeding session. At the end of session 3, Isabel asked if we could have more music and less discussion during the therapy. The group and therapists then agreed that the following session would begin with music rather than verbal discussion. Within sessions 4 and 5, the therapists took more of a supportive role in the therapy and began to lessen the verbal directives.

As the group progressed, the music gave the group members something to work toward. The group members became more invested in the music they were creating and the sound they were producing. The members began to ask each other questions about various elements of the music improvisations such as instrument selection and tempo. The *"band"* they were forming was becoming increasingly significant and was compared to the family structure in session 5 by Rachel:

> *Rachel:* I used to play in a…it was a bit similar experience because I used to play in a black metal band. And well, in a way it feels like you're in a house full of relatives and family people and there is lots of…there is some tension involved but there is also a nice sense of accomplishment when all the thing goes, and sometimes when the rhythm does not go nicely, you feel a bit like 'eek', but there are these little moments it works, so its a bit like being in the middle of this chaos, that is sometimes my husband, family and I really like it, it was similar experience.
>
> *Therapist:* So band reminds you of a family?
>
> *Rachel:* Yeah in a way.

3.3.2 The Change

During session 6, my co-leader and I decided to propose a change in the music. We suggested that we would be observers of the music rather than play with the group. When introducing this new setup, the response from Isabel was *"okay, great"*, and it seemed no one had a problem with this change. We continued this path for sessions 6, 7, and 8; however, it was during session 6 that evidence of strong group cohesion had been established.

In the beginning of session 6, the group decided to listen back to the improvisations from the previous week. When doing so, each member selected a mat to lie on the floor in whichever direction she felt. Session 6 was the first time all group members laid in row next to each other while listening to the music. Then, after listening back to all of the improvisations and discussing the music, the group decided they wanted to play.

Throughout the session, the group played 4 improvisations without the therapists participating musically. As we sat and observed the music, the first improvisation seemed quite repetitive and rigid. When the music stopped abruptly, the group began to laugh and reported that the music was *"weird"*. They laughed while stating, *"changing is so difficult"* and reported being unable to change the rhythm. When asked what they would name the piece, they reported it sounded like *"drugged kids"* and continued to laugh.

The second improvisation began after the group members changed instruments. During this improvisation, Isabel began to hum and then spontaneously sang the following lyrics:

No more drugs (4x)
Gotta get sober (4x)
No more drugs (4x)
Gotta get sober (2x)
No more drugs (2x)
Sober (2x)
No more (2x)
No more drugs (4x)
Ah ah ah ah ah ah

After the music ended, the group began to laugh and Rachel stated, *"that was weirder than the first one."* They continued to laugh and comment about the *"drugged kids"* in the music. Without much discussion, the group members began to prepare themselves for a third improvisation. Isabel asked her peers which drum they felt sounded the best in order to help her make a decision regarding which drum to play.

The music from the third improvisation seemed to be calmer and somewhat more synchronized than the others. The ending seemed to be very natural and instinctual unlike the other improvisations as well. After the music ceased, Rachel reported the improvisation was *"less weird."* Subsequently, a discussion followed regarding the group members ideas about what is weird and normal. Kate reported that playing this different sounding music *"raises a bit more ideas and questions rather than just being in the comfort zone."*

The originality that can result when group members feel comfortable to be themselves is essential in furthering the therapeutic process. McFerran & Wigram (2007) report, "the feeling of newness that is created by playing freely has an influence on the musical community (Ritholz) and a sensitive group will be able to nurture this living in the present, supporting it and letting it bloom," (Playing Spontaneously section, para. 1). The group seemed to be nurturing their music about *"drugged kids"*, as McFerran & Wigram (2007) describe, letting it naturally grow and develop, rather than dismiss it for fear of its abnormality. Isabel also discussed the difference between playing the *"weird"* and original music in comparison to ordinary music.

> Isabel stated:
> "Yeah because if we just try to play something that we are used to then we would have those feelings, ok well somebody would do this better or play these things better, but when we do something totally different we can't say that someone would do it better. It's original and that's kind of fun thing."
>
> Rachel went on further and stated:
> "It's not about what's weird, but what's normal and who said it was normal. Who defines that for us? So doing something like that is a moment of realization that you don't have to take it as normal and making fun of yourself."

It was in this moment when the group members were allowing themselves to laugh and make *"fun of"* themselves, that it seems the group cohesion was strong. At this point, there was a change in their way of being in the group; the members stopped being polite and started to question societal norms and their own behavior within the group. They have also begun to permit genuine spontaneity and creativity within the music without fear of judgement. "The ability of group members to participate spontaneously in the musical creation is essential to being able to work therapeutically in group improvisations….Furthermore, spontaneous playing is more likely to be self-expressive (Marcus) because it implies bringing whatever comes to mind into the world and hearing it" (McFerran & Wigram, 2007, Playing Spontaneously section, para. 1).

As the group progressed, the connection musically also seemed to become very strong. McFerran & Wigram (2007) express, "As the culture of listening grows, people become more sensitive in their relationships with others (Ansdell), they begin to listen to what is happening in the moment rather than focusing on the output of the future (Ritholz). When this quality of listening develops, the group music begins to change and the listening process is reflected in the musical material (Ansdell, Shapiro)" (Listening to the Music of Others section, para. 1).

This idea seems to be nicely communicated by Tina during session 7:

"We've advanced in a way that we're considering each other. Maybe in the beginning we didn't play as much as a group, but we've been doing that. It's not just 'boop boop', everyone doing their own thing. We are trying to do something together."

Kate also comments on the progress of cohesion:

"I think the group is opening more and more every session and the stuff shared are more personal. I like the fact that people comment and raise questions."

3.4 Presenting Challenges

Music therapy can provide an opportunity for clients to challenge themselves, their way of thinking, perceiving, and being. At first, the challenges, which the co-therapist and I provided were musical. Being a client in music therapy can be challenging in itself because it is not necessarily the most common everyday experience. Individuals who are musical have had difficulty engaging in music therapy because it might be unusual to improvise with another

person rather than playing music that is technical. It can also be a challenge for individuals who are not musical and have no knowledge of music techniques because often they question whether they are doing 'it right,' as the participants of this particular case study have done.

In the beginning of the process, the clients identified musical challenges such as having difficulty changing the beat, finding the feeling, and finding the rhythm. The clients reported that they attempted to follow the rhythm but they were unable to or that they felt they *had* to follow the rhythm even if that was not necessarily what they wanted. The clients also reported having difficulty expressing themselves musically and if they did manage to express themselves, then it was difficult to speak verbally after the experience.

Since the group was communicating well together and the cohesion appeared to be strong, the co-therapist and I wanted to continue to develop communication further by presenting a musical challenge. Our aim at this stage in the process aligned with McFerran & Wigram's (2007) statement that, "music can provide ways of developing communication, of interacting and becoming fully human (Marcus). This requires not only a capacity for listening, but also an active participation in sharing music" (Playing in a Communicative Way section, para. 1). We felt this was an important next step in order to continue deepening the group members' relationships with one another.

In session 8, dyadic music improvisations were proposed while the other two members observed on the outside looking in. In this experience, both pairs would have the opportunity to play music while the other pair observed. Then, each group member would be given paper to draw or write about the music they made and the music they observed.

The co-leader and myself intentionally selected the pairs. In the beginning of the therapy, two of the women describing a desire to become more self-expressive through the experience of engaging in music therapy, as where the other two women reported a need to regulate their emotions more efficiently. We decided for this dyadic experience, it would be interesting to put people with contrasting needs together in order for them to have an opportunity to learn from each other.

The first group to play music was Kate and Rachel. We gave the clients the option to select any instrument of their choice and to select their location in the room during the improvisation. At first, Rachel was sitting on the floor and chose to play the kantele. Kate had selected the drum set and was sitting quite far away from Rachel. However, after my co-therapist asked if the pair was satisfied with their positioning, Rachel stated, *"you're suggesting I should go there?"* Simultaneously, the co-therapist and I stated*, "no, it's up to you"* and she then replied, *"yeah just I think if it's the point that we play something…both of us...and also you could place the recorder."* Rachel then positioned herself closer to Kate who was sitting at the drum set. Although we decided to let the clients sit wherever they pleased during the improvisation, the decision to move positions could have been influenced by our response to their positioning.

The music seemed to be soft and slow where the drums seemed to be grounding and keeping a moderately consistent tempo. The kantele held the melody, which seemed to be minor throughout the improvisation. The pair did not make eye contact while the music was playing, although after the improvisation they made eye contact and reported the music sounded *"very nice."*

After the improvisation was over, the pair was given time along with the observers to write any feelings, thoughts, images, or pictures they had during the improvisation. After that was completed, Tina and Isabel played their music. They were also given the opportunity to select instruments of choice and location within the room they wanted to play. Tina chose to play the metallophone and Isabel chose to play the tone bars. The two sat across from each other on the floor in close proximity while playing the instruments sitting in front of them.

This improvisation seemed to be a musical dialogue of a call-and-response nature. Isabel began the improvisation with a single hit of the tone bar. Tina then responded on the metallophone with a set of three notes. The improvisation continued this way until Isabel began to give a steady beat on the tone bar. The two began to play together and the dynamics increased. Isabel also changed the tempo frequently which led to Tina also changing the tempo of her melody on the metallophone. The music became increasingly fast with Isabel keeping a rhythm on the tone bar while Tina played a melody on the metallophone. The improvisation ended quite similarly as it began, with Isabel's single hit of the tone bar. The

pair did not make eye contact while playing, however, they seemed considerably connected during the improvisation.

As after the second improvisation, the group was once again provided with a piece of paper to encourage another form of expression after the improvisation. Once the group finished writing, we engaged in a verbal discussion, however, due to the time constraints of the therapy, the discussion was limited to 10 minutes. Within this time, Isabel and Tina discussed their improvisation.

> *Isabel:* When we first we played always that I play then you play, then I play then you play, then we start to play together, so I think that was quite the same…I have to say I kind of burst out. I have kind of really angry feeling and I just wanted to destroy everything. And I think in the end I tried to do that, I'm sorry, somehow cause that's my feeling. I don't want to listen to anything at all."
> *Therapist:* Is there something you want to share that's making you…
> Participant I: Oh no, that would be too long story. No I don't want to share, but yeah…
> *Co-Leader:* There is nothing to apologize for. The whole point was figuring out how you feel and bring that into your music.
> *Isabel:* Yeah...what I wrote here, its kind of funny. I think one of my personal goals was kind of, at least now it is, that I would learn how to listen to others or I would concentrate more on them but still today, I have…because I have so much problems with that, that sometimes I just don't want to listen to anyone, kind of, it came out…maybe."

