**Exploring the Role of Music Therapy in Attachment, Identity & Creativity:
A Case Study**

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Music therapy has been implemented within healthcare to treat individual's suffering from various forms of illness today. Music and the creative process are a fundamental component human life, bringing order to inner chaos and understanding to our human experience. However the intricacies of the creative process within clinical music therapy often leaves many questions unanswered and its tangible effects often remain illusive to those outside of the therapeutic process.

This case aims to illustrate the unique music therapy process of Mary, a young woman suffering from emotional, identity and attachment problems. This case also seeks to document and explore how the therapeutic relationship and the music were used in bring forth therapeutic change. The therapeutic process was conceptualised and previous literature was applied in order to explain and provide new insight into the therapeutic process. This case has the potential to further thinking if how music therapy can be used with clients suffering from emotional, identity and/or attachment disorders.

This study was conducted within a clinical context during the Fall of 2015. The client attended twelve weeks of music therapy while each session was recorded on video. Video recordings, the therapist's notes and the client's post therapy reflection were used as primary sources of data for the analysis. An inductive qualitative case study approach was implemented, as the IPA case study method was used as a methodological basis for the data analysis.

This case study demonstrated how the therapeutic relationship might be used as a facilitator for the process and in the provision of a secure base and attachment relationship. Furthermore the role of music was studied extensively and concluded that music may be used a powerful tool for symbolising pain, building the therapeutic relationship, facilitating emotional expression and empowering an increased sense of identity.

Säilytyspaikka – Depository	

Muita tietoja – Additional information

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"My heart is confident in you, O God!

I will sing and make melody with all my being!

Awake, O harp and lyre!

I will awake the dawn with song.

I will give thanks to you, O Lord, among the peoples;

I will sing praise to you among the nations.

For your steadfast love is higher than the heavens.

Your faithfulness reaches to the clouds.

Be exalted, O God, above the heavens!

Let your glory be over all the earth!

Psalm 108:1-5

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1   INTRODUCTION

> Music…will help dissolve your perplexities and purify your character and sensibilities, and in time of care and sorrow, will keep a fountain of joy alive in you. – Dietrich Bonhoeffer (Gould, 2016).

Music remains a mystery to many of us, yet as the Theologian Bonhoeffer proclaims, music is an endless source created for our enjoyment with the capacity to refine us and keep us alive even in the darkest of times. This study is therefore an attempt to document and further our knowledge of how music can bring healing, empowerment and restoration to our lives. Music therapist's rest on the belief that music lies at the heart of life and can be used to support and facilitate our physical, mental, social, emotional and spiritual well-being (Bunt, 2014). It is exactly these principles that motivate us and guide us as we work with clients, seeking to bring music's unique capacities to the lives of individuals. I hope through this study to convey a vignette of the influence of music on man.

This was my client's first experience of music therapy. After years of psychotherapeutic treatment Mary[1] was delighted to be informed that she had been accepted for music therapy from the music therapy department in Jyvaskyla. Throughout this study I wish to document and investigate the story of Mary, her music therapy journey and growth throughout the therapeutic encounter. Although diagnosis wasn't specified or emphasised at any stage of the process, the description provided within her application[2] provided a partial insight into her rationale and need for therapy. It was consequently clear from the description provided that Mary came to music therapy seeking help with various aspects of her life including anxiety, sleep problems and emotional expression. As a young woman of 28 years, who had received psychotherapy treatment from her mid-teens, we met and began our music therapy journey together. Mary came to the clinic weekly for twelve weeks and this is her story.

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[1] For the sake of this research I have substituted the client's real name to retain upmost confidentiality.
[2] See Appendix B.

2   RESEARCH RATIONALE

The rationale behind this study lies in the process's rich nature and Mary's substantial progress made over the twelve-week intervention. This case was therefore rendered highly worthy of study by my professors and was encouraged as a suitable avenue for research and documentation. Such findings also have the potential to expand knowledge of how music therapy can be used to work with clients suffering from issues such as attachment disorder, anxiety, identity problems and emotional expression. Additionally upon reviewing the literature, very little research has been conducted exploring the relationship between music therapy and attachment theory. Therefore I also hope through this study to investigate new territory between attachment theory and music therapy. Through meticulous analysis of the therapy content I wish to illustrate Mary's idiosyncratic journey with the potential of furthering understanding of music therapy and the processes therein.

Due to my stance as an active researcher, one therapist engaged both in the therapeutic work and research, this allowed me to convey my own subjective experience regarding the process as a therapist throughout. Although at times this presented certain limitations, allowing the potential for bias to occur. However it has been concluded for the purpose of this research that such an approach allowed for a rich and meaningful account of the case, in spite of the limitations. In addition key concepts were identified inductively within this study shall be discussed extensively in later chapters. Such concepts arose naturally throughout the therapeutic process, data analysis and from my personal therapeutic stance and working theoretical framework. What is more, this research also aims to provide insight into the realm of music therapy with clients suffering from identity and/or attachment disorders. As a recent profession, one still in the process of becoming (Bruscia, 1998a), music therapy research still remains on the fringes of psychotherapeutic work. Hopefully this case study shall pave the way for further, perhaps more rigorous scientific studies into this specific area.

3   KEY CONCEPTS

3.1   Music Therapy

Music therapy is a professionalised contemporary form of holistic care (Alvin, 2003; Bunt, 2014; Darnley-Smith, 2003), one that is currently implemented within a variety of settings for an array of purposes within healthcare today (Bunt & Hoskyns, 2002). Due to the flexible and contemporary nature of the profession, a comprehensive definition of music therapy is often hard to obtain and is still in motion (Bruscia, 1998). Yet, there are core fundamental definitions shared between practitioners across various settings. Therefore, in this chapter I shall briefly outline relevant definitions of music therapy, discuss current frameworks of thought underpinning the work of music therapists, and finally seek explain how music therapy can help clients.

3.1.1   What Is Music Therapy?

Human beings are innately musical beings (Darnley-Smith, 2003). As a result we cannot dissect music from human life and in particular, health. However to many the connection between art and health remains ambiguous and therefore one may fail to see music therapy's potential within healthcare. In spite of this music therapy is slowly educating the world around it of its unique approach and is slowly creeping into the conscious of the general public (Bunt & Hoskyns, 2002). Music therapy began as a form of care highly influenced by psychoanalysis and still draws heavily from psychotherapeutic thought (Bunt & Koskyns, 2002). Psychotherapy has been referred to as a particular process bringing change away from dysfunctional or maladaptive feelings, values, attitudes or behaviours through informed and meaningful techniques (Messer & Gurman, 2003, p. 4). In light of this, we can conclude the goal of therapy is to promote health (Bruscia, 1998a) and in particular, music therapy has been deemed to be a means of promoting health through the "controlled use" (Alvin, 2003, p. 38) of music. Here we must begin as our starting point of inquiry; music therapy is here to help and to bring change to people's lives. This is the foundation of music therapy work.

Nevertheless in spite of the profession's concrete roots in psychotherapy, music therapy often faces the critical question; how is music therapy defined? Furthermore, what constitutes *'music therapy'* and how does this manifest within clinical work? In light of this Kenneth Bruscia published a book in 1998 called "Defining Music Therapy" which discusses and portrays a series of articulated arguments and ideas concerning the definition of music therapy. Bruscia (1998a, p. 20) defined music therapy as follows,

> Music therapy is 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 dynamic forces of change.

Within such a definition we are introduced three fundamental aspects of music therapy. Firstly, music therapy is a *systematic process*, involving time, thought and the use of relevant interventions, leading to the promotion of health. Secondly, there is a *relationship* between client and therapist that characterises the setting of the process stated above. Thus music therapy requires a specified relationship between client and therapist. Thirdly, *musical experiences,* and the relationship(s) created through them are at the heart of the work. One further definition of music therapy defines it as, "…the used of organised sound and music within an evolving relationship between client and therapist to support and encourage physical, mental, social, emotional and spiritual well-being" (Bunt, 2014, p. 8). The importance of the relationship as a crucial context for music therapy to occur and its holistic nature is reiterated here, with music remaining an indispensable component. Thus we can conclude that music therapy must consist of a relationship between a therapist and client involving the creation and/or use of music. It is also stated that the uniqueness of music therapy interventions arises from its inherent focus on "…sound, beauty and creativity (Bruscia, 1998a, p. 21)." Art, beauty and the creative process are also decisive components of music therapy, ones that shall be addressed in subsequent chapters.

3.1.2   Philosophy of Music Therapy

Music therapist's work from many theoretical understandings that are more often implicitly implied yet rarely articulated. In spite of this various author's have considered the connection between music, creativity and health and have sought to conceptualise the philosophy of art and creativity. Storr (1997) asserts how no culture yet discovered lacks music and it avowed that through music, man has found an outlet for expression and to extinguish creative

impulses (Denham, 1997). What is more, music has been documented to affect an infinite number of factors psychologically, physiologically and socially (Denham, 1997), encompassing *all* of our emotions and musical expression itself is noted to touch some of our most basic forces of human experiences (Alvin, 2003). Consequently, music remains an intrinsic part of being human, an inherent creative medium ultimately forming relationships with man.

As a result we can begin to uncover how music may be beneficial within a therapeutic context and health in general. However, how exactly is musically expression linked to well being? And how does creativity unlock such potential? Theories of artistic expression strive towards illuminating how, why and to what avail, we as human beings engaged in creative activity and more so, in the act of "musicking" (Small, 1998). McNiff pertains that art provides order by expressing the chaos that lies within (McNiff, 1981, vii). Such a view regards art as a means of comprehending and bringing order to our human experience. Such a transcendental view is reiterated by the philosopher Nietzsche (1968) who believed that art was an end in of itself, a great stimulus to life and a metaphysical transcendence supporting, maintaining, affirming and enhancing life. In light of this Storr (1997, p. 168), influenced by Nietzsche, concluded that music, "…exalts life, enhances life, and gives it meaning … music is a source of reconciliation, exhilaration, and hope which never fails." Therefore it is evident that by engaging in artistic activity, life and our human experience is somehow brought into order and has the potential to benefit human life. Ruud (1986) affirms such a conclusion by stating that art is a way of understanding our reality and by engaging in artistic activity we come to see and learn things otherwise not understood. Herein lies the cornerstone of thought when approaching music therapy. Music therapists believe that humans are "inherently musical beings" (Darnley-Smith, 2003, p. 5) and therefore art and music cannot remain on the fringes of society and healthcare but must become a central component in how we view and treat each other.

3.1.3 Improvisation, Art & Health

Therefore as we approach the practicalities and frameworks of music therapy we must subsequently view the work with the above in mind; music can exalt reality, transform experiences through the creative process and is a fundamental part of our very nature. Aigen

(2007, 1995) relates this to clinical work within music therapy and concludes that music's aesthetic qualities are not a means towards an end but have meaning within the process, providing a medium for interpersonal, emotional and aesthetic experiences of clinical value. Within one notable case of an elderly lady in expressive art therapy, it is documented how the art process provided her with a non-verbal medium of expressing her emotions of hopelessness, helplessness, loneliness, isolation, emptiness, sadness and depression (Kim, 2010). Here, art therapy provided this individual with a way of accessing painful emotions, allowing her to transform and process them through the creative process (Kim, 2010.). This is an incredible facet of the creative process and one that often defines interventions within music therapy; art has the power to transform and re-create our experiences and perceptions, particular in overcoming pain.

Consequently within music therapy musical improvisation is used as a form of art making and communication, existing as fundamental component of the work (Wigram, 2004). Bunt & Hoskyns (2002, p. 49) describe improvisation as one of the three fundamental "I's" of the profession. At the core of it's implementation lies a belief regard that music creations can ultimately reflect personality, be used as a tool for communication and represent symbolic images (Wigram, Pedersen & Bonde, 2004). Alridge (2003) reiterates this as he affirms how within music therapy there is an established view regarding humans as intrinsically communicative beings. As humans we communicate and one-way of communicating is through music. Therefore the music therapist seeks to make the best possible interpersonal music that is intensely personal, authentic and unconstrained by 'musical' or 'artistic' qualities in order to bring about a highly inter-subjective emotional relationship between client and therapist (Pavilcevic, 2000). The focus is on intimacy, relating and non-verbal communication, one likened to the relationship between mother and child (Pavlicevic, 2000).

Conclusively musical improvisation seeks to establish, maintain and deepen the therapeutic relationship through the medium of music; a medium that reaches into a mans soul, rendering him powerless against it's influence (Alvin, 2002). Furthermore music allows one the opportunity of a new way of relation to the world and being in the world (Trondalen, 2008) and can be used as a means of performing ones personal identity (Ruud, 1997). Musical improvisation may therefore also help clients to construct, renegotiate and strengthen ones identity. As music is one of the most powerful yet mysterious forms of communication we

have as humans' beings, music must be viewed as an incredibly powerful and deeply human facet of therapeutic work. In relation to the case, musical improvisation and creative processes were used to explore Mary's psyche/identity, build the therapeutic relationship and as a tool for emotional expression. This was a critical part of our work together and such a philosophical approach of creativity and health defined my therapeutic thinking and interventions made throughout the process.

3.1.4 The Therapeutic Relationship in Music Therapy

The development of the relationship between therapist and client – one characterised by support, reassurance, persuasion and active coping – is foundational, with the working on towards agreed goals as the aim (Bruscia, 1998a). Such collaboration between therapist and client has been defined as the *working* or *therapeutic alliance* (Messer & Gurman, 2003) and it is within such a collaboration that change is sought to occur. Relationships are crucial for the development of the self, relating to others, and the world around us – "…The essential ingredient of any therapeutic relationship is seemingly in the meeting of two souls" (Bunt & Hoskyns, 2002, p. 35). Therefore the connection between two individuals is essential within an effective therapeutic relationship. Regardless of theoretical orientation, clients must feel that their therapist's are there for them, valued and above all, heard. As we introduce the concept of music, one can begin to see how music, one of the most ambiguous yet powerful forms of expression and/or communication, may have the potential to be used to great effect within psychotherapy - a healing process involving the meeting of two individuals.

It is stated that music therapy is fundamentally concerned with *relationship* and connection with another (Pavlicevic, 2002). Yet the relationship established between people – namely client and therapist – is only one side of music's capacity to connect. One of the founders of music therapy Juliette Alvin states how music therapy exists on the relationships that music intrinsically creates with man (Alvin, 2002). This leads us onto a pivotally unique aspect of music therapy; music creates a relationship between itself and man. Therefore in comparison to other forms of therapy and/or psychotherapy, music therapy may provide an alternate entity within the therapeutic relationship, one that shall be addressed in following chapters. In light of this Bruscia affirms how music therapy contains three dynamic elements: the client, the relationship and the music. The music and therapist are compared to that of a parent, both

working together to help their child, both with the capacity of serving as a source, activator and object for transference and counter-transference, and in providing space and support within the triadic relationship (Bruscia, 1998b, p. 76). Therefore the music not only exists as a mere activity or a tool, rather the music takes on a predominant role of it's own, providing a third entity within the therapeutic relationship. The therapist and client are no longer alone with each other, they experience and share the music together, at times using the music as a safe place and an alternative resource throughout the process.

3.2   Person Centered Therapy

It was throughout my first year of music therapy studies when I began to develop my own therapeutic stance and discovered Carl Roger's framework of person (or client)-centered therapy (PCT). Despite the fact many of the other popular therapeutic frameworks have greatly influenced my thinking, the empathic approach and emphasis on the client and their empowerment drew me again and again towards person-centered therapy. As my experience as a therapist grew over the course of the internship, I also realised how my personal approach towards therapy shared many qualities and ways of thinking found within the work of Carl Roger's. Although there are certain aspects of PCT that I do not agree with, and my therapeutic approach remains wholeheartedly eclectic, certain aspects of PCT influenced me greatly and have defined my therapeutic stance. During the process of this case study, particular characteristics of therapy illustrated in PCT came to life within the therapy and directly influenced many of my decisions as a therapist throughout the process. I shall now exemplify core aspects of PCT in this chapter and how this approach was highly relevant throughout this case and my approach as a therapist.

3.2.1   Understanding PCT

The most important and exclusive aspect of PCT is its view and regard of the client – emphasised notably by its title. PCT regards humans and their psychological state as one existing in a state of fluidity, changing over time and adapting constantly to the environment and the individual's experience from life (Bohart, 2003). Nonetheless forces that precipitate growth and allow for healthy adaption throughout one's life are stated to exist within almost every individual (Bohart, 2003). This bears significant implications within therapy as person-

centered therapists now rely fully on forces within the client; the client's capacity for growth is now positioned centrally. As Rogers (1951, p. 418) illustrates:

> He [the therapist] has learned that the constructive forces in the individual can be trusted, and that the more deeply they are relied upon the more deeply they are released … the client knows the areas of concern which he is ready to explore; that the client is the best judge as to the most desirable frequency of interviews; that the client can lead the way more efficiently that the therapist into deeper concerns....

The client is essentially trusted, regarded and accepted as capable of directing and leading the therapy into areas that *they* deem to be important and most beneficial. This stands in clear contrast to other forms of therapy and has received severe scrutiny from many within psychotherapy (Rogers, 1951). Despite the fact that other therapies may place partial trust in the client at times, therapists still remain the expert in the client's world and seem somewhat unwilling to give control and trust onto the client (Rogers, 1951). Thus PCT stands aloof to other therapeutic viewpoints by implementing a non-directive approach. The therapist's goal is seen primarily to be, "a companion on the client's journey of self-discovery" (Bogart, 2003, p119). Emphasis no longer lies on the therapist and in their ability to solve problems, rather importance is placed on the client, their capacity for growth and the relationship between. The client is trusted and viewed with the capacity for growth and self-actualisation.

3.2.2 "Favorable Conditions"

Roger's places one fundamental condition for change and for the full potential of the client to be realised. The aim of therapist is no longer to provide analysis or to lead the client but rather to provide "…necessary and sufficient therapeutic conditions of congruence, unconditional positive regard, and empathic understanding" (Tan, 2011, p. 134).[3] Moreover such "optimal conditions" (Bohart, 2003, p. 120) are said to impart a safe atmosphere, one where the client's innate capacity for growth may flourish. Emphasis is placed on *being with* the client and in maintaining a strong therapeutic relationship. Certain conditions for constructive change to occur are asserted as follows; two individuals in psychological contact; the expression of *unconditional positive regard* from the therapist; the therapist experiences understanding of the client's inner world and expresses this within the relationship; and empathic concern and understanding is communicated somewhat to the client (Tan, 2011, p. 135). The remains the most important aspect of PCT, it's ability to bring forth change and is crucial in understanding

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[3] Three core characteristics of the "favorable conditions" are detailed in 3.2.3

the person-centered approach, "…only one condition is necessary for all these forces to be released, and that is the proper psychological atmosphere between client and therapist" (Rogers, 1951, p. 420). Change now arises from insights stemming from the client and in the client's leading of the therapeutic process, facilitated purely through the favourable conditions created and maintained by the therapist.