Isabel's eyes began to swell with tears; she looked down at the ground, and did not say anything further.

> Tina also shared her experience and stated:
> "Sometimes, I felt there were some demands…and I tried to answer them…but then in the end it was also like there was support and I could go on my own tracks in a way. Kind of…demands turning into support."

It was through this session and the ones to follow, that the music began to transfer to their lives outside of the music therapy. Each client began to connect the music experiences to their personal lives and life situations outside the group setting. Personal memories, thoughts, and perspectives were shared. However, this did not happen without some resistance during the process.

3.5 Resistance

Throughout a therapy process there are often instances of resistance. Resistance has been defined as opposition to the process that makes itself known "in a variety of ways which would serve to defeat the objective of change. Resistance may take the form of attitudes, verbalizations, and actions that prevent awareness of a perception, idea, memory, feeling, or a complex of such elements that might establish a connection with earlier experiences that contribute insight into the nature of unconscious conflict" (Austin & Dvorkin, 1998, pp. 122). It has also been noted that the phenomenon of resistance is more often experienced when engaging in "insight-oriented psychotherapy" (Austin & Dvorkin, 1998, pp. 122).

The idea of resistance is one that holds a negative connotation, however, I agree with Teyber & McClure (2011) when stating that, "every client will be ambivalent, defensive, or resistant at times. One way to say it is that resisting clients are simultaneously struggling with a conflict between their genuine wish to change and need to maintain the status quo" (pp. 98). When people enter a therapy situation, they are usually hoping to get something in return, whether it is to meet specific goals or needs, or maybe to further integrate their mind and body. Nevertheless, wanting change and embracing change are two different things and it may take time for clients to fully allow themselves to make the developments they wish. Teyber & McClure (2011) report that, "further integrating parts of ourselves will ultimately lead to improved effectiveness of self. In order for improved efficacy, it is important for the therapist to work with the client's resistance to show that they possess the internal resources, and have the help they need, to make the changes in their lives they choose" (pp. 143).

I view resistance to be a natural element to any process where an individual is striving to change. Resistance is something that is not fully transparent and it could even be unconscious for the client. However, there are several ways that resistance can manifest and be observed. Austin & Dvorkin (1998) describe resistance in music therapy and identify a variety of ways that resistance could be observed with clients in a music therapy setting. Austin & Dvorkin (1998) also stress, "that contrary to what much of the music therapy literature suggests, resistance is not something to be eliminated but instead offers a way toward understanding the client. It should be seen as a form of communication and respected in the same way" (pp. 128).

When clients have difficulty verbalizing music experiences in music therapy, this could be a form of resistance. Austin & Dvorkin (1998) report "the clients' clinging to the vagueness of the musical expression and unwillingness to talk about the experience in more detail can indicate that they need to protect their fragile sense of self by hiding in the music" (pp. 127). This was observed during session 5 of this case study.

The group and therapists engaged in 3 music improvisations throughout the session. The first improvisation sounded as if the group was experimenting. Musical cohesion seemed difficult to obtain and it took the group 6 minutes to come together. After the group began to somewhat play together, the music seemed to be quite dark and fast paced. Once the first improvisation finished, little was said.

Kate reported that this improvisation was *"super difficult"* and she felt *"stuck in a rhythm I couldn't change cause I didn't have the ability to go any faster with my fingers."* Kate continued to report that this made her feel *"annoyed."* Rachel also reported being annoyed because she has *"cold hands when playing".* Lastly, Tina stated, *"I was feeling calm."* Following this brief discussion, the group immediately began to pick up different instruments in preparation for the next improvisation.

The next improvisation sounded very similar to the first experience. It was played in a minor key, the mood seemed dark, and the tempo was fast paced. However, this improvisation seemed to have more musical contour. After 5 minutes, the music slowed down and the dynamics decreased. The music picked up speed once again after 2 minutes when I hit a wrong button on the synthesizer piano. The women began to laugh and embraced the sound on the synthesizer. They appeared to be engaged as observed by head movement, shoulder movement and verbal report from Kate saying, *"I like this."* The music again slowed down 3 minutes later and ended naturally after 4 minutes of slow and soft music. When the music came to a complete stop, there was brief silence for 28 seconds and then I attempted to engage the group in a verbal discussion.

> *Therapist:* What are you thinking Kate? You seem very focused.
> *Kate:* I'm not sure...
> *Isabel:* How did it feel like? (directed toward Kate)

Kate: I can't remember what I thought because I was in a different place when you said what are you thinking.

Therapist: What place were you in?

Kate: I don't know.

Isabel: I think its what you said, I really don't think about other things while I'm playing, like my work or something.

Therapist: No, I understand. You're doing.

Isabel: Yeah, like meditative very much.

Therapist: What did it feel like at least?

(Silence) -5s

Therapist: Maybe you're not thinking, but are you feeling something? What made your fingers move?

Isabel: It didn't make me bored, I think I could have continued this for quite a while, kind of like meditating, I don't listen at all in the same way when I'm listening to music from the radio. This is totally different thing. You listen in a different way.

Co-Leader: How does it feel different?

(Silence) -10s

Tina: I was happy. It was nice to fool around. Looking at others playing, concentrating.

Therapist: Yeah I remember last time when you played the drums you said you feel at home, you feel comfortable with the drums.

Tina: Yeah, I feel good playing them, more than guitar or anything.

(Silence) -12s

Co-Leader: What about the rest of you? How does it feel to listen to the music you are making? Listening at the same time as making the music but its not just your own, its everyone.

Rachel: I think this time I tried to be more aware of what she was playing because it brings back experience from bands, trying to listen to the bass and follow it. I think it worked quite nicely and yeah, what she said it feels different when you are actually making the music. First of all, you are focused more on what the music is about, its not like it's on the radio and you are cooking here and you don't really care about it. There is intention and there is focus and well, you are making it, some little part of your ego is involved and if you feel good about it and you are happy that its working.

Co-Leader: What you do think your music was about now, if you put a name to that song?

Tina: It was changing every now and then...so it was quite ...can't name it all.

Co-Leader: You can name sections of it, if you think it was different after one point.

Isabel: Just trying

Co-Leader: Yeah but that's your effort, how about the music?

Isabel: Yeah but music also...

Tina: Also you are just concentrating on the moment that much so afterwards it's hard to say like how did it sound.

Therapist: It is.

To me, the music felt heavy and dark, which is why I felt it should be discussed. However, after my co-therapist and I attempted to engage the group members in a discussion about the music, I recognized that the group might not be ready to fully verbalize the music. Therefore, I felt it natural to acknowledge and validate this difficulty to the group.

> *Therapist*: It's always really hard to verbalize what's happening after the music. There is a quote that says, when words fail, music speaks, because you can't always put everything into words, right? I think that's part of the challenge, but it's a good challenge and maybe something to think about as our sessions continue. Trying to be aware of each other but also what's happening inside of ourselves because something is making your fingers move. Something is making you play a certain way or have a certain sound. You play what you like to hear, what is good for you. So it's really interesting…

Kate then responded, *"In some sense, I think the mind is limited in experiencing, so if you try to put everything into words and explain by your mind, then you are only catching a glimpse of what you did do."*

The group concluded the session with a third improvisation; however, this time Isabel expressed interest in singing. I decided to accompany Isabel with my voice as well in order to support her. The music from this improvisation was drastically different than the previous two. The music was softer and seemed to be very intimate.

After the last improvisation, the group began to discuss technical elements of the playing such as how the drum set sounded. Tina also commented that the singing was *"really nice"* and Rachel stated the music was *"beautiful!"* The discussion did not continue further because the group wanted to listen back to the recordings. However, due to timing we had to wait until the next session to listen to the music.

In the following session, the group listened back to the improvisations and then seemed more able to discuss the music. The group members reported there were "more risks" in the first 2 improvisations, although they were *"a bit disturbing"* and *"a bit chaotic"*. They also reported the music elicited an *"image of getting stuck somewhere."*
Then, I went on to ask:

> *Therapist*: What do you think it is that makes it easier to say these things today? Because in the moment it's hard, like we talked about last week, it's hard to put words to music sometimes.

Isabel: When you are focusing on something and you usually don't even- okay, when you take a couple of steps back and look at the things it seems different, you take a little time, you see it differently.
Therapist: It's always easier after a situation to recognize how you were feeling then rather than in the moment to say ok I'm feeling this way, what am I going to do to change it.
Isabel: Yeah yeah, you're right.
Rachel: Certain aspects that you can only notice in any situation after you reach a certain level of detachment from it because if you are too much into it, first of all you want to be right or something like that, like if it's a discussion for example, you have too much focus and involve.
Isabel: Maybe if you are...how do you say, work with these things, and develop, maybe you are able to learn how to recognize those feelings already in the moment and not just afterwards...that's kind of interesting thing that would help people if they can't do that thing at the moment and not just with time.
Rachel: I think recognizing the feeling is how we kind of work on it because sometimes I'm aware, very aware of what I'm feeling but it doesn't help...
Isabel: Yeah sometimes you want to be in that feeling so even if you recognize it, you want this.
Therapist: I think this is all really important to see, and I think you're both right. Sometimes it's good to learn how to recognize our feelings, some people have a hard time doing that in the moment and then once you are able to recognize it, you can figure out what you want to do with it- is it important for you to sit with that feeling or is it important for you to move forward and feel something else. And like how we are looking at the music- maybe the second improvisation was disturbing, and maybe it was hard to realize that while it was happening because everyone was experimenting and doing something and it was kind of dark and mysterious but then the final one we ended the session with was calming. Maybe there is a reason that it was calming, maybe that's what needed to happen after something that was so heavy.
Rachel: Natural sort of tendency when we experience anything, I think that at least on some unconscious level, we kind of reach a balance somehow so I think that's very nicely reflected on how we make the music here.
Therapist: So with that, are there any other thoughts?
Tina: Well actually again, my problem is that when I have a feeling, I am too conscious of it sometimes and I reason my way out of it.
Kate: I think I'm a bit more on your boat.
Tina: Sometimes I like to go straight into the feeling and not think about it...and when I'm playing sometimes I forget about myself a little bit but very often I'm just thinking all the time and somehow being conscious. We have opposite.
Therapist: There is a two and two thing, which is good because that's part of a group. Everyone comes in with their own life and we learn from each other. There are things everyone can teach each other and I think its really good Tina, to even know this about yourself.
Tina: Yeah that's the problem, knowing it. (laughter)
Co-Leader: If you know something about yourself, you are way better than most people because self-discovery is a goal for all of us. So at least you know that about yourself and if it's something you like that's ok and if its something you don't like, its something you can try and change.