3.2.3   Three Core Aspects of PCT's "Favorable Conditions"

As stated above the stance and provision of the therapist in providing necessary conditions are a crucial component of PCT. Three aspects of the favourable conditions and therapeutic relationship are notable defined and affirmed as primary conditions in forming a good therapeutic relationship: unconditional positive regard, empathy and genuineness/congruence. Unconditional positive regard has been referred to as acceptance, warmth or respect but is defined as a non-possessive deep and real caring for the client that is non-judgmental and positive (Tan, 2011, p. 136). However unconditional positive regard remains as an ideal, no therapist can retain this at all times, and does not mean the support/acceptance of dysfunctional behaviour (Bohart, 2003). Rather the therapist is called to assert a strict dichotomy between the client as a person and the client's behaviour (Bohart, 2003). Through showing such acceptance it is noted that clients may begin to feel safe to explore their experience, distinguish their intrinsic worth aside from dysfunctional behaviours and enhance their own unconditional self-regard (Bohart, 2003; Tan, 2011). Furthermore empathy refers to the therapists' ability to enter deeply into the client's subjective reality, identifying with it and feeling *with* the client their subjective experiences as far as possible (Tan, 2011).

> "...empathy allows the therapist to gather information about the world the patient lives in and to use the information to build connectedness with the patient" (Cohen and Sherwood, 1991, p220).

This reiterates PCT's emphasis on being with and acknowledging the client, including their emotions, experiences and attitudes. Within PCT, what better way to accept and validate someone's feelings than by feeling it with them and conveying such empathy? Bohart (2003) proposes that perhaps the feeling of being known is intrinsically therapeutic and through empathy we remind the client that they are not alone. Empathy may also help the client to achieve a deeper understanding of their reality through the identification of another (Tan, 2011).

Finally, empathy is regarded as being more than merely responding to the client's feelings and entering their emotional world, it is also requires an understanding of the individual's goals, intentions and values (Watson, 2002). Empathy therefore builds and strengthens the relationship with the client whilst also allowing the client to feel understood and see their experiences through the lens of another. Thirdly genuineness or congruence describes the therapist's ability to retain authenticity and be him or herself within therapy (Bogart, 2003). Such a therapist remains real, open, and transparent, allowing for the use of appropriate self-disclosure and expression of their positive and/or negative emotions throughout (Tan, 2011). Thus genuineness is viewed as essential, as authenticity on behalf of the therapist begets authenticity from the client. The therapist has a defined role to play in facilitating the therapeutic conditions but also in setting the tone and atmosphere of the therapy, therefore by showing a degree of authenticity from the therapist the client is also encouraged to become *real* within therapy.

3.2.4   Person Centered Therapy & Creativity

Clinicians have recently combined the approach of person-centered therapy with the arts, and more specifically, the creative therapies. It is important to note that Carl Roger's (1967) and more recently his daughter Natalie Roger's (1993), acknowledged the importance of creativity, not only in life, but also in the therapy room and human development. PCT affirms how the arts are essential to creativity, long-life learning and nourishing the soul. Creativity is viewed as a key ingredient in everyday life, as individuals are confronted with continuously exploring, leaning and applying new ways of being in relation to the past and experiences (Bohart, 2003). Likewise expressive arts are stated to facilitate a process of self-discovery that furthers emotional fullness and personal insight (Rogers, Tudor, Tudor & Keemar, 2012). Consequently we can draw a parallel between the role of creativity within person-centered therapy and creativity among the arts. Moreover PCT regards communication between individuals, experience and feelings, as crucially important in life and therapy for individuals as sources of information (Bohart, 2003). A focus on ones experience and emotions are held in high regard as they facilitate the development of a relationship between oneself and the world, allowing for a creative adjustment of oneself and how they relate to the world around them (Bohart, 2003).

Therefore PCT and the creative therapies share a common understanding of experience and how creativity activity can enhance and facilitate ones understanding of the self and the world around them. Thus PCT is highly applicable to music therapy; a form of care that wholly embraces the benefits of creative expression and affirms the powerful nature of creativity to bring meaning out of illness, relief from suffering, restoration of identity, empowerment and finding meaning in difficult situations (Aldridge, 2003). Such creative expression with music therapy allows individuals to gain insight – a significant component of PCT – without the fear of expressing such truths verbally (Kim, 2010). Natalie Roger's (1998, p. 115) understood this and the power of expressing oneself through creative avenues:

> Our art speaks back to us if we take the time to listen to those messages.

In addition Roger's asserts how one of the best ways to approach our unconscious is through various art forms (1993). Art is a process of discovery, uncovering our unconscious, allowing to view ones experience through an alternative lens, leading to a better understand of oneself to deal with harmful or painful negative experiences (Kim, 2010).

Concluding, the person-centered approach acknowledges the power of creativity throughout life in facilitating communication, self-understanding and personal development. Therefore within music therapy a person-centered approach remains highly suitable, as the focus is placed on the creative process and understanding of the individual. As aforementioned, providing the favourable conditions for the client to flourish are at the core of the person-centered approach. However to reach a state of *creativity* which allows for such expression to occur favourable conditions are encouraged for one to reach this sate. Roger's (1967) presents two conditions that foster creativity; psychological safety – defined by acceptance, non-critical stance and understanding – and psychological/symbolic freedom. Again, it is the responsibility of the therapist to facilitate these conditions throughout. Within the creative therapies this means placing an emphasis on process over product and deriving the meanings of artistic products from ownership, expression and communication rather than aesthetic judgment (Kim, 2010). The therapist consequently attempts to provide a non-judgemental, artistic environment for the client to reach a state of creativity, allowing for emotional integration and transformation through art.

3.3 The Therapeutic Relationship

Within Bruscia's definition of music therapy and person-centered therapy, the *relationship* established and maintained between client and therapist plays an indispensable role within the therapy process, and thus therapeutic outcome. Accordingly I shall briefly discuss the relationship, explaining its role within music therapy.

Wampold (2001) states that the relationship between client and therapist may be more powerful than that of any particular intervention. The relationship between client and therapist is a fundamental foundation shared by most psychotherapies (Wampold, 2001, p. 37), and the term *therapeutic relationship or alliance* stems from Freud (1940); refering to a working union between client and therapist and the strength and quality of such a collaboration (Wampold, 2001). Therefore the therapeutic relationship much be considered as a principal component of therapeutic work. In addition, relational psychotherapy asserts how an intense relationship is an essential part of change (Curtis & Hirsch, 2003, p. 87). Within such an approach the relationship between client and therapist is deemed mutual but not asymmetrical (Aron, 1996). Meaning, that the subjectivity and uniqueness of therapist and client remain throughout the process, in recognising each other and showing empathy, yet the therapist still remains within a *therapist* role at all times. How the therapist feels, counter transference, and how the client feels towards the therapist, transference, much be paid attention to and can be used as a source of data for the therapist in understanding the client (Wolstein, 1975). Additionally, within the relationship it is important for clients to feel safe and accepted, prompting a collaboration as two fellow humans beings (Messer & Gurman, 2003). A good relationship is core to everything else that happens in therapist and particularly in regards to the client's capacity to self-reflect. As a result, the function of the relationship provides a safe and secure context for the client; acting as a catalyst for self-reflection from the client, whilst allowing for a deeper understanding between therapist and client.

By extension Wolitzky (2003) suggests ways in which the therapeutic alliance can be fostered. Such as follows; though listening empathically without judgment; managing counter-transference; explaining rationale and framework; respecting patients uniqueness, integrity and autonomy; encouraging exploration; being un-dogmatic; being humble, personally and intellectually; displaying forgiveness and sympathy; and by becoming partners

with the client. Additionally the interpersonal skills of the client greatly impact the therapeutic relationship. It is stated that the therapists' ability to understand and appreciate the client's inner world, seeing life from their eyes, is directly linked to the alliance (Wampold, 2001). Moreover Roger's asserts how the creation of a correct "psychological atmosphere"[4], characterised by warmth, understanding, safety and a strong senses of communication are predominant characteristics of a successful therapeutic relationship (Rogers, 1951, p. 220). It is the client's session and it is the therapists'' task to keep it so (Rogers, 1951). Still such qualities are not only found with person-centered approaches but also within music therapy. Bunt & Hoskyns (2002) assert how in music therapy the most fundamental role of the therapist is to *be with* the client. This is termed therapeutic presence and has been defined as, "…the quality of attention and listening given to patients who need to feel that their every communication is valued and really heard, features that go beyond any particular clinical orientation" (Bunt & Hoskyns, 2002, p. 37). Such a concept is related deeply the therapeutic alliance and acts as a prerequisite for positive therapeutic change and/or a deepening of relationship between client and therapist.

> The important thing is not our flowery language, but rather that we are fully present and attentive to our companion (Muller, 1996, p. 117).

3.4   Containment & Holding

A further aspect of the "therapeutic alliance" and a concept related to the supporting role of the therapist, is termed "holding" (Winicott, 1965) or "containment" (Bion, 1962). A strong holding/containing environment is associated with the client feeling understood and may beget an emotionally meaningful insight (Wolitzky, 2005). Such terms express a parallel between the work of a mother with a child – providing safety and an environment for emotional expression – and the work of a therapist, helping a client to work through their emotions with a reflecting therapist, one containing and reflecting their own emotional experience (Finlay, 2015). One definition of therapeutic containment is as follows,

> [Containment is a]… powerfully felt, active and interactive process which involves a process of shedding and projecting what are felt to be damaged, frightening or undated parts of the self for psychosomatic containment inside another (Miller-Pietroni, 1999, p. 410).

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[4] See 'Favorable Conditions" 3.2.2

The therapist seeks to contain projected aspects of the clients self, allowing for the client to reveal aspects of himself or herself needed for therapeutic insight and growth. Such a process is labelled as physic digestion on the part of the therapist, by chewing, digesting and thus discarding aspects that are psychologically harmful and keeping those that are useful (Miller-Pietroni, 1999). Moreover the importance of the therapists' ability to contain the client is deemed vital to the client's mental survival and development (Miller-Pietroni, 1999). Therefore, the work of the therapist in providing the necessary ability to contain and maintaining such an environment is fundamental within therapeutic work and shares similarities with important aspects of therapy illustrated within the "favourable conditions" of person-centered therapy and the fostering of the therapeutic alliance.