When analyzing these two sessions, it seemed that after acknowledging the difficulty the group was having with verbalizing music and discontinuing our attempt to encourage the discussion, the group was able to discuss the music the following week. During session 5, it seemed that this difficulty to verbalize the music could have been an unconscious resistance to identifying the "disturbing" feeling or that the group simply needed "time" to "assimilate the experience of increased intimacy evoked by a shared musical peak experience" (Austin & Dvorkin, 1998, pp. 124).

Another form of resistance that the group members exhibited was a verbalized unwillingness to engage in the music experience. During session 8 when the group was presented with the challenge to play in musical dyads (as described in section 3.4 Presenting Challenges), Kate reported after the experience:

> "Even though I knew the task was to communicate, I didn't really feel like communicating so I was just kind of focusing on the stuff I was playing and I didn't really feel like playing, so actually I realized I was more actually focusing on just the visual image of the plates I was playing and kind of, not really, trying to make a beat or anything, but more hitting them and watching them move like the meditative bowls."

Isabel also verbalized some resistance after this experience when stating, *"I don't want to listen to anything at all."*

As discussed in the beginning of this section, resistance occurs as a response to change. Consequently, these verbalized forms of resistance during session 8, seem to be quite natural considering the circumstances. The group had become accustomed to playing a specific way, with all group members involved. However, this specific week, the co-therapist and I asked the members to make a change from what had become standard to playing in pairs.

These resistances seemed necessary and significant in the therapy process. The therapists presented new experiences and challenges and in return the group members possibly struggled with the objective. It is then up to the therapists to utilize the resistance in a way that is helpful, empathetic, and accepting. By giving the group members space, accepting their honesty about the difficulties, and working through these resistances, insight can occur.

3.6 Gaining Insight

The ultimate aim of the therapists was for the group to develop insight to increase understanding of themselves and the way they relate to others. The music therapy sessions aimed to aid the group members in improving "the ability to express the self musically and increase self-understanding", which "represents a high level of achievement within music therapy group improvisations" (McFerran & Wigram, 2007, Awareness of the Relationship Between Self and the Music section, para. 1). A study conducted by Amir (1993) investigated moments of insight in the music therapy setting. The results reported those moments of "insight occurred to clients while being engaged in a creative dialogue with the therapist (musical or verbal)" (p. 90). In this case, the clients had the opportunity to be spontaneous and creative through the experience of engaging in improvisational music making with the therapists and each other. Then, the members were afforded time to express, reflect, and process these experiences verbally. After presenting musical challenges and verbalizing difficulties, the group members began to verbalize newly identified realizations.

While discussing the music in session 8 between Kate and Rachel, visualizations and memories were discussed. Rachel reported that the music took her back to Germany, to a memory of being there for the first time. Rachel then discussed how she was feeling about observing the music between Tina and Isabel. She stated that she had a *"peaceful feeling connected with water and connected with just being by myself, which can also be relaxing. I think it's something I haven't felt in quite a while. Just being by myself."*

Rachel continued:

> I had this little moment of realization right now, that I'm not dedicating enough time for myself. I give my time to the university, to family, to the cat, and I have very little time for myself. Something I perhaps should change.

During this session, Isabel also reported realizing that she has difficulty listening to others, which she identified to be *"one of my personal goals."*

The discussion continued throughout session 9, and lasted 48 minutes. Rachel continued to discuss her realization from the previous session. She reported that during the week she took a walk in the forest. She shared how much she enjoyed her walk and how relaxing it was for her.

She continued to state:

> *Rachel:* Yeah the funny thing about it, I have the chance to do this whenever, but today my husband left home, he had 4 lectures. I was alone here…the fact that he left, gave me courage to also go and do something.
> *Therapist:* Who gave you courage? Your husband?
> *Rachel:* No, myself. He just left and I thought, well I should do something too. In theory I could have done this at any time, it's just that I needed to be forced to be alone to do something about being alone.

During session 10, Tina also seemed to have a moment of realization. Within this session, my co-therapist and I proposed another change in the music structure. For sessions 10 and 11, we proposed the idea of implementing a soundscape. The idea of a soundscape is to have one client lying down or sitting in a relaxed state while the other group members and therapists play for that client. The client who is the focal point will tell the group what she needs and then the others will attempt to provide her with those needs through the music in the most sensitive and intuitive way. The client in the center also has the option to verbalize what instruments she would like to have played and where she would like everyone to be positioned in the room. The idea is to create a musical environment specific to the central client. Within the group, each member has an opportunity to be the client in the center.

> While it was Tina's turn, she reported:
> "Ok, I would like to feel kind of, everything will be fine, and a bit...as we're talking about deadlines, I had mine already and I have some in few weeks, but now I feel that I gave all the energy already and now I'm a bit lost what to do…how to start. So maybe something to change it, but everything will be fine, that would be the name of the song."

Before the improvisation, Tina was encouraged to get comfortable any way she could. She chose to lie on her back on a mat located on the floor. She had a pillow under her head and a blanket on top of her body. I provided brief verbal directions prior to the playing where everyone closed their eyes and mentally prepared for the music. Tina was asked to open her heart, open her mind, and take in the music. The players were asked to be sensitive to Tina's needs, to each other, use their intuition, and play what they feel can help her achieve her needs.

The improvisation began moments later with Isabel playing the djembe softly. The instruments used were two djembe drums, metallophone, kantele, and ocean drum. The music picked up speed quickly and seemed to be quite active. The tempo was upbeat with a fast

moving melody on the metallophone. Midway through the improvisation, Tina sat up and changed her positioning so her head was facing the opposite direction. Two minutes later I started singing *"everything is gonna be alright"* in a repetitive, chant-like fashion. The music lasted for 7 minutes and gradually slowed and faded.

After the music ended, Tina sat up and quickly stated*, "I noticed that its really hard for me to just receive...its…"* A discussion followed.

> *Therapist:* What's hard for you?
> *Tina:* Just…kind of...maybe...yeah, its a demand from other people, something, like support or anything...only it's maybe…maybe like the really close family then it's easy to take...but then also maybe I find it right now it's hard...but still it's nice...but somehow...
> *Therapist*: How did u feel in this moment?
> *Tina:* I feel a bit stressed somehow.
> *Co-Leader*: Anxious?
> *Tina:* No, not really.
> *Therapist:* Was it the music or was it the worry of having to put demands on people?
> *Tina*: Yeah I don't know...maybe yeah...it's like somehow, I kind of have the feeling that I...I know what is best for me and then it's hard to…let other people know as well.
> *Therapist*: I think that's another interesting word, demand.
> (Silence)- 15s
> *Tina*: Yeah...and also maybe not always knowing what I...I think I know what I need but then I don't actually know it always. It's also, you say something allowed and then it's not what you mean.
> *Kate*: Do you mean it's hard to ask for other people to give you what you need or to trust that other people might know what you need?
> *Isabel*: Or you don't know how to say, how to formalize your needs?
> *Tina*: Yeah in a way or maybe admitting those needs to yourself also.

As the discussion continued, I provided some thoughts and feedback and also encouraged others to contribute their thoughts.

> *Therapist*: I think it can be complicated, and that's okay too...and also you never know until you try right, so if you never tell anyone what you need then you'll never know if it was the right or wrong need. You told us one thing and maybe half way through you realized that wasn't what you needed but you wouldn't know that wasn't what you needed if you hadn't told us. Does that make sense?
> *Kate*: It's like you kind of learn from your mistakes as well. There's no bad decisions because you can always learn. If its kind of a "bad" decision you'll learn oh that wasn't right for me but if it's a good one, you'll know. You can never kind of do wrong with making decisions because you always learn something.

Therapist: What about other people? What was this experience like- giving Tina music?
Isabel: I think it was more difficult than those needs of Rachel were more easy, to give energy is more easy than to give kind of hope that everything is gonna be...(everyone laugh). I think it needs more words, more melody, and uh, I'm not sure but it's more difficult need.

The concluding statements:

Therapist: Is there anything else Tina? Are you okay?
Kate: Is everything gonna be alright?
Tina: Maybe…
Therapist: Thank you for sharing and maybe it was a good learning experience for all of us today.
Tina: Yeah for me it was like...to...what...good practice, how to receive...and maybe that's something that should be...practice more...I should practice more
Isabel: I think the problem is because I think never you can worry, I think it depends on the person, but never, you will never get just what you wanted kind of. But the point of learning how to receive what you will get and take that.
Kate: You don't always even know what you really...like you know what you want but maybe that's not the best thing that you need so you might find another thing.
Isabel: Yeah, be more open to get what's coming.
Tina: That's what I was thinking. When we first talked about responsibility, that's also like when you're doing something then you don't know how it goes but you have to take the risk…and also receiving that's...yeah.

Kate also related to Tina and reported:

"*Kate*: And I think its kind of nice. I also sometimes have a hard time asking for things or asking for help or...like I also need to kind of learn to get more or be open to getting but I think its like also good practice in a way that when you feel like you were asking for something or...but then actually I realized I was enjoying this much more than I probably...like I didn't need that but I was enjoying just kind of giving…so sometimes you think its a burden when you ask something from other people, but actually they might get quite a lot out of it. And if you don't give them the chance to give you, then you are denying them the situation."

Support

Support seemed to be a significant concept throughout the group music therapy, as discussed above and as identified as the group's collective goal during session 3. Group music therapy can be a place where members can feel a sense of support or begin to understand how to give and receive support from others.

Ahonen-Eerikäinen (2007) indicates:

> "…people come together with similar kinds of struggles and problems. Everyone's aim is to help themselves and each other by taking turns. Clients tell and listen to each other's stories. During this telling and listening, they try to understand each other's subjective realities, to feel each other's feelings, cry together, laugh, and feel acceptance within themselves and with other group members" (pp. 24).