In light of this, clinicians have applied Bion's theory of containment within the use of music therapy. The music with music therapy offers a new opportunity for the client to project through improvisational music, a non-evasive and subjective medium, as the therapist creates a musical environment, containing, binding and shaping the chaotic expression of the client (De Backer, 1993). De Backer (1993) addresses the accompaniment of the music therapist as a musical skin that holds the client's musical projections together. Furthermore when the therapist improvises with the client the therapist can begin to understand their feelings, work with them and contain them in musical idioms (Bunt & Hosykns, 2002). Thus the concept containment plays an important part within music therapy and may be applied directly within the context of musical improvisation. Containing the client through music allows for the client to be held, providing a safe place and context for emotional content to be worked through. Such a theory is relevant to my clinical work and the case of Mary, particularly within our music improvisations together.

3.5   Attachment Theory

Finally I wish to draw attention to the theory of attachment. I wish to illustrate attachment theory and its application in regards to this case study and the therapeutic process.

3.5.1 What is Attachment Theory?

Attachment theory stems from developmental psychology and was conceived by John Bowlby & Mary Ainsworth throughout the 20th century (Bretherton, 1991). Both theorists drew from other areas such as ethology – the study of animal behaviour -, developmental psychology and psychoanalysis and thus formulated a new theory regarding human nature and interpersonal relationships. Such a theory shared similarities at the time of its conception with object-relations theory from Winnicott, yet Bowlby's thinking towards the parent-child relationship is unique (Bretherton, 1991, p. 10). The basis of attachment theory rests on the belief that a child's experience with a primary care giver, namely the mother, can shape expectations, beliefs about the self, the world and relationships (McConnell & Moss, 2011) - maintaining the view that past ultimately affects the present and future (Shemmings & Shemmings, 2011). Consequently the attachment experience with a primary care giver has been defined as an affectional bond, one that a child develops with the mother figure (Bowlby, 1988). Such bonds are said to arise when an individual seeks security or comfort from the relationship (Ainsworth, 1989). Therefore children form attachment bonds in early life and creative a hierarchy of attachment figures influenced by amounts of time spent, quality of care, frequency of appearance and emotional investment towards the child (Fonagy, 2001).

Additionally Ainsworth (1991) affirms how attachment figures may also include surrogate parental figures, in cases were the mother is lacking, such as mentors, pastors, priests or therapists. It is exactly such attachment bonds that have significance upon a child's life and play a crucial role in their development and well-being into adult life. In addition whilst attachment bonds are formed, the attachment figure(s) acts as a "secure base" from which the child can explore the outside world, knowing that the base will always be there in times of distress (Bowlby, 1988, p. 11). It is the *secure base* that is important for a child's development, health and future. As Bowlby illustrates the role of the attachment figure in providing a secure base,

> Attachment behaviour is any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiver. At other times the behaviour is less in evidence. Nevertheless for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship. Whilst attachment behaviour is

at its most obvious in early childhood, it can be observed throughout the life cycle, particularly in emergencies (Bowlby, 1988, p. 26-27).

Consequently, although attachment primarily deals with aspects of the individuals childhood and the relationships therein, it is avowed that attachment theory is of particular interest to psychoanalytical work, as models of working learnt within childhood emerge later in life and psychopathology (Fonagy, 2001). Therefore in specific cases attachment and problems that arise from dysfunctional attachment bonds during childhood may render themselves particular relevant in understanding and approaching particular adult cases within therapy. It became evident throughout Mary's therapeutic process that particular issues within her life may have arisen through dysfunctional attachment bonds and insecurity throughout her childhood. Thus such a theoretical construct helped me in conceptualising and understanding the process.

3.5.2   Attachment Disorder

It is important to note that there are many causes of attachment disorders that lead to dysfunctional working models and behaviours in life, yet there are certain communalities between causes that assist in understanding how such disorders arise. Problems consequently arise when the security of the attachment is jeopardized, either by lack of responsiveness and/or availability (Fonagy, 2001). Factors which influence attachment insecurity include – parent alcoholism, higher levels of maternal punitive, controlling and/or insensitive parenting, depression and other anti-social characteristics (McConnell & Moss, 2011). Furthermore negative life events that affect the caregivers' ability to provide care, such as environmental stress, depression and death are important factors for the onset of attachment insecurity within the family (McConnell & Moss, 2011). Consequently dysfunctional relationships between a child and its primary caregiver, inhibiting safety and the quality of care needed, cause the development of unhealthy *internal working models* (Craik, 1943) that shape the child's beliefs their about the self and others. This inability to find love and protection at an early age leads towards the onset of dysfunctional working models that are carried throughout childhood and into adult life if unaddressed (McConnell & Moss, 2011).

Consequently childhood stress and attachment dysfunction leads to a significant risk of mental-health, resulting from a dysfunctional internal working model that hiders the formation of mutually satisfying relationships, stemming from a deeply disturbed view of

oneself and unlovable and unworthy of affection (Shemmins & Shemmings, 2011). Accordingly, specific areas of attachment patterns learnt from figures in childhood, affect the ability for the individual to form new attachment relationships leading towards a loss of health, stability and life (McConnell & Moss, 2011). Thus it is clear that due to a lack of security throughout childhood manifesting in a lack of a secure base, has a severe impact on the child's future and their capacity for secure attachment and meaningful relationships in adult life.

As a result through the lens of attachment theory, disorders and maladaptive behaviours in adult life may now be conceptualized, understood and thus treated. John Bowlby discovered in his early research that young offenders simply yearned for attention, self-esteem and approval. Their destructive behaviour arose due to neglect and abandonment during their early childhood (Shemmings & Shemmings, 2011). This may be an extreme example yet it illuminates the potentiality of how disruptive bonds throughout childhood lead towards dysfunctional ways of being and relating to the world in later life. Finally I wish to address how attachment dysfunction can be addressed effectively within the context of music therapy and the therapeutic relationship.

3.5.3   Attachment Theory in Therapy

So how may attachment theory be addressed in a therapeutic context? As stated before, therapists may play the role as attachment figures in the lives of individuals (Ainsworth, 1991). Likewise Bowlby proposes the idea that therapists should assume the role of an attachment figure, that through the building of a safe and trusting relationship may provide the individual with a "secure base" from which the client may readdress working models of attachment figures and explore themselves (Ainsworth, 1991, p. 36-37). This bears major implications for the therapist and client within therapy. The therapist now acts as a prominent support figure, one providing safety and the provision of meaningful relationship for the client to depend on and grow through. Five therapeutic tasks for the therapist defined by Bowlby (1988, p. 13) as follows:

> 1. Provide the patient with a secure base to explore painful aspects of themselves, ones otherwise unable to do so without the support of another trustworthy companion.

> 2. Help the client to explore ways that they engage with significant figures.

3. Encourage the examination of a relationship with one significant figure.

4. Encourage the client to consider working models – perceptions, expectations, feelings and actions – with their significant figure.

5. Help the client to recognize themselves and others, leading to the adjustments of thoughts and behaviours.

It is particularly the first, fourth and fifth task that are applicable to this case. The identification of a significant figure was never articulated throughout the process, yet the provision of a secure base, the consideration of ones working models with others and the self-realizations leading towards healthy adjustment were present. Moreover it is stated how the effects of disorganized attachment can be reversed through warm, responsive and predictable relationships (Shemmings & Shemmings, 2011), much like that of a healthy and meaningful therapeutic relationship. When such security is available the individual is able to move from the secure base with confidence, resulting in the engagement with other activities and the world around them (Ainsworth, 1991). Consequently if the therapist succeeds in creating safety, becoming an attachment figure for the client, the therapeutic relationship has the potential to provide a secure base, leading to the increased capacity for the client to engage in exploration of the world around them and themselves. This is crucial for our understanding of therapeutic work and shares distinct parallels with the formation of 'favourable conditions' and the working alliance mentioned within person-centered therapy. Yet little research has been conducted exploring the application of attachment theory within music therapy, therefore I hope this case can provide a new insight into how music therapy can adopt theories stemming from attachment in clinical work.

4   METHODOLOGY

Throughout this chapter I shall discuss my chosen methods for data collection, justifying their usage against the research aims, whilst explaining the practical and theoretical process conducted throughout this study.

4.1   Research Aims

My aims for this study were to provide a rich narrative and account of Mary's music therapy journey, allowing for concepts and questions to arise from the research process. As the research process matured and upon analysis, the following research aims arose and were explicitly defined as follows:

> 1. Document the uniqueness of this music therapy case and the process therein
>
> 2. Identify what therapeutic change occurred? And by what means?
>
> 3. To examine what role the therapeutic relationship and the music played throughout the process and in bringing forth change?

Such aims guided the research, providing necessary boundaries and direction for the analysis. In addition the role music played in catalyzing therapeutic change and fostering the therapeutic relationship were also considered. However, the uniqueness of the case was ultimately the focus of this study. Consequently the relationship between the music, the therapeutic relationship and the client has been analysed and discussed at length. Firstly an overview of the research process will be presented, whilst the research approach and methodology are discussed. What is more the discussion of the key concepts, in relation to the case, provided a solid theoretical base for discussion and the conceptualisation of the therapeutic process and it's various components in later chapters.

4.2   Research Protocol

As stated above the aim of this study was ultimately to document, analyse and discuss the unique music therapy process and outcomes over the twelve-week period with my client Mary. This study began with no specific research questions, working from an exploratory and/or inductive stance with themes and theory arising from the therapeutic process and analysis. Rather than beginning with theory and analysing from a theoretical standpoint, the themes of the study were allowed to arise from the data and thus viewed openly from this lens. This provided a way for the uniqueness of the case study to manifest itself and for the research to be data led rather than theory led.