This supportive atmosphere is one that Brabender, Smolar, & Fallon (2004) feel should be established in the beginning stages of any therapeutic process. Within the authors' description of support, they identify five components of support that are necessary in group therapy setting. These components are "instillation of hope", "acceptance", "altruism", "universality", and "cohesion" (Brabender, Smolar, & Fallon, 2004, pp. 87). These supportive factors in group therapy seem to not only be relevant to verbal therapy, but group music therapy as well.

Within group music therapy, the therapist may be able to recognize at any given moment one or more of the supportive components in the music. When making music in the group setting, boundaries of language and differences can be transcended and everyone arrives on a level playing field. All people are engaged with each other through music and are either consciously or subconsciously aware of each other's music. "The highest levels of musicing involve the artful blending of individual instrumental or vocal voices in which individual expression exists in concert with communal expression. When done artfully, the two forms of expression become completely complementary rather than compete with one another" (Aigen, 2005). Clients have the opportunity to support each other in the music and all music is accepted and appreciated by all group members. "…There are people who are trying to understand and help themselves and each other "in concert" to accomplish a sense of effectiveness in the world around them" (Ahonen-Eerikäinen, 2007, pp. 6).

Specifically pertaining to the above excerpts from session 10, Tina seemed to be working through a process of understanding how she asks for help and support from others. By this point of the therapy process, the group had developed bonds strong enough to openly discuss their difficulties within the group process and individual processes. Broucek (1987) discusses "openness" as another factor that contributes to "nurturing the life spirit" and suggests that music therapy can provide people with an opportunity to experience "profound emotions and

self-discoveries" (pp. 56). However, "people only share deeply when they feel that it is safe to do so. Music therapy, particularly when it involves active music-making, incorporates boundaries which provide safety factors" as discussed in section 3.1 Uncertainty (Broucek, 1987, pp. 57). Not only was Tina able to express the depth of her experience and her difficulty receiving the music, but also Isabel was openly able to verbalize that she had a difficult time giving music to Tina due to her identified need.

At times, it seemed challenging for Tina to verbalize what she was thinking and feeling about the experience, although she was able to state that receiving support is something she would like to continue to improve. Tina was able to find meaning from this music experience, enhancing her opportunity for self-development (McFerran & Wigram, 2007). Kate could also connect similar experiences, such as difficulty accepting help from others in relationships throughout her life. This experience was just one of the many pivotal moments throughout the process that led to the insight gained and the emergence of relational dynamics as the main theme for the therapy.

3.7 Pivotal Moments

After analyzing and reflecting on the course of the therapy process, there were several moments that could be identified as pivotal. These specific instances included moments, which seemed to challenge the group members, discussions that stimulated self-reflection, and moments that confirmed substantial group cohesion. These moments seemed to be exceptionally meaningful to the process, as they have directed and shaped the depth of its development. Throughout the description of this case and within the following chapter, I have discussed these moments in detail. However, I would like to reiterate and clarify which instances could be seen as significant and for what reason.

3.7.1 Session 5

During session 5, the clients and therapists engaged in music improvisation. The therapists attempted to engage the group in a verbal discussion about the improvisation. Questions were posed regarding emotions, thoughts, and images, which may have been evoked by the music. However, the group seemed to be having difficulty discussing how the music affected them or

how they effected the production of the music. There was a significant amount of silence throughout the discussion and the participants verbally reported inability to process the music through verbal communication. This occurrence can be viewed as a challenge the group faced in processing the musical material in the cognitive realm where they would begin to understand and reflect on how the music could be related to their emotions.

3.7.2 Session 6

In session 6, the challenge experienced in the previous session resurfaced when listening back to the recordings from session 5. In the process of listening back to the improvisations, the group seemed more able to identify words that describe the music and how it made them feel when hearing the recorded version. The group discussed how it could be easier to express emotions after the moment has passed and how it is not always easy to recognize how one feels in the moment. This discussion seemed to be reflective and brought up important ideas for the members to continue questioning outside of the therapy.

Through session 6, strong group cohesion also seemed visible. The group engaged in music improvisation without the therapists. The group members seemed to enjoy the music as observed by laughing and reported the music sounded *"weird"*, which ignited a discussion regarding the terms 'weird' and 'normal'. They appeared to be accepting of their own *"weird"* music and seemed to feel comfortable. This experience seemed to be significant because the members were feeling comfortable to be themselves in the group.

3.7.3 Session 8

Session 8 also appeared to be significant in furthering the group members' therapeutic process. As described in 3.4 Presenting Challenges, participants were asked to play music in pairs. The change in musical setting from being a group experience to a more intimate experience seemed to arouse various reactions. Kate reported that she did not want to play music or communicate and although she did engage in the music, she verbalized some resistance to the experience. Rachel reported feeling disconnected during the music improvisation and shared a memory, which the music elicited. Isabel reported feeling angry during the music and reported that she did not want to listen to her partner. Tina also reported feeling as though she was being demanded of something from Isabel during the

improvisation. These musical conflicts seemed significant and later lead to further discussion during session 9.

3.7.4 Session 9

Session 9 consisted of verbal dialogue for a large portion of the session. The group elaborated on the discussion from session 8 about the music improvisations in which they engaged. Topics regarding responsibility and relationships seemed to arise through the discussion. The participants expressed feeling as though there was greater sense of responsibility in the music dyads because it was a more intimate setting. They began to relate this idea to relationships outside of the therapy. They discussed the differences between being in large groups and small groups. They discussed their patterns of behavior in relationships in their lives and how it related to their childhood experiences.

3.7.5 Session 10 & 12

In session 10, the soundscape was introduced to the group members. Each member would have an opportunity to be the focal point while the other group members play music for the specific person. During Tina's soundscape she reported wanting to feel that everything would be alright. After the music Tina reported that she had difficulty receiving the support and felt that her need was not the same or that the group was not giving her what she wanted. A discussion transpired regarding the topic of support and how we ask for support from people in our lives.

Lastly, another significant moment was when Rachel played the bass in honor of Isabel during the music improvisation in the final session. This moment seemed to illustrate how the group cohesion had developed and become strong by the final session and it will be further described in the following chapter.

All of these moments were significant in the group's process and the members' individual processes as well. Through the challenges and discussions, the members seemed to learn new things about themselves while giving support and providing feedback to each other. They asked questions and appeared to be invested in the group as a unit. The table below serves to

condense these moments, which described the explained situations and how they were significant in the process.

TABLE 2. Significant moments throughout the process.

Session Number	**Pivotal Moments**	**Session Experience**	**Description of Experience**
Session 5	1. Challenge transferring music experiences to cognitive level	1. Verbalizing music improvisation	1. Difficulty discussing feelings and thoughts evoked from the music experience
Session 6	1. Overcoming challenge, self-reflection, and gaining sight	1. Listening back and discussing the music from session 5	1. Group members were able to identify emotions felt after listening to the music Discussing the difference between understanding emotions in the moment and after time has passed
	2. Establishment of strong group cohesion	2. Music improvisation	2. Able to make "weird" music together, laugh, enjoy it, feel safe to take risks Discussing societal norms
Session 8	1. Musical challenge and conflict	1. Musical dyadic improvisation between Rachel and Kate	1. Physical distance between the members Kate discussed not wanting to play music or communicate with Rachel during the music
	2. Musical challenge and conflict	2. Musical dyadic improvisation between Isabel and Tina	2. Isabel reported having an angry feeling during the music improvisation and did not want to listen Tina reported feeling as though she had demands put on her in the music
Session 9	1. Self reflection, gaining insight into personal self	1. Verbal discussion	1. Related to session 8 dyads Discussion of responsibility (expectations and burdens) Discussion about relationship behaviors (being alone, asking for support)

Session 10	1. Musical challenge 2. Gaining insight into how to receive support from others, sharing personal thoughts and emotions	1. Soundscape for Tina 2. Discussion of soundscape	1. Getting musical support from peers and therapists 2. Tina expressed difficulty receiving support from peers She realized her need was different than what she expressed Isabel reported having difficulty providing support for Tina
Session 12	1. Appearance of strong cohesion and investment in group members	1. Discussion after music improvisation	1. Rachel discusses playing the bass because Isabel was not present Rachel discussed missing Isabel

4 RELATIONAL DYNAMICS

After closely analyzing this therapy process, it has become clear that relationships played a significant role and was the major theme throughout the therapy. As discussed in the beginning of chapter 3 and as supported by Amir (1996), the therapy process was non-linear and therefore, the development of this theme was also non-linear. There were many factors, which contributed to its development and in order to present the information clearly, I have devised the following sections: (4.1) the relationship to music, (4.2) the role of the therapists, and (4.3) the clients' initiative. These sections serve to describe how this theme emerged, and how numerous relationships existed and became interrelated.

4.1 The Relationship to Music

Aigen (1991) discusses music and reports the "key to understanding the purpose of music is to see how it enhances the conditions for life. Because music therapy is oriented toward establishing, maintaining, and improving one's health and general functioning, it is a *life-enhancing* activity" (pp. 83). In reference to Broucek's (1987) description of the "life spirit" (pp. 51), Aigen (1991) later continues to suggest, "music is the natural voice of this spirit" (pp. 93). It seems to be argued that music is necessary in self-improvement for the fact that all people are inherently musical. However, not all people have discovered and cultivated their relationship to music. This, of course, is an opportunity that music therapy can provide, as Katsh & Merle-Fishman (1995) state, making music is, "an endless resource of energy and joy, to continue to celebrate, discover, and proudly share who you are with yourself and with those around you" (pp. 83).

Within this case study, the music experiences seemed to support the above statement. Prior to the group members having developed strong cohesion, they were able to share who they were through the music. The women identified their existing relationships toward music and shared past musical experiences. Rachel and Tina reported having previous music experiences where Rachel played in a band and Tina enjoyed playing percussion. Isabel and Kate reported enjoying listening to music and expressed a desire and interest in playing different instruments during the therapy. These first moments of personal sharing and interaction inside and outside of the music, helped to develop the relationships between the group members and

the therapists. All of the group members were observed to express through body language or self-report enthusiasm they felt regarding the active music making during the sessions. This motivation to engage in music experience with others can be the match that ignites the flame, which will then stimulate self-expression, activity, and conscious awareness (Aigen, 2005).

However, before conscious awareness and self-discovery took place, the music experiences seemed to be a time when the group members could experience enjoyment and creativity. During session 2, Isabel stated, *"I tried to think about how it sounds. What sounds nice…just trying to play and have fun and trying to try everything."* Kate also stated, *"it was fun to just experiment with it and be in your own little bubble."* Engaging in music therapy can be an intimidating occurrence for all people, but for people without a musical background, it can be difficult due to a lack of confidence in their musicality or the perception that they must have a seasoned understanding of music techniques. Therefore, participating in an experience that is enjoyable and playful can be helpful for clients to feel comfortable in the setting.

Engaging in music also provides an opportunity for self-empowerment, as it is a creative expression where the group members could take responsibility and initiative regarding their own music. The clients could be proud of the end result and take ownership of something they created. They could make decisions as to how the music sounded, what instruments were used, how long the music lasted, and the way in which it is played.

4.2 The Role of the Therapists

It is then the job of the therapists to aid the development of empowerment by strengthening the clients confidence, safety, and trust in the therapy.

> Rolvsjord (2004) describes the music therapist's role in empowering the client:
> "The nurturing and development of strengths is very important within the philosophy of empowerment… the process of nurturing and recognizing the clients strengths and developing new skills and resources must be concerned with helping the client to achieve what is important for that person: a process of enablement. Taking the client's strengths seriously impels us to recognize the knowledge and competences related to the process of therapy that the client possesses and may develop." (A Resource-Oriented Approach section, para. 7).

In this case, as previously discussed, the therapists were directive at the start of the therapy. Specific tasks were provided in order to ensure safety for the clients and promote interaction between the group members and the music. We were active within the music experiences during the first 5 sessions, as observed by playing with the group members.

The group began to self-govern, as evidenced by the women communicating more with each other about the music, asking each other questions, calling fellow members by name, and verbalizing their desires for the sessions. Then, we decided to stop participating in the music making in order to promote stronger bonds within themselves as a unit. Our role at this time was to act as observatory support. For sessions 6 and 7 we proceeded in this fashion, however, while holding this musical observatory role, we provided opportunities for different music experiences to contribute a multi-layered relational experience.

TABLE 3. Identifying the focus of the music interactions throughout the case study.

The Focus of the Music Interactions					
All: Clients & Therapists	All Clients	Two Clients	All: Clients & Therapists	One Client	All
Session 1 Session 2 Session 3 Session 4 Session 5	Session 6 Session 7	Session 8	Session 9	Session 10 Session 11	Session 12

While the group advanced, it seemed that providing rich relational situations could be a beneficial objective. We began to think of the group music therapy process as a series of relational experiences where the members could be given opportunities to engage in music interaction all together and with different group members. After presenting the challenge in session 8, to improvise in pairs (as discussed in chapter 3), the following session naturally seemed to consist of mostly verbal discussion. After the discussion, the therapists proposed making music together as a group, which had not happened during the previous three sessions. The rationale behind this was because the group members all shared a great deal of personal information and it seemed crucial to validate and support the discussion through the use of group music making.

Taking into consideration that the group would soon be coming to an end, the therapists felt it necessary to address each client individually. In sessions 10 and 11, the therapists determined that soundscaping could be a favorable direction in order to focus attention to each individual group member. One of the advantages of a group music therapy setting is that the group members can work together to support fellow members. While one client was the focus, identifying her needs to the group, the others made music for the individual. Lastly in session 12, we played music as a unit once again with the intention to reflect on the music therapy group process and provide closure to the experience.

Another consideration regarding the role of the therapists in developing the relational theme is the relationship between the clients and therapists. Although in group music therapy, the clients have an opportunity to help each other, the relationship all the group members have with the therapist is also very important. Aigen (1993) points out, it is important to acknowledge how the relationship between the practitioner and participants will ultimately affect the outcome of the research because when this relationship is strong, there is greater probability that the participants will be cooperative and interactive.

Within this setting, developing a relationship with the group members seemed to be a fundamental need in the beginning of the process. After analyzing the sessions, the relationship was felt strongly by the therapists, although the group members never verbally discussed it. The strength of the relationship could be observed in non-verbal ways such as, the group members missing few sessions, which could be interpreted as high investment in the therapy. If a group member had to miss a session, she would make contact by phone or email as well. The group members engaged in discussion with the therapists, made eye contact regularly, seemed aware and connected during music improvisations, and seemed to accept feedback provided by the therapists as well. As previously discussed, self-disclosure also increased as the sessions progressed, which can be interpreted as the participants feeling safe, comfortable, and trusting of the therapists and each other.

4.3 The Initiative of the Clients

Although the therapists aided the development of relationships becoming the main theme for the therapy, the clients took the initiative that cultivated this idea. Initially, the clients reported

that one of their goals would be to form a *"band"*. This idea seemed to help the group become invested in the music, work together toward a common goal, and support their connection in the therapy. They began to understand each other musically and take on different musical roles. It became known who would take which instrument more frequently, such as Tina often selecting the drum set and Isabel selecting the bass. It is clear that these roles were noticeably developed by session 12.

4.3.1 The Missing Member

When session 12 began, the therapists informed the group that Isabel was unable to attend. The therapists then reported that the group could start with music and while playing, reflect on the process they experienced during the past 11 sessions. The improvisation lasted 9 minutes. At first it seemed that the group was trying to find each other in the music. However, after 5 minutes, the sound changed when Rachel began to take a musical lead on the bass. Her volume became louder and clearer. I was playing the piano and was able to match the notes she was playing. While she played more deep bass sounds, I filled the melody by playing soft higher notes on the piano. The co-therapist provided more space with her rhythm on the djembe where Kate and Tina filled the rhythm on the djembe and symbols. The music sounded cohesive, as if we had managed to find the same musical world and come together one last time. The music then came to a natural faded ending 4 minutes later.

After the music ceased, Rachel stated:

> "This was the end. We managed to play together, and it's a bit weird, like it felt Isabel…cause I don't know, I at least feel there's something missing. And she usually plays the bass. Although she said she doesn't know how to play, she is really good with coming up with ideas for this. So I don't know, in a way, while I played this, I think I could have been doing something else. But this is a way of trying to fill the gap cause she would be playing this. I really liked how we managed in the end. It sounded like music."

In this excerpt, Rachel expressed how it felt for her to have a member of the group missing. She chose to play the instrument that the missing member would most likely have chosen to play had she been in the session.

It is clear that for some individuals, when the people who attend the session change, the group dynamics can change as well. It can feel that there is a "gap" or something is different. Prior to the last session, the co-therapist and I had this in mind, which is why we had decided to

make modifications regarding who would be playing music together during various sessions. As previously discussed in chapter 3, the therapist presented a musical challenge during session 8. This experience elicited a great deal of verbal discussion in session 9, where the group members transferred the experiences they embraced in music to their lives outside of the therapy. They expressed past experiences, patterns of behavior, and concepts of relationships.

4.3.2 Transferability

During session 9 the discussion stemmed from the dyadic improvisations of the previous session. The group first began to express how the connection is different when two people are playing music compared to four people. Then, the discussion opened to interactions outside of music when Tina expressed that when two people are together, *"you are more dependent on the other one in the conversation. In bigger groups you can be either be more silent…nobody notices necessarily."* Other group members began to engage in the discussion as well. Kate stated, *"if it's just two, then you have 50% responsibility for keeping the relationship going in the moment, but when it's like 5, it's 20%. It's less of burden you can say or responsibility."*

As the discussion continued, the group members discussed their own behavior when engaging in interactions with others.

Rachel stated:

> "With some people I'm clearly more active and with others I'm way too passive and I think it's a very bad thing. In sort of, lets say a romantic relationship, this can be that much of a burden no matter what side you are on, and I think that this kind of roles become apparent and of course they create tension. Not because of the other one but like you say the expectations and this is something that very strongly regulates how we relate to things. If they don't meet our expectations, we find everything wrong about the person, the environment, it's pretty hard to see, regulating responsibilities."

From this point, Kate began to discuss making commitments with others. She reported that if she is not in a good mood but has made plans with a friend, she would cancel her plans and not do them.

When questioned by the therapists, Kate stated:

> "I'm fairly independent when it comes to taking responsibility for my own moods. So I'm not really…I don't have the desire if somebody else offers to push me out of it, I'll do it kind of myself. And normally, I think I give the same freedom for my friends as well. If they tell me- I always say just be

honest, if they don't want to do something. I always encourage other people also to trust their feeling. If you don't feel like it, don't do it."

Kate went on to identify herself as *"pretty stubborn"* and reported that her behavior could be perceived as *"being selfish"* by others, although she does not feel that way. Other group members began to ask Kate questions regarding her ideas about making commitments to others. Kate began to discuss a situation with her best friend, which spiralled into what qualities are important for her in a relationship. She then reported that *"freedom and honesty"* are important elements in her relationships.

The conversation continued with a question from the therapist:

Therapist: And there was one thing you said I wanted to ask you. You are supportive of the people in your life when they need you, but what about the other way around? Because all we need support, and its also important for us to give support.

Kate: I have a hard time asking for help or like accepting help from others. I can give it quite easily and I'm there to support, but for example, a good example is one of my friends is a bit more sensitive and she's always needed a lot more support and help. And I'm not as sensitive usually and when I deal with things, I deal with it myself usually. It's like I go into a place, I deal with it, I go over it and then I come out, I'm fine. I don't need to discuss it anymore or make a big deal out of it. And then I remember when we were younger, I rarely cry that much or publicly. And then I think once she was very, very…she got very happy once when I cried in front of her. And she was like, she realized…that I could cry…even though we've been friends for years, but then it like was such a big thing for me to do, to trust her enough. Yeah...For me its hard to accept help. I think most of the times I feel like I don't want it or need it somehow. Again, because I have my own way of dealing with things.

Tina reported that she could relate to this and stated:

Tina: Yeah I have quite the same. I'm used to doing everything by myself. Somehow I think I don't want to expect anything from anybody because then you like...get disappointed and also to be in charge of your own mood. But yeah sometimes it saddens me not to trust people so that you don't expect something.

Co-Leader: Is disappointment something that has happened?

Tina: I don't know, nothing that would really...but maybe its just that I used to, I learned to be alone when I was a kid quite a lot. I did things by myself. It's not a problem now-a-days. I have a sister who has always had friends and for her it's a problem to be alone.

Therapist: Was that okay for you as a kid, being alone?

Tina: Not that much then. I really wanted some company. But somehow, for me now it's hard to not be alone.