The therapy intervention was conducted over a twelve-week period with weekly sessions of 45 minutes. Supervision was also given weekly from my professors and peers shortly after each session, lasting 30 minutes. After each therapy session time was given to write a personal reflection, while further notes were gathered during supervision and upon watching and transcribing the video recordings the day after each session. Thus, over the course of the therapeutic process a wealth of therapy transcripts and personal notes were collected. However to avoid bias and to increase the validity of the data and analysis, a space of two months was giving between the termination of the process and the commencing of the data analysis. Nevertheless as an active researcher - one intrinsically involved with every part of the process and the phenomenon under analysis - the analysis process began unconsciously during the therapeutic process. However as stated time was given between termination of the therapeutic process and the beginning of the data analysis in order to retain objectivity.

The research process was thus as follows: watching of videos and reading through notes, whilst documenting key words and concepts that arose. Key sessions were identified and further analysed. Concepts were therefore grouped together into larger themes. At this stage themes were then refined and some discarded. As Bromley (1989) affirms case studies are not exhaustive in their description and analysis, but rather are selective in addressing particular issues and not others. In this specific case themes were regarded important due to their ability to convey Mary's journey, therapeutic change and the role of the therapeutic and/or music throughout. Then the conceptualisation of the therapeutic process began, studying, analysing and making sense of the data thematically. A conceptualised narrative was accordingly

written and elaborated. Finally, upon the completion of the analysis the therapeutic process was discussed in relation to previous literature and final conclusions were achieved in light of the stated research aims. Nonetheless, what approach and research method was most effective in bringing forth the most reliable and accurate conclusions to the research aims? In the following chapter I shall explain and justify my chosen methods used throughout this study.

4.3   Research Approach

The primary approach was qualitative as my research aims were to describe the complex intricacies of this unique music therapy process. It is avowed that qualitative research suits music therapy as the field requires well-documented clinical research and this particular approach is suitable in describing experience and meaning (Wheeler, 2005). Furthermore the purpose of qualitative research is to provide a comprehensive picture of findings with a minimum of interpretation (Wheeler, 2005). Thus this approach provided an applicable method and necessary scope for this research and set a framework for the data analysis and process therein. Patton (2002, p. 40) defines the unique capacities of qualitative research as,

> …observations that yield detailed, thick description; inquiry in depth; interviews that capture direct quotations about people's personal perspectives and experiences; case studies; careful document review.

Consequently it is precisely such thick descriptions, personal experiences and explorations of meaning that I wish to study. Thus qualitative research was deemed the optimal approach in achieving comprehensive answers to the research questions above[5]. Furthermore a case study approach was deemed highly suited in documenting and analysing the therapeutic process. An exploratory stance, one allowing concepts and theories to derive from the process and data, was adopted as such an approach is best suited when no single set out outcomes are particularly defined (Yin, 2003).

What is more an idiographic case study design was chosen as an applicable approach, as it is capable of exploring simple through complex phenomenon whilst providing a vital method within health science research in developing theory, evaluating programmes and developing further interventions (Baxter & Jack, 2008). Consequently in the context of studying the

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[5] See "Research Aims" 4.1

intricacies of the therapeutic process – one that is characteristically complex and multi-facetted – the case study appeared to be the best suited in approaching the phenomenon in context. Moreover the case study method was implemented primarily due to it's focus on a *specific* moment in time, seeking to view a closely as possible the delicate interplay and effects of music therapy within an evolving therapeutic relationship (Bromley, 1989). Furthermore although some authors believe that case studies are limited due to their case specific and context bound nature (Alrdridge, 2004), it is avowed that case study's provide insight into complex phenomenon (Baxter & Jack, 2008) that are important in conveying the stories of patients, extracting meaning from experience and in developing theories (Aldridge, 2004).

Another major strength of the qualitative case study approach is the ability to use a variety of data sources, ensuring a multi-facetted view at the phenomenon in question thus strengthening research credibility and validity (Baxter & Jack, 2008). The use of multiple sources of data is called triangulation - the process of obtaining data from various alternative sources. Triangulation was therefore implemented in order to obtain a fuller and more detailed picture of the therapeutic process. Each data source acts as an independent a piece of the puzzle, leading for a deeper understanding of the phenomenon in question (Baxter & Jack, 2008). The three data sources used for this study are as follows:

1. Video Data from Clinical Sessions

2. Client's Reflective Report (Post-therapy)

3. Therapist's professional notes, pre/post therapy reflections and supervision discussions

Additionally, throughout the process the role of both clinical therapist and researcher was maintained. Such an approach and stance as a researcher is described as a "collaboration" between therapist and the client (Wheeler, 2005) and it is warned that it may give way to ethical problems throughout the course of the research. This provided some ethical problems and problems concerning research bias, allowing my own intentions as a researcher to blur the objectivity of this study and my work during the process as a therapist. Yet objectivity and focus was striven for and sustained throughout the 12-week therapeutic process by allowing my professor to guide my thinking and time was giving to 'step out' of my role as therapist.

Although this research was explicitly qualitative, using a case study approach, no one specific case study method was used exclusively, rather inspiration and certain individual methods were taken from a variety of approaches and tailored to meet the needs and resources available for this study. A primary method that inspired my approach, was the 'Interpretative Phenomenological Analysis' (IPA). IPA is a case study method that is able to provide descriptive accounts of certain phenomenon, such as a therapeutic encounter (Pietklewicz & Smith, 2012). One of the primary aims of the IPA method is its focus on experience and how individuals experience a phenomenon. An open inductive approach is therefore used when analysing data and concepts are derived accordingly. Such an approach furthers understanding of a particular phenomenon in a naturalistic setting, while existing previous literature and concepts are implemented in order to illuminate and provide new insights (Pietklewicz & Smith, 2012).

Moreover Smith & Smith & Osborn (2003) assert how IPA analysis seeks to get as close as possible to the insider's world, obtaining an "insider perspective". This is achieved through rigorous iterative analysis, a process characterised by a close engagement with the text and the reader. A cyclical movement is carried out by a sustained engagement with text and interpretation (Smith & Osborn, 2003). Additionally, this process may be referred to as a hermeneutic circle; "…an interpretative process that is dynamic, non-linear and mysterious" (Lee & McFerran, 2015, p. 369). The part under analysis is studied in light of the whole, and thus the whole is studied in light of the part. Such a procedure of analysis is carried out until the research reaches saturation and a sufficient picture of the phenomenon under study is obtained. The advantage of such an approach is its ability to deal with complex phenomenon, real life processes and in producing rich first-person accounts of experiences (Pietklweicz & Smith, 2012; Smith & Osborn, 2003). Such detailed descriptions, along with poignant and articulated interpretations, lead to a fuller understanding of phenomenon. As Lee & McFerran (2015, p. 376) illustrate,

> Researchers can use this tool to generate deep and powerful descriptions of lived experiences and find implicit meanings beyond these descriptions.

Thus, such a focus on the individual's experience, arising from a naturalistic setting, resulting in the generation of thick descriptions, suited my aims of conveying Mary's process and the components within. Moreover IPA's relationship between theory and data greatly influenced

my approach, as theory was used as a source of illuminating conclusions stemming from the data leading towards new insights. This method helped me to frame my decisions as a researcher and provided necessary tools to begin the case study process. IPA's method of analysis was therefore drawn from as a starting point for the analysis of the videos. Each video was analysed separately, generating multiple descriptions that were then in turn analysed in regards to their context along the therapeutic timeline. Furthermore such findings and conclusions made were then considered in light of the whole and the two other sources of data. In regards to this research, the process of Mary was the phenomenon under study with further understanding of the therapeutic process and her experience in light of my aforementioned research aims, being the ultimate goal.

5   THE CASE

5.1   Introduction to Mary

I remember the first visit I had with Mary. She came to our preliminary meeting abounding with enthusiasm and excited to begin her first music therapy journey. As I shared with her the specific details of the process and how we would work together, she disclosed how pleased she was to receive a reply from our music therapy department in being chosen as a client. As a 28-year-old physiotherapy student and teacher, Mary knew the complexity and significance of beginning a new therapy process. This displayed early signs of her high motivation and rationale for applying for music therapy. Mary was seeking therapy and had a strong motivation to try new things and explore new areas of life. We briefly discussed her on-going psychotherapy – a process she has been in since she was sixteen – and affirmed how our journey together would embark onto new territory, however leaving room for her to bring thoughts from her psychotherapy if needed. Here is the story of Mary, her development and of how we came together within music therapy.

5.1.1   The Case

Throughout the data analysis of the session videos, my therapeutic notes/reflections and Mary's post-therapy reflection, particular themes arose and the data was analysed and grouped accordingly. Although the data analysis was mostly inductive by nature, allowing themes and subjects to emerge from the data, due to my stance as an active researcher and a therapist deeply involved in every moment of the process, certain themes and my conceptualisation of the process began over the course of therapy, my own reflections between sessions and within weekly supervision. However in order to allow for the case study to be data led, a break of two months was given between the commencing of the data analysis and the termination of therapy. This gave myself time as a researcher to detach from any preconceptions and subjective misunderstandings I may of had by being too closely involved within the process, thus allowing me to treat the data objectively. This proved to be effective as aspects of my thinking were discarded upon the data analysis whilst other aspects were strengthened, increasing my conclusions and conceptualisation of the therapeutic process.

Moreover multiple themes were generated upon analysis, yet the scope of the study was narrowed down and certain themes were amalgamated to form four foundational themes. At all times throughout the research process I tried to remain as objective as possible, nevertheless implementing my own subjective experience as the therapist at times, using it as a valuable source of data; as I was there, witnessing and *feeling* the process with the client.