Kate also discussed her childhood and how it might relate to her way of being in relationships:

> "Well I moved a lot so I think I've been in like 12 or 13 different schools so that meant my friends changed constantly. I could make friends really fast and get close but then I knew I had to give them up at some point, so I think that like had something to do with it. I can't trust people being there around me indefinitely. So again, I would have to leave the place and be again by myself and get new friends so I think that's the reason like trusting the outside doesn't work because the outside changes. I think maybe that's my mentality. But being strong inside and trusting myself, well I'm here all the time so that's not gonna change."

Rachel also began to engage in the discussion and communicated her difficulty asking for help:

> "I think my main problem's that I have really trouble identifying hardship. That's why I don't like to ask for help that much because I have that impression that I am mourning over some very little issue and life is much more than that."

Rachel went on to discuss her difficulty reaching out to people in her home country. She discussed how difficult it is to keep in contact through the Internet and stated, *"it erases so much of the relationship you have with these people...and the impression I have is that we don't understand each other anymore."* She expressed feeling that she cannot *"complain"* to her friends and family in Brazil because *"they kind of cut my right of feeling bad about something right away."* She continued to express feeling that she does not have support in Finland *"at all"* including her husband and his family, and *"it's a bit hard sometimes."*

She concluded her expression by stating:

> "So at the moment, I'm sort of in a vacuum in the middle of nowhere, just with myself. And I really would like to have this, to recognize when is something hard. I don't have that connection with people anymore."

The group members provided encouraging support and feedback to Rachel's feelings and thoughts. As the group was nearly ending, the therapists suggested all group members and therapists play one improvisation together to conclude the session.

During the following session, the topic of responsibility surfaced again. After improvising a soundscape for Rachel, in the discussion to follow, Isabel reported that making the music felt like *"some kind of responsibility."* My co-therapist asked if Isabel felt that she was able to provide Rachel with what she needed. Isabel responded, *"I'm not sure."* Then, a discussion

concerning the group members' ideas about responsibility began to unfold.

Kate: Yeah...I think when other people expect something you know they expect something in particular. So usually you have a burden to aim for what you think they are expecting. But when its yourself, then maybe you have a hazy goal but it kind of lives as your doing it.
Co-Leader: It's your own expectations instead of someone else's.
Kate: Yeah, exactly.
Isabel: Isn't that always a kind of negative meaning of what responsibility. I think kind of its always negative.
Co-Leader: For you?
Isabel: Yeah I think. Cause if you have a goal, which is good and you want that, it is just the thing that you do your action as, but still it's negative thing even if your goal is really nice.
Therapist: That's okay, that's your opinion.
Isabel: I'm trying to get an analogy with something...okay, if you don't like jogging but you want to lose your weight and you go running because of that, well its negative thing that running even if...
Rachel: You mean you have to go through some sort of pain or struggle...it causes some sort of degree of suffering.
Isabel: Yeah
Therapist: It's like there are certain obligations you have to meet before you can reach the end, kind of thing?
Kate: I think in general taking responsibility always requires you giving something, you giving your energy to get something.
Isabel: Yeah sometimes it's a strange thing for me to see it as a very, very positive thing- to have responsibility of something. It doesn't mean I don't want to take responsibility or something.

The discussion continued:

Tina: There's always kind of a risk of failing when there's a responsibility or goal and that's like, we're afraid to fail so that's why it feels really negative, although it can give really positive effects in the end.
Isabel: I think every people have some kind of things that you do without any responsibilities, you can sometimes do something without responsibility. I'm not sure if this is just theoretical, but well...if you are alone and you are doing that alone, you don't hurt anyone…you don't have responsibility for anyone.
Therapist: Maybe something to think about then is whether what Tina said applies to your belief on responsibilities. Like meeting expectations, cause maybe its about the expectations other people have, like if you're doing things alone like you just said, then there's not so much responsibility because you are doing it for you and you're not going to be so hard on yourself, is that what you mean? But if there are other people involved, maybe there is a fear of failing.
Isabel: Yeah I think I usually, if you talk about responsibility, it's always...
Co-Leader: About other peoples expectations of you taking responsibility?

> *Isabel:* Yes, cause the stuff you are doing just for yourself, you don't feel the responsibility. Always the responsibility means there are some other people, so society or something.
> *Therapist:* Yeah, well I think in this case, Rachel let us know that we did okay, right?
> *Rachel:* Yeah. I lift the weight of responsibility from you. I free you from that.

This segment concluded the discussion about responsibility, initiated by Isabel. This discussion and the one from the previous session felt quite important. They seemed to be strongly relevant to the group members' perceptions of relationships and commitment to others and themselves. The women seemed to express that their ideas of relationships were often tied to having responsibilities, burdens, expectations, and demands.

At this stage, the participants were able to deeply reflect on these concepts, which originated from the music experiences. They were able to connect themselves to their own perceptions, ideas, behaviors, and past experiences outside of the therapy. They were able to question their own ideas or receive questions and feedback from their peers and therapists, recognizing that other individuals have different insights of the same concept. Lastly, they were able to support each other's expression, as Rachel did for Isabel in the last statement of the above quote, *"I lift the weight of responsibility from you. I free you from that."*

5 THERAPIST'S REFLECTION

5.1 Dual Roles

Aigen (1993) discusses qualitative research practices and the importance of music therapy research being conducted on clinical experiences. He reports, "I will offer support for the idea that, 'the clinic *is* our laboratory. Clinical research is not something that must be performed apart from treatment but is *contained in* our activity as clinicians' (Aigen, 1991, pp. 376-377)" (pp. 18). I also agree with this notion and believe that the best way to research music therapy is through a hands-on approach, taking place within the actual therapy setting. This was one additional element that led me to conducting a case study based on my clinical training.

Conducting this qualitative case study was my first experience engaging in any type of research project. It was an experience in which I have learned a great deal regarding music therapy research and clinical practices. One of the most valuable and challenging experiences I have learned was how to be a clinician and researcher simultaneously.

It is my belief that the clients are the fundamental priority for the work and I made sure to focus solely on the needs they presented during each session. However, I was aware that I would write the master's thesis about the music therapy group and began the group with a topic in mind. Though, I did not reference a theoretical approach and conducted the group inductively.

While facilitating the group, I proceeded carefully each week, creating interventions that I felt would aid in their process and help with my research. However, it was important for me to maintain an objective view and help the clients in anyway they needed in the moment, even if that meant straying from the course. I made a strong effort to move with the flow of the group, letting things unfold organically while also providing some structure and opportunity for change, always keeping in mind not to direct the group in order to get more favorable

results.

During the therapy process, I kept a journal, which I have discussed in chapter 2.5 Data Collection. As I previously described, the journal held several purposes such as supporting my personal process as a young clinician and researcher. After each session I would spend as much time as needed to write down any thoughts or concerns I had about the sessions and my way of leading the therapy. In this way, the journal served the purpose as a kind of catharsis where I could release any emotions and possible self-doubt.

After session 3, I reflected on the challenge of maintaining different roles simultaneously. I felt it was important for me to determine what it means to be a clinician and what it means to be a researcher. I found myself asking how are these things different? Can I somehow separate these two ways of being in order to provide quality care for my clients and then subsequently determine how this can help improve the field? When discussing what it means to me to be a clinician, I wrote:

> "I am present in the moment with them, in tune with their needs, validating their expressions, creating a safe space for them to be their whole selves and containing their expressions; grounding when they need grounding, giving space when they need to explore. I am encouraging them to take initiative, risks, and control of their situation in the music. I am encouraging them to make decisions, to continue to develop their concept of themselves and get to know and trust each other."

After writing and relieving my mind of this internal conflict, I investigated this quandary with my thesis supervisor. Writing my thoughts down helped to make them clear so I could then discuss my concerns with my supervisor. After receiving some guidance, I felt confident in my ability to maintain my therapeutic presence within the therapy and activate my researcher intellect only outside of the sessions. I was able to overcome this obstacle and provide the highest level of care I could for the clients.

5.2 Co-Leading

Another new experience I gained from this case study was the ability to co-lead a music therapy group. Prior to the group, I had never had an opportunity to co-facilitate music

therapy sessions. This was a positive challenge due to our cultural and educational differences. My co-leader and I were both music therapy Master's students, however, our training and prior knowledge regarding music therapy differed. I had a background in music therapy, whereas my co-leader had a background in psychology.

In the beginning of the therapy, it seemed that I took more of a leadership role during the verbal discussions. This could have been contributed to the fact that I had music therapy work experience prior to studying in Finland and my previous education in the field. However, this could also be attributed to characteristics of my dominant personality type in a professional setting. Knowing that I have a tendency to take control, I believed it necessary to often discuss our work together weekly. I wanted to make sure I was not overbearing because I was aware that this was also an important experience for the co-leader's education and it was important for her to learn and improve her clinical skills as well. We would meet weekly to discuss the previous session and how we would proceed for the following session. We felt it was important for both of us to maintain open communication to discuss the group and our roles in the group regularly. We also utilized clinical supervision each week to discuss the sessions along with how we were working together.

At times in the beginning of the process, I was somewhat hesitant to let go of control when leading the music experiences. I felt slightly apprehensive because I knew this group would become my thesis topic and I felt I would be upset if something unplanned or unwanted happened when the co-leader was leading a portion of the session. As I struggled with these thoughts and feelings, I utilized my journal to reflect and try to change my perception of the situation. I realized this worry was coming from the structured and rigid researcher side of my brain that I was allowing to creep into my mind in the beginning stage of the therapy. However, once I recognized that I needed to let go of the researcher and let go of the control, I was also able to let go of these feelings about co-leading.

As we completed the first half of the sessions, I felt I was really able to let go of my inner feelings about control and I felt we worked increasingly well together. We began to understand

each other and naturally alternate in leadership and assistance. We both became able to have a confident presence within the sessions while letting the women lead their own process. When reflecting on this, it seems that the process we underwent by co-leading the therapy was similar to that of the clients building a relationship with each other during the therapy. We too, started with uncertainty and had to establish goals regarding our work together. Only after adjusting to sharing the therapist role, did we finally develop cohesion and understand what it means to work together in such an environment.

There are also wonderful advantages to co-leading therapy that I have come to realize after this experience. I agree with Earley (2000) when he expresses how having more than one therapist present can help to uncover "hidden dynamics, group resistances, interpersonal patterns, and non-verbal cues" (pp. 290). This held true during our sessions because the co-leader was also able to recognize things that were happening in the therapy that I might not have been able to see. Having two sets of eyes and two perceptions of the same experience can help to bring things into greater focus in order to provide better care for the future.