5.1.2   The Case Themes

Thus I shall present the case thematically, describing the narrative of the process, her change and my conceptualisation of the therapeutic process throughout. Pivotal moments also occurred and have been thus articulated within their corresponding theme. The four themes that arose are as follows:

1. The Therapeutic Relationship

2. Emotional Expression & Creativity

3. Identity

4. Fear

A brief introduction to each theme and how it arose shall be included. In addition the relationship between themes will be discussed accordingly. However it must be stated that the themes are not mutually exclusive and at times they overlap with each other, yet the content of the analysis was categorised as a result and overlaps have been addressed within the discussion. Sessions 3, 5, 6, 8 & 11 were analysed in great detail and provided the foundation for this study. These sessions were chosen due to their pivotal nature and rich content – each contributing towards a narrative of Mary's therapeutic journey. Moreover through the use of my own personal therapeutic reflections and the client's post-therapy reflection, the conclusions have been solidified through the process of triangulation, increasing the validity of the results (Greetham, 2009). Finally after the presentation of the case and process therein I wish to conclude by addressing the key aims of this study and what was discussed therein:

1. Document the uniqueness of this music therapy case and the process therein

2. Identify what therapeutic change occurred? And by what means?

3. To examine what role the therapeutic relationship and the music played throughout the process and in bringing forth change?

5.1.3 Conceptualisation of Process & Initial Assessment

Mary came to music therapy with only a vague diagnosis and comprehension of her problems. Although her high motivation and need for psychotherapy provided information that she needed and mores-so, wanted to receive music therapy. Moreover her rationale for applying is witnessed within Appendix. B as Mary stated her problems with depressive feelings, emotional expression, anxiety and an unidentified traumatic childhood. However as I began the therapeutic process with Mary I adopted Yalom's (2009) provoking approach of discarding diagnosis for the sake of expanding and increasing ones ability to *be with* and relate to the other person, as diagnosis can limit vision.

Yet as the work developed and much assistance was given throughout supervision from my supervisor and peers, it became evident to me that theories of attachment dysfunction, it's conception and impact of the adult life, were highly applicable to Mary's life and provided me with a basis of thought in my clinical thinking and approach – theoretically and practically – throughout. In light of this case Mary disclosed the death of her father at the age of one and how this has affected and still affects her, particularly in her relationship with her mother and stepfather since. Therefore theories of attachment dysfunction became peculiarly relevant as the therapeutic process developed and Mary disclosed more regarding issues in her current life and traumas from her past. This was a core goal of the therapeutic process with Mary; providing a secure base for the client to explore aspects of herself, re-learning new internal working models towards a healthier way of being and the formation of a safe attachment bond providing security and reliability for Mary. However such a goal was not fully realised until at least halfway through the process and even more conceptualised fully until after the termination of therapy and the beginning of my own reflection on the process and research.

Although during the course of the twelve-week therapy small conclusions were made regarding Mary's needs and issues, it was until after the therapeutic process that a solid conceptualisation began. Supervision was used to a great extent and every week new therapeutic aims and reflection on Mary were generation, yet only to guide my thinking and

stance throughout. It was therefore upon analysis that key ideas and concepts were identified, striving to understand what happened within the process and how change occurred.

5.1.4   Goal Setting

Early within the therapeutic process - S3 – goals were vocalised and agreed upon between Mary and myself. The client was an integral part of the goal setting and at various stages throughout the therapy the goals were readdressed and amended. During S3 our therapeutic goals were defined as follows:

> 1. Live in the moment
>
> 2. Be more herself in life, the good and bad
>
> 3. Be okay with emotions and able to express these (Mary, S3)

However at this early stage the goals merely acted for a starting point as our relationship - as the therapeutic dynamic of the therapy was very much in process and maturation. This is evidenced by Mary's amendment of her therapeutic goals during S6:

> I think the most important goal is to empower me to be myself and less afraid to make mistakes, to relax and improvise. (Mary, S6)

Collaboration was crucial between both client and therapists as Mary was empowered to realise her own needs and address them accordingly. Mary asserted her needs and directed the therapeutic process, whilst I retained my position as a facilitator, a mere guide throughout her process providing the necessary conditions and environment for her growth and self-realisation(s). In summary, between these two statements our therapeutic aims were defined and worked towards. This provided a mutual working basis and/or collaboration between the client and myself.

5.2   The Therapeutic Relationship

The first and foremost theme to address within this case study is the examination and analysis of the therapeutic relationship and it's consequences therein. Therapy is ultimately built upon the relationship (Wampold, 2001) and played a seminal role within the case. Therefore data

was analysed accordingly and the working of the therapeutic relationship was examined and conceptualised. The therapeutic relationship cannot be examined without taking into account the arc or timeline of the therapeutic process, as the relationship is something that requires fostering and is an essential part of therapeutic outcome (Curtis & Hirsch, 2003). It is stated that the relationship can be furthered by empathic listening, refraining from judgement, being un-dogmatic, being humble, being partners with the client, respecting the patients individuality, displaying forgiveness and sympathy and in creating a warm, understanding, safe environment characterised by a strong sense of communication (Wampold, 2001; Rogers, 1951). Therefore I wish to illustrate the narrative of Mary's process, how the relationship was fostered and ultimately its impact on therapeutic change.

Upon analysis it became clear that sessions S1 through to S4, the beginning of the process, were clearly centred on the building of the therapeutic relationship – evidenced by significant changes occurring within S4 & S5 that shall be discussed at a later stage. During S3 Mary was giving the freedom to play the drums, something that she always wanted to do. As we played together we began to communicate with each other, as I accepted her playing and mirrored aspects of her music. A connection was witnessed at this session, one I believe was the fruit of the safety and trust built over the previous sessions.

How have I got so in the moment after two sessions? (Mary, S3).

She reflected on the level of her openness and presence within therapy after two sessions. Perhaps due to my empathic stance, one defined by PCT and characterised by acceptance and warmth (Rogers, 1951), this may have given Mary the freedom to be herself and open within therapy. This proved to be a fruitful beginning to our process, creating foundation within the first four sessions providing a safe environment and trusting relationship for the therapy to continue.

Now I wish to address session 5 and the implications of the relationship at this stage. As a prequel to this session I noted within my personal reflection after S4 feeling a sense of increased authenticity in our relationship and her character. Within this previous session Mary drew to music and we used art to allow her to express her breakdowns and anxiety. My reflections are as follows:

> I felt a lot in the session but just rested in the mystery and let myself feel. I think this translated to Mary as I felt like she was more herself and we are beginning to get somewhere...I feel the drawing was a great way into her and she enjoyed very much…can feel true deepening of our relationships (Therapist, Post-S4 Reflection).

Additionally Mary also disclosed information at this stage regarding the suicide of her father when she was 1 year old. This was a pivotal moment in the process as a new level of trust and sharing between us appeared. As a result within S5 new themes arose for the first time. Mary disclosed her anxiety about how I view her and her fear of rejection from those who come too close. She talked about her mother not accepting or letting her express her emotions when she was young, thus instilling a sense of shame and fear regarding her ability to share and confide in others. It was at this stage that I adopted an empathic approach, allowing Mary to express her fears and concerns, and then I mirrored back to Mary my views towards her and my acceptance of her fear. Through showing sympathy rather than rejection I responded to Mary with a deep respect and acknowledgment of her pain. Another indicator of the strength of the therapeutic relationship was noted in Mary's willingness to talk freely about her fears, rather than trying to hide them from me. Here I affirmed Mary's sharing through the mirroring of her thoughts whilst often verbally reiterating the purpose of our sessions; they are her sessions and for her to express herself safely.

Additionally the idea of Mary experiencing a new way of being *with another* by sharing her emotions and experiences - an area which she finds difficult - can be affirmed from an intense five minute silence that we shared together within this session. This shall be discussed in greater depth in the following chapter regarding the therapeutic relationship emotional expression, yet it affirms the idea of the most therapeutic component of the process is simply Mary experiencing herself *with another* without rejection. We sat together with our eyes closed in silence as Mary struggled to play music. Although the silence could be viewed as a negative, I felt the silence in that moment spoke louder than any music and at the moment, she was heard even louder than before. At that moment Mary got to experience her pain safely *with* another, an experience possible due to the mutual trusting relationship established. Here we sat together, embracing the silence, feeling it's weight and music together. This was a crucial turning point in Mary's journey and our relationship together.

S6 also proved to be a pivotal moment within the process. Mary began the session sharing about a conversation she had with her mother and how certain fears are being realised in real

life. Here she allowed herself to cry and share freely her feelings. Then proceeding reflect on our relationship and the process so far:

> I think you are getting very easily what I mean…it's nice to feel that you are understanding so quickly, and it helps me to understand that maybe I am not so hard to understand….I have been thinking about this…because usually I don't think about this, usually I've been discussing my problems and what has happened but this music therapy is forcing me to think in a different direction about my life and my experiences (Mary, S6).

This reflection accurately summates how the open, non-directional and empathic approach assisted Mary in realising how she can be understood, accepted and helped by other people. What is more towards the end of this session after the second out of three musical improvisations', Mary commented how it felt playing with another and *being with* me:

> It was nice to play with you, and in some section I thought that I could even play with you, hearing what you are saying… (Mary, S6).

This session was a significant moment within the process. By accepting Mary's emotions, being with her in them, affirming and not dismissing her feelings, this may have provided Mary with a safe space for her to explore who she is and her feelings. At exactly half way through the process, this is perhaps the fruit of the relationship built upon so far, Mary's reflective abilities and her progress made. This idea also arose within Sessions 8 & 11. During session 8 I mirrored Mary's thoughts regarding her breakdowns and days that she feels like the world is crashing down:

> It's okay to feel like that at times, when you're tired and feeling like everything is going the other way (Therapist, S8).

Her feelings towards herself and her emotions were thus validated and accepted within the relationship. As a result Mary reflected on her life during this session, thus coming to a further understanding and acceptance of herself. In addition self-disclosure was also used as I shared about my own personal therapy process and my affirmation of the strength it takes to admit a need for help - accepting her needs and showing Mary that it's okay to require help from others.

> It actually takes a very strong person to say, I need help here and I have needs….I'm here to help….I think in the process I've seen you've grown in certain areas and become fearless and more real with me, and I think you want to move forward like the drawing, you want to move forward, and that is amazing and takes guts (Therapist, S8).