We were also able to alternate roles (Earley, 2000) in the therapy. For example, if I was more active during the discussion, the co-leader was more active musically. When we began to understand how to work together in the space, we started to lean on each other during and outside of the sessions. Lastly, within the time period of this music therapy group, I became physically injured and without the co-therapist I would have had extreme difficulty taking care of the technical issues with music equipment during the therapy.

6 DISCUSSION

The aim of this study was to investigate how group music therapy could be helpful for healthy adult women. The objective was to examine a music therapy group to determine what occurred and how it contributed to the improvement of the members' quality of life.

6.1 About Results

After examining the data, the results, which have been determined are that a group music therapy process can be beneficial for healthy adult women for the purpose of having (1) opportunities for self-discovery and (2) to make connections between their relationships with each other and relationships in their everyday life.

Through this process, each woman is able to develop insights pertaining to her current situation, interactions with others, and ways of behaving in society after embracing creative music experiences. This creativity and spontaneity plays an essential role in constructing the environment for growth and improvement to take place. As Kenny (1985) illustrates, "when we enter the realm of music, and experience the randomness and organic development emerging from the improvisational form, it is possible to find once again the whole deep self and its relationship to others" (pp. 8).

This spontaneous and natural development that Kenny (1985) describes was evident during the process of this case study. As the women established cohesion and became comfortable within the setting, they began to accept each other and be themselves in the group. The music making supported each group member's personal expression and intrapersonal process that lead to their insights and self-actualizing experiences. The music making also supported the development of the group cohesion by providing the group members with a shared experience where they could invest their efforts.

Tina stated in her journal:

> "I think the group worked well, we all felt comfortable with each other and were able to talk about many things quite openly…All in all, I found it really interesting to try to express myself through music and playing, though I found it hard to combine both expressing our feelings and communicating

> with others at the same time… Maybe what I also realized during these sessions was that although I tend to do things in my own way, I'm still quite dependent on the patterns and that applied in general in my life. I think I gained some encouragement to overcome those patterns/rules. I found out that the drums (especially djembe) is my favorite instrument. I'm not sure if I got any big insights, but maybe some tools and new perspectives how to approach things happening in life."

This excerpt illustrates Tina's reflection on her music therapy process and exemplifies how cohesion, challenge, and new understanding were recognized by one of the group members through the music therapy process. First, she acknowledged how she perceived the group members feeling comfortable and able to share things openly. She then identified a challenge she experienced regarding expressing her feelings and communicating with others concurrently. Lastly, she made connections from the therapy to patterns in her behavior outside of the therapy and reported having gained courage to overcome her patterns.

Making connections between the behaviors and relationships exhibited during group music therapy and the behaviors and relationships outside of the therapy is another outcome of this case study. Formulating this connection is supported with the help of the music, the therapists, and the initiative of the clients. First, the group members develop a relationship with music or strengthen a pre-existing relationship, as engaging in music is an enjoyable experience. Through making music with others, safety and trust are promoted and cohesion is developed. In order to continue strengthening the cohesion between the group members, the therapists incorporate interventions during the therapy. These interventions are changed or modified throughout the therapy process depending on the clients' needs during each session. The needs become clear based on the clients' initiative in the therapy such as the identification of individualized and group goals and self-disclosure.

I have realized that this therapy process was non-linear and many of these sections happened concurrently either for a moment or throughout the entire therapy process. I have been able to draw upon different literature and recognize similarities between this case study and other models of music therapy and psychology theory. It has become clear that this therapy aligns with beliefs regarding Amir's (1996) holistic model of music therapy in the way that all systems within the therapy are interconnected. This includes all the individuals in the therapy,

the music, and the relationships between them. I have also recognized how my approach is similar to interpersonal theory for group psychotherapy. Concepts such as acceptance, belonging, support, feedback, universality, and cohesion (Brabender, Smolar, & Fallon, 2004) are all elements, which resonate with beliefs about group psychotherapy. However, not only do I feel these are elements for group psychotherapy, but they are transferable to music therapy, as there have been moments when these elements were apparent and visible within the case.

6.2 Unexpected Findings

In addition to the aforementioned results, there was an unexpected finding. When analyzing the data, I recognized that situations appeared to first happen within the music and then slowly over the course of the process were transferred and connected to the participants' everyday life.

An example of this is the topic of change. Change was discussed 12 times throughout the entire therapy process. Initially when change was discussed during the sessions, it was with respect to the music improvisations. It was reported during session 1 by Isabel that she *"changed*" her music because *"I have problems to stay anywhere, if I start with something I will change."* In session 5 *"change"* was also used to describe the music when Kate stated, *"the pace may change a bit but its kind of familiar all the time" the song never really changed that much but it was constantly changing a bit."* However, in session 6 the references to change began to shift. Within session 6, change was discussed in a more general worldview regarding how human behavior can change in different situations.

Rachel initiated this topic and stated:

> "Its not easy somehow especially because we change and we experience so much and we kind of have these situations where we feel different each time. And sometimes we are not ourselves anymore .So are we bad because of that or are we good because of that?"

It seemed at this point, mental processes were beginning to evoke reflective questions and examination within the group members. This continued further in the following session when Kate expressed her unyielding position toward change.

Kate stated:

> "Situations change but I'm not changing in the situation, so in a way I'm kind of just really honest about myself."

It was later discussed in session 9 that Kate's family moved frequently during her childhood and her *"friends changed constantly."* In this session, the topic of change became directly linked to Kate's past experiences as she described how it has affected her life and ability to establish and maintain relationships. Lastly, Tina discusses a desire to make changes in her life outside of the therapy in session 10.

TABLE 4. This table illustrates the progression of the topic, "change", as discussed above.

Change		
Session:	**Client:**	**Change related to:**
Session 1	Isabel	Music experiences
Session 5	Kate	Music experiences
Session 6	Rachel	General life outside of the therapy
Session 7	Kate	Personal aversion
Session 9	Kate	Personal childhood experiences
Session 10	Tina	Desire to change in present day situation

The above table serves to make the progression of the topic "change" visually clearer in understanding how it evolved from the music to the self. The finding is one, which supports the theory of the therapy context as a microcosm of the client's outside world. However, I was pleasantly surprised that this could also be true with the music specifically. This example can support the perspective that music within music therapy can be "symbolic communication" (Frisch, 1990, pp. 19), which "stands in the intersection between our inner

and outer worlds" (Aigen, 1991, pp. 92). In music making, individuals are able to express their unconscious in a non-intrusive way. Through creating music, the unconscious rises to a state of preconscious, where the clients are invited to verbalize and interpret the music. When processing the music verbally, the musical information existing in the preconscious begins to rise to the conscious where the clients are able to gain greater self-awareness and have an opportunity to make positive change. Ruud (1998) also communicates how music is a way of expressing emotion that may touch upon how people expressed themselves during early life. Then, the verbal discourse and personal reflections concerning the music experience is relevant to strong emotions in one's own life circumstances.

As this was not the discovery I was intending to research, it is one that I did not thoroughly investigate. Therefore, I am unable to say that the pattern described, where things happen in music first and then slowly rise to the conscious, is consistent throughout every instance of this case study. However, it seemed to be a noteworthy occurrence.

6.3 The Methodology

The method I used which lead to the aforementioned results was Qualitative Content Analysis, as discussed in chapter 2. The analysis was completed systematically, conventionally, and inductively. For a large portion of the analyzation phase, I remained close with the data, where all codes were derived right from the exact words the clients used during the sessions. As this was my first time conducting a research study, I proceeded carefully and thoroughly during the analyzation and methodology report.

The challenge I faced was underestimating the massive amount of data I had collected and time necessary to code and re-code the data. I had 12 hours of video footage, which I transcribed during all verbal dialogue. I also had journals from the clients, which I typed and opened with HyperResearch. Since I was coding the data inductively, at first I had an overwhelming number of codes. The codes seemed to be unmanageable because I was viewing every moment of music, discussion, and non-verbal cues as important. It took a great deal of time and focus

to become completely knowledgeable of the data in order to group the codes. HyperResearch helped to tame the overwhelming amount of codes and to maintain organization throughout the analyzation phase. However, I also used manual methods in which I cut out pieces of paper containing each code and subsequently laid them out and moved them around like puzzle pieces. This process was quite tedious but also exciting when I was finally able to formulate groupings and make connections. The thoroughness and variety of data sources helped to strengthen my ability to interpret and gain understanding of the research topic. However, it is possible due to being a novice researcher with massive amounts of data collected, there could have been additional useful information to substantiate my findings. Though, the credibility of my existing concepts was ensured by my supervisor's assistance and by use of data triangulation.

6.4 Limitations

While identifying the results of this research, it was important to also consider the limitations of this study. Although this study produced stimulating results, the actual therapy process was quite short. Had there been more than 12 sessions, there would have been more opportunity to build greater cohesion to aid in more personal disclosure from the members. With more time for the engagement in therapy, there would be increased opportunities for challenges and greater insight to occur. The group size was also quite small, meaning this case study could be difficult to duplicate. On the other hand, larger group sizes might not be conducive to therapy settings. According to Mann (1965), "a number of studies have shown that smaller groups are more efficient and productive than larger ones" (p. 83).

Other limitations consist of audio difficulties and language competency. During session 11 there was audio complications for the first 34 minutes and therefore, a portion of data was lost and not included in the analyzation process. The therapy was also conducted in English while the native languages for the clients were Finnish and Brazilian Portuguese. This could have influenced the word choice of the participants when communicating their thoughts during the sessions. Language competency also leads me to one further limitation, which could have been the combination of both music and verbal discussion in the therapy. This could have

been a limitation because it is not always possible to verbalize every experience or emotion that is evoked through music and on the contrary, it can be difficult to save enough time to verbally process the music experiences when the clients do want or need to speak about the music. As a result, there was a delicate balance needed between music and verbal expression within this case study and at times the balance was unsteady.

6.5 Recommendations

For further research in this paradigm, I would recommend a longer group music therapy process. It would be beneficial to see if and how the process would change and develop further given more sessions. Being that this case study was only concerning healthy adult women, it is also important to examine how music therapy could be utilized with healthy adult men. As a result, researchers would be able to determine potential differences between the genders in therapeutic approaches and arising themes. Also, one step further would be to conduct group music therapy for healthy adults without a gender specification in order to determine if the treatment direction and process is different when the group is unisex.