This proved to be a fruitful moment in strengthening the therapeutic relationship and collaboration between us. In this moment I modelled as a therapist that it's okay to show weakness at times, hence allowing her to re-model her thinking away from maladaptive thought. Consequently the improvisations that followed reflected our connection and ability to being 'in mistakes' together. As a result Mary requested before our second improvisation that I improvise with her, rather than simply provide a musical accompaniment. This potentially reflected Mary's need to simply experience herself and exist *with another* in a mutually communicative relationship, as she is interested in not only being with me but also hearing and acknowledging that I am with her in the music and therefore her life.

Subsequently the most therapeutic component at this moment was displaying understanding and empathy towards her by creating the necessary environment for Mary to feel secure and in control of her own life and process. Such conclusions were echoed within S11 as Mary ratified how different she feels since the beginning of the process and has come to many rich conclusions about her life. "Thank you that you lead me to this, out of my comfort zone…" (Mary, S11). She admits how she feels like therapists have raised her but also how her needs, stemming from an emotional deprivation within childhood, have been met through therapy and such corrective meaningful experiences.

To conclude, the therapeutic relationship and it's attributes therein created a crucial environment for Mary to reach her own realisations, to experience acceptance and the ability to express herself and view herself through the context of a secure and meaningful relationship. In this case the relationship provided two salient functions:

> 1. To serve as a facilitator and secure base for Mary's development, creative expression and consequently therapeutic change

> 2. Providing a *corrective emotional experience* through the provision of a stable attachment bond and accepting relationship

This is confirmed within Mary's post-therapy reflection as she states how by experiencing a reliable male model in her life, something that she's never fully experienced before, has

empowered her with a new ability to approach situations more positively (Mary, Post-Therapy Reflection, 2015[6]).

5.3   Emotional Expression & Creativity

One of the central aspects of this process was facilitating, developing and exploring Mary's creativity and emotional expression. As stated within our defined goals, emotional expression, self-acceptance/presence and empowerment were key areas of our work together. In this chapter I wish to illustrate how creativity was used to meet Mary's goals and needs of emotional expression and self-acceptance.

During the first two sessions we listened to songs that Mary brought to the sessions and afterwards exploring musical improvisation together. However upon analysis it was evident that Mary's creativity potential wasn't fully realised until S3. During this session we both played the djembe and engaged in a call and response improvisation. This was a significant moment were we made contact through the music, as I mimicked and embellished her rhythms throughout the improvisation. Mary began to express herself as we spoke to each other through the music. When asked about her experience, this was her response:

> At first odd but then I felt that I have to respond something…sometimes stressed but also power to do whatever I want, but this is the problem, I usually want to do as you are, then I also play like you, I try to do something different… (Mary, S3).

This marked the beginning of our musical journey together. Mary experienced the empowerment of playing through music, finding her own musical voice and using music as tool for emotional expression. Moreover Mary also stated her difficulty in finding and expressing her own voice; at times she was inclined to follow me - "It's very difficult to show the real me…" (Mary, S3). Furthermore within the following session, S4, Mary created a piece of visual art through drawing to music, one that conveyed a visual representation of her breakdowns. This is one instance of how through artistic expression and creativity, a greater understanding of herself, her pain and experience was furthered. Through the creation of an objective piece of visual art, this allowed myself as the therapist to engage and respond to Mary's inner world.

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[6] See Appendix A.

Within S5 Mary disclosed about her Mother who failed to defend her within family conflict and inhibited her from expressing her emotions. As a result Mary learnt from any early age that if people come near or if she expresses herself she might be hurt. We then proceeded to play Mary's breakdowns, the darkness and light forces found within her drawing. We played the dark force twice, on the second time I encouraged Mary to sit with the feeling, to feel and express as much of it as she could through the music.

> I think it's like a headache…it's like a mess in my head…like everybody is pulling me in different directions…easier than the first time...usually when I'm so down, the mess is fading because I'm so down, in dark silence, but first there is a messy feeling, but still one feeling is the most common is anxiety (Mary, S5).

By expressing her darkness through the music, Mary managed to transform her painful experience of darkness through art, objectifying it and being able to manage it safely within the music. The music thus became a symbolic expression of Mary's inner experiences, facilitating her self-acceptance and providing a cathartic release. Yet the most significant expression came afterwards as we attempted to play the light force in Mary's life. I encouraged Mary to really feel this force and express it through the music together as we began. Then ss I waited for Mary to play, I heard no sound and we sat together in silence for five minutes. As stated in the previous chapter, I viewed this silence not as a negative but as a great expression from Mary, one conveying her evident anxiety and detailing the trust and safety built within the therapeutic relationship, one that enables Mary to experience her pain and silence *with another*.

> After silence, that which expresses the inexpressible is music (Huxley, 1931, p. 19).

Her silence in that moment, as music failed, possibly expressed more than music could of and provided a powerful moment of emotional release. Shortly after within S6 Mary expressed more emotion with the therapy, as she began the session in tears, disclosing how emotional she gets at times and her sadness towards not playing as much piano anymore as she did when we was younger. We then proceeded to improvise together on the piano side by side and decided to play the power and warmth, an idea stemming from Mary's imagery of a bear, representing two sides of herself. I sat on the left playing the power on the lower notes whilst Mary sat on the right playing warmth on the higher notes. I began by emulating her style, providing a grounding melodic and rhythmic structure whilst Mary improvised over my musical backing. I gave Mary lots of space and followed her musical ideas at a distance,

letting her know that I was there in the music yet providing enough freedom to express her voice. After the improvisation Mary cried and we talked about her past experience with the piano and her love to express herself through the instrument:

> …Because I enjoyed playing the piano, I was playing many hours, it was like flying away my real life and now it's a little bit…maybe that's why I haven't played piano…[would you like to play more?]…yeah, yeah, I don't want to end this kind of feeling (Mary, S6).

Here Mary didn't shy away from her feelings and persisted in playing more, even though the music brought forth many strong emotions for her. This was huge sign of change as Mary was now empowered and willing to face to emotions within therapy and the music. We then progressed towards playing a free improvisation together and a final improvisation of 'call and answer.' Towards the end of the call and answer improvisation I made the decision to join in with her playing after a few minutes, supporting her with strong base notes and she embellished and improvised over the top. Here we visibly connected and began to create our own musical piece together.

> It's nice to know how easy it is to laugh and cry at the same time, or in the same meeting, it's odd and positive. Life should be like that, and express your feelings (Mary, S6).

Such self-realisations were highly significant within the process, particularly at this half way stage. During this session Mary faced her emotions, expressed them safely and came to the realisation that in life a person should be able to express her feelings, whatever they may be.

Furthermore in the following session we began to discuss freedom within music and I explained how within some forms of jazz music, the musicians use what some would regard as mistakes in traditional harmony to make art and create new possibilities. Then within S7 we tried to 'play mistakes', approaching music in an open way with no predefined ideas of what is right and wrong. This proved to be significant for Mary as within S8 she disclosed about how this idea and playing it through music had impacted her:

> …it was like, very amazing idea that when you said about jazz, they are trying to do mistakes or mistakes are their music…when I tried to listen how my mistakes sounds, it was like, a different aspect…when I play and am curious of how every sound is sounding, then I am not scared of how I play…can I transfer that idea in every moment in my life real? That I am not scared but only curious….because I am afraid of everything… (Mary, S8).

As a result the symbolic use of music and the playing out of 'mistakes' in the music began a thought process with Mary regarding her fear of mistakes. Through musical improvisation she got to experience herself in a new way and face the idea of approaching situations with curiosity rather than fear within a safe environment. Consequently Mary made the connection between the music and her everyday life, wondering if her new experience could translate into her life.

We then continued playing two musical improvisations together, this time on separate pianos. We choose together to explore this idea of freedom and playing out our mistakes within the music. During the first improvisation Mary used chromatic scales and 'sampled' notes found outside of conventional harmony, whilst I listened carefully, experimenting beside her and mirroring certain aspects of her playing. This was her response:

> I think it was funny…tried to focus how these notes sound...they sound very funny, not normal, normal is boring sometimes and abnormal is interesting (Mary, S8).

Before we began the second improvisation Mary inquired about what I was playing and asked if I could improvise more, without thinking musically. Then as we began to play, the music grew more chaotic as we both explored the entirety of our pianos together, playing any notes, melody and rhythm that came to mind. The music lasted three minutes and ended with Mary laughing.

> I don't remember when I have been laughing while playing, usually I am so serious…when I repeated my mistakes they actually sound pretty good and I was wondering is everything I do, the mistakes, in my life, and when I play, are they only in my head? But when I repeat them I see that they are basically normal…do I need approval from everybody else if I don't think they are mistakes? Is that okay?...because I have a very clear idea or what is normal and what is abnormal, is it okay like I am now?...now that I've been playing in this improvised way I can see that my way can also be normal, or special way to play, to live my way… (Mary, S8)

This was an important part of Mary's journey, as the music provoked many self-reflections and allowed Mary to come to a place of acceptance towards her mistakes, allowing her to approach life in a different way. Through musical improvisation and the creation of art together, Mary experienced a new way of being, facilitating a deeper understanding of herself, her emotions and fears. The symbolic power of music was evident in this session, brining froth new realisations and applications into life outside of therapy. Finally within S11 Mary furthered her reflections and acceptance of herself and emotions.

> I have to accept that sometimes I'm not so happy and sometimes I'm happy…that's what music does, it reminds us that we have all kinds of shades… (Mary, S11)

For the first time Mary decided to play bass for an improvisation while I accompanied on the drums. It was clear at this moment that she was very open towards playing and expressing herself, especially as she was on an instrument that she was not familiar with. This was her response:

> It was so easier to play and be interested and see how the sound is coming, more than the piano and drums, because I cannot play bass… thank you very much, I enjoyed this. I rock n roll! (Mary, S11).