6.6 Conclusions

Aigen (2005) believes that making music is a beneficial human function in which therapy can exist; therefore, this would suggest that music therapy has implications for working with all people including those who are clinically healthy. Individuals who are seen as healthy and do not have a diagnosis still continue to possess basic human needs and desires of self-improvement, as individuals could always strive to improve personal quality of life. Examples of these needs could be to strengthen relationships, gain greater self-understanding, strengthen identity, and improve self-expression. Broucek (1987) believes that music therapy is an opportunity for "whole-ing", which involves "a creative self, a spirit which embraces the fullness of life" (pp. 57). Aigen (2005) and Broucek's (1987) concepts of music therapy and its capabilities are ones, which resonate with my beliefs of music therapy. Through a creative process, people are able to further develop their self-concept and make connections with

others more effectively (Leite, 2003). However, more specifically, group music therapy is a beneficial way for people to engage in a therapeutic process.

Aigen (1991) states:

> "In a therapy group, musical activity shapes and forms the social environment, as well as transforms and reconstructs our internal selves. Engaging in the therapeutically-guided creation of music facilitates our social and emotional development by creating a field in which diverse entities- such as the constituents of our psyche, the members of a therapy group, the various groups that comprise society- can meet, engage in conflict, and relate in a manner that facilitates the life and functioning of the whole" (pp. 92).

The above quote depicts exactly what has become apparent during this case study. The group members were engaging in a community process but also experiencing their own separate internal processes. Each of the participants were each going through their own process, they were also supporting each other in the group process, as evidenced by words of validation and acceptance of each others thoughts, emotions, and behaviors. Each group member could gain a sense of meaning by helping fellow members. "Each client is the helper, and the helped, the needy, and the needed…everyone has needs, they also learn to help each other" (Ahonen-Eerikäinen, 2007, pp. 28).

This case study also provided me with an indescribable learning experience. I gained a unique and valuable clinical experience working with this target group, which I had never had before. I also feel that I grew a great deal during the process, as a result of my constant self-reflection about the experience of co-leading and maintaining two roles simultaneously. However, the most important information I obtained was creative music making could be beneficial for all people because the quintessence of music therapy is endless.

REFERENCES

Ahonen, H. & Houde, M. (2009). Something in the Air: Journeys of Self-Actualization in Musical Improvisation. *Voices: A World Forum for Music Therapy, 9*(2).

Ahonen-Eerikäinen, H. (2007). *Group Analytical Music Therapy.* Gilsum, NH: Barcelona Publishers.

Aigen, K. (1993). The Music Therapist as Qualitative Researcher. *Music Therapy, 12*(1), 16-39.

Aigen, K. (1991). The Voice of the Forest: A Conception of Music for Music Therapy. *Music Therapy, 10*(1), 77-98.

Aigen, K. (2005). *Music-Centered Music Therapy*. Gilsum, NH: Barcelona Publishers.

Aldridge, D. (2005). *Case Studies in Music Therapy.* London: Jessica Kingsley Publishers.

Amir, D. (1996). Music Therapy-Holistic Model. *Music Therapy, 14*(1), 44-60.

Amir, D. (1993). Moments of Insight in the Music Therapy. *Music Therapy, 12*(1), 85-100.

Austin, D. S. & Dvorkin, J.M. (1998). Resistance in Individual Music Therapy. In K. Bruscia (Ed.), *The Dynamics of Music Psychotherapy* (pp. 121-135). Gilsum, NH: Barcelona Publishers.

Barrett-Lennard, G. T. (1998). *Carl Rodgers' Helping System: Journey and Substance.* London, GBR: Sage Publications.

Brabender, V., Smolar, A. I., & Fallon, A. E. (2004). *Essentials of Group Therapy.* Hoboken, NJ: Wiley.

Brandalise, A. (2004). Music Therapy: The Use of Music for Healing. *Voices: A World Forum for Music Therapy, 4*(1).

Broucek, M. (1987). Beyond Healing to "Whole-ing": A Voice for the Deinstitutionalization of Music Therapy. *Music Therapy, 6*(2), 50-58.

Bruscia, K. (1998). *Defining Music Therapy*. Gilsum, NH: Barcelona Publishers.

Bruscia, K. (1998). *The Dynamics of Music Psychotherapy.* Gilsum, NH: Barcelona Publishers.

Cohen, N. S. (1994). Speech and Song: Implications for Therapy [Abstract]. *Music Therapy Perspectives, 12*(1), 8-14.

Dies, R. R. (2003). Group Psychotherapies. In A. S. Gurman & S. B. Messer (Eds.), *Essential Psychotherapies: Theory and Practice* (515-550). New York, NY: The Guilford Press.

Earley, J. (2000). *Interactive Group Therapy: Integrating, Interpersonal, Action-Oriented and Psychodynamic Approaches.* USA: Taylor and Francis Group.

Elo S. & Kyngas, H., (2008). The qualitative content analysis process. *Journal of Advanced Nursing 62*(1), 107–115 doi: 10.1111/j.1365-2648.2007.04569.x

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K. & Kyngäs, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open, 4*, 1-10. doi: 10.1177/2158244014522633

Erkkilä, J. (2004). From Signs to Symbols, from Symbols to Words. *Voices: A World Forum for Music Therapy, 4*(2).

Frisch, A. Symbol and Structure: Music Therapy for the Adolescent Psychiatric Inpatient. *Music Therapy, 9*(1), 16-34.

Ghetti, C. (2011). Active Music Engagement with Emotional-Approach Coping to Improve Well-being in Liver and Kidney Transplant Recipients. *Journal of Music Therapy, 48*(4), 463-485.

Grocke, D. (2009a). The Effect of Group Music Therapy on Quality of Life for Participants Living with a Severe and Enduring Mental Illness. *Journal of Music Therapy, 46*(2), 90-104.

Grocke, D. (2009b). Music Therapy Research and the Mental Health- Well-being Continuum. *The Australian Journal of Music Therapy, 20,* 6-15.

Hillard, R. E. (2003). The Effects of Music Therapy on Quality and Length of Life of people Diagnosed with Terminal Cancer. *Journal of Music Therapy, 40*(2), 113-137.

Hsieh, H. F. & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research, 15*, 1277-1288. doi: 10.1177/1049732305276687

Hussein, A. (2009). The use of Triangulation in Social Sciences Research: Can qualitative and quantitative methods be combined? *Journal of Comparative Social Work, 1*, 1-12. Retrieved from http://jcsw.no/local/media/jcsw/docs/jcsw_issue_2009_1_8_article.pdf

Katsh, S. & Merle-Fishman, C. (1995). *The Music Within You*. Gilsum, NH: Barcelona Publishers.

Kowalik, Z., Schiepek, G., Kumpf, K., Roberts, L. & Elbert, T. (1997) Psychotherapy as A Chaotic Process II. The Application of Nonlinear Analysis Methods on Quasi Time Series of the Client-Therapist Interaction: A Nonstationary Approach, *Psychotherapy Research, 7*(3), 197-218, doi: 10.1080/10503309712331331973

Laukka, P. (2007). Uses of Music and Psychological Well-being Among the Elderly. *Journal of Happiness Studies, 8,* 215-241.

Leite, T. (2003). Music, Metaphor, and "Being with the Other". *Voices: A World Forum for Music Therapy, 3*(2).

Lipe, A. W. (1991). Using Music Therapy to Enhance the Quality of Life in a Client with Alzheimer's Dementia: A Case Study [Abstract]. *Music Therapy Perspectives, 9*(1), 102-105.

Mann, J. (1965). *Changing Human Behavior.* New York, NY: Charles Scribner's Sons. Groups.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review, 50*(4), 370-396.

McFerran, K. & Wigram, T. (2007). A Review of Current Practice in Group Music Therapy Improvisations. *Voices: A World Forum for Music Therapy, 7*(2).

O'Callaghan, C. (1999). Recent Findings About Neural Correlates of Music Pertinent to Music Therapy Across the Lifespan [Abstract]. *Music Therapy Perspectives, 17*(1), 32-36.

Pavlicevic, M. (2003). *Groups in Music: Strategies from Music Therapy.* London, UK: Jessica Kingsley Publishers Ltd.

Rolvsjord, R. (2004). Therapy as Empowerment: Clinical and Political Implications of Empowerment Philosophy in Mental Health Practises of Music Therapy. *Nordic Journal of Music Therapy, 13*(2), 99-111.

Rolvsjord, R. (2006). Therapy as Empowerment. *Voices: A World Forum for Music Therapy, 6*(3).

Ruud, E. (1998). *Music Therapy: Improvisation, Communication, and Culture.* Gilsum, NH: Barcelona Publishers.

Ruud, E. (1997). Music and the Quality of Life. *Nordic Journal of Music Therapy, 6*(2), 86-97.

Schreier, M. (2012). *Qualitative Content Analysis in Practice.* London, GBR: SAGE Publications Ltd.

Shoemark, H. (2009). Music Therapy as an Exercise in Humanity. *The Australian Journal, 20,* 31-44.

Tennant, M. (1997). *Psychology and Adult Learning.* London, GBR: Routledge.

Teyber, E. & McClure, F. H. (2011). *Interpersonal Process in Therapy: An Integrative Model.* (6th ed.). San Bernardino, CA: Brooks/Cole Cengage Learning.

Vanderark, S., Newman, I., & Bell, S. (1983). The Effects of Music Participant on Quality of Life of the Elderly. *Music Therapy, 3*(1), 71-81.

Walworth, D., Rumana, C., Nguyen, J., & Jarred, J. (2008). Effects of Live Music Therapy Sessions on Quality of Life Indicators, Medications Administered and Hospital Length of Stay for Patients Undergoing Elective Surgical Procedures for Brain. *Journal of Music Therapy, 45*(3), 349-359.

Wigram, T., Pedersen, I.N.B., & Bonde, L. (2002). *Comprehensive Guide to Music Therapy: Theory, Clinical Practice, Research and Training.* Philadelphia, PA: Jessica Kingsley Publishers.

Wood, J. C. & Wood, M. (2008). *Therapy 101: A Brief Look at Modern Psychotherapy Techniques and How They Can Help.* Oakland, CA: New Harbinger Publications.

Yeasmin, S. & Rahman, K.F. (2012). 'Triangulation' Research Method as the Tool of Social Science Research. *BUP JOURNAL, 1*(1), 154-163. Retrieved from http://www.bup.edu.bd/journal/154-163.pdf