Thus throughout the process in regards to emotional expression, Mary grew and Mary began to become more comfortable with emotional expression and trying new things musically, as evidenced within this session. The conclusions drawn within this chapter in regards to emotional expression and creativity will be summated and discussed at length within the final discussion.

5.4 Identity

One prevailing theme that reoccurred over the course of the therapy process and upon analysis was the idea of identity and/or authenticity. This theme was generated from key words that were identified throughout such as: self-acceptance, self-image, identity, mask, insecurity, perfection and ideal-self. It became clear that 'identity' was a critical part of our work together and highlighted important issues within Mary's life. Here are two examples from early with the process that highlight the importance of identity:

> I really don't understand how people see me because my own picture of me is a mess (Mary, S1).

> It's very difficult to show the real me…I'm coping with myself, and then if I would show my real me to other people, I think I don't want that other people feel that it's hard to be with me….I think it's hard to be with me…I would like to be the real me…I fear what the people would think about me….sometimes I think that I don't even know who I am, because I have so many masks and I'm hiding myself… (Mary, S3).

Mary disclosed her feelings regarding how other people view her, as she doesn't always know how she views herself. This causes her anxiety as she isn't fully aware of who she is and finds herself 'wearing masks' in front of people, inhibiting her from showing her true self. This issue is apparent within our set goals, to be herself, live in the moment and to be able to

express how she feels, the good and the bad (Mary, S3). Moreover within S5 Mary affirms her anxiety about how I as the therapist view her. She is concerned that I may reject her and push her away after I get to know her and see her for who she is:

> After sharing I feeling shame…I want to be normal…I'm scared that people change their minds about me after I share…shamed of breakdowns…not let many come close…let people to near, they may do something that breaks me…who am I? What do I say? I don't know who I am, how can I tell someone else?...scared that by telling stories that my feelings transfer and affect you… (Mary, S5)

Therefore Mary feels a deep vulnerability when sharing with others and lives in a constant fear of rejection, one that perhaps explains her need to wear a mask and put on a false self in front of others. In addition within S5 we decided to play out the idea of a 'Mummy Bear', one of us playing warmth and the other power, two aspects of the bear. Through the symbolic representation of Mary's character and identity, this proved to be a significant moment within the therapeutic process, allowing Mary to objectify her thoughts and experience this *with another*. This was reiterated within my own therapeutic notes at this point as I simplified my own professional goals and stance within the therapy process:

> My goals are simple: be present, bring a healthy secure relationship to her life, give her the space to be herself – the good and bad, be responsive and listening to her, mirror back her thoughts and emotion. Use music/expression to bring beauty and order to her pain. Let her be (Therapist, Post S5 Reflection).

This was my stance at this stage, one that guided my thinking, my choices and remained throughout the course of the therapy in regards to facilitating a strengthened identity. Additionally within S8 Mary conveys her difficulty of how people view her and perceive her. She affirms that she views herself as abnormal, due to her need for therapy and dependence on others. Mary also reflects on her need for approval from other people, yet acknowledges that perhaps her perceptions may come from herself and that she needs to learn to fully accept herself. This is realized in a significant way through our musical improvisations together. Upon the playing of mistakes within our musical improvisations Mary gains insight and reflects deeply upon this:

> I have a clear idea of what is normal and what is abnormal…how should I act and behave, is it okay like I am now? Like I am different and in my own way I am a special mistake? Mistake that is moving to the special person…different and in my own way I am special…mistake which is moving to the special person….did you get the point? (Mary, S8)

Mary comes to the realization that she can be special in her own way and for the first time begins to view herself as unique, rather than someone who is abnormal. She is learning to be

okay with mistakes in life, acceptance herself and assert her uniqueness. As echoed further within S8:

> Therapist: When you play that? How did you feel?
>
> Mary: That I have the power, I am empowered…
>
> Therapist: Therefore what steals the power in your life?
>
> Mary: If I'm thinking that I'm not good enough or I am comparing myself to much to other people, and I'm not relying that my way is a good way, I'm always thinking how other people are doing something and that's the best way, my way is the wrong way… I have no confidence, my talents or my skills to do things…

Such reflections highlight how by facing mistakes through music and experiencing herself in a new way, thus strengthening her individuality, that leads towards a healthier perception of herself and reduces the fear of how other's view her. Mary concludes that she can live her own way and not in fear of others or comparison:

> Always comparing me to other people…to live my life my way, not the way I think that all people are forcing me to live… (Mary, S8)

This conclusion is reiterated within Mary's post-therapy self-reflection as she states how she has… " the power to be myself and respect that I am also precious" and to accept her and see herself in a positive light (Mary, Post Therapy Reflection, 2015). Furthermore within S11 Mary affirms her newfound courage and how she no longer wishes for her fear to control her life. Towards the end of our therapy process Mary also comes to the realization that illness is only a label and is not 'abnormal'. She asserts how at times she is powerful and at times she is more sensitive, experiencing both good and bad in life, and growing to learn that she has many sides and these are okay. After one improvisation on the drums she vocalized her new realizations:

> Thinking about the African dance course, they used these drums and how differently I can use these drums! Maybe it's like also because you asked me to think about this journey, sometimes more powerful and sometimes more sensitive…I think that bear can be a very scary animal, my journey can look very scary but also there is different sides, powerful, sensitive, softness and sometimes I think that it's quite nice that I have been living my life every though it's not perfect. If things didn't happen in my life I wouldn't be here. I wouldn't be in Jyvaskyla, experiencing things that have taught my something. I have to accept that sometimes I'm not so happy and sometimes I'm happy…I don't want to be a human being that experiences things on the same level, even though when I go to the sad side of me, it's so difficult to cope and to see then sun, but when I'm happy I can like the Mother Teresa, loving everyone. Because I don't want to loose that so happy feeling, because I cannot even describe that, how

amazing it is when I have that feeling, I have to suffer something if I want to get something very special. (Mary, S11).

These reflections were very significant and perhaps solidified many aspects of our work together throughout the twelve weeks. Mary learnt through the therapeutic relationship and musical exploration to accept herself and learn that she can show weakness at times. Her identity thus strengthened and her ability to cope in challenging situations increased. In light of our therapeutic goals, Mary learnt to accept herself to a greater extent and to be okay with all sides of her emotions, consequently addressing our second and third therapeutic goals[7]. To conclude, strengthening Mary's identity was a fundamental component of our work together and one that proved to be a fruitful endeavour.

5.5 Fear

Now I shall address the final theme, fear. Although the title connotes a negative aspect, the concept of courage and empowerment are included as the antithesis of fear. Throughout our journey together addressing fear and empowering Mary to approach life and others with less fear played a major part of our work together. Moreover, as I will address within the discussion, the concept of fear appeared to be a symptom, one stemming from deeper psychological issues and a result of her learned behaviour from childhood. Nevertheless fear was a recurring topic and one deemed worthy of exploration throughout the therapeutic process and my research. The concept of fear in relation to Mary's life outside therapy arose and was vocalised explicitly during S3 & S5:

> I fear what the people would think of me (Mary, S3).

> After sharing I feel shame…I'm scared that people change their minds about me after I after…scared that by telling stories that my feelings transfer and affect you (Mary, S5).

Mary articulated her fear of being rejected by and opening herself to others. She feels shame when sharing her problems and is scared to show weakness due to her fear of rejection or by being hurt. Mary's indwelling fear was further self-actualised during S6 as she readdressed her goals of the therapy, "…I think the most important goal is to empower me to be myself and be less afraid to make mistakes…" (Mary, S6). This was a pivotal moment within the

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[7] See 5.1.4 'Goal Setting'

therapeutic process as Mary came to realise the strong connection between empowerment within therapy and the ability to face fears in ones life.

Yet although the issue of fear within her life was not vocalised until S5, the fear of rejection and vulnerability was visible throughout our musical activities and conversations in S1 & S2. Mary was slightly nervous and hesitant in the music, playing only for a short time together and stating her fear of me grading or judging how she plays. However she was aware of her need to face her fears and move forward in her life with courage. Mary spoke about-facing her fears during the first session and conveyed how she doesn't want to be controlled by her fears. Here is a short except from Session 1 detailing her thoughts:

Therapist: Would you like to play piano?

Mary: I'm a little bit afraid because…the feeling that I've forgotten the old life, all my skills…

Therapist: ...here in music therapy it's never about how well we can play, but about playing our feelings and having fun…you are more than welcome to play piano or the drums…would you like to play something else?

Mary: I would like to try the drums…

(Improvisation on Drum Kits)

Mary: I try to get rid of my fear that you are grading me…

(Second Improvisation on Drum Kits)

Mary: More free, I think this therapy is giving me some courage to do things that I want to do…

Therapist: Like playing the drums?

Mary: Like playing the drums even though I cannot… I feel like I have a wall which is stopping me improvise or 'being normal….

Therapist: Why is that do you think?

Mary: Because you are a new person and this is a new situation.... but I think I have to head on these situations every time? This is good…I just have to be brave…

Mary acknowledged her fear of improvising, making mistakes and what other people think of her. Nevertheless she also affirmed how music therapy may have the potential to help her face issues in her life. This initial dialogue was crucial for the process in setting the tone for our

future sessions together and creating a working boundary. Such ideas around fear were also reiterated early in the process within S2 during our discussions and music making:

> I think I found some rhythm and some music but still when I made a mistake I was confused…but when I found a flow I was enjoying it…the problem is when I do mistake…I want to stop playing (Mary, S2).

The fear of making mistakes was a recurring theme evident within our improvisations and consequent discussions. This fear was holding Mary back from improvising and embracing a form of communication where mistakes are not applicable and one must reach outside of their comfort zone. Similarly Mary's fear of how she is viewed, actualised within session 5, highlighted an insecurity surrounding how close she allows people to come and how congruent she remains as an individual. However during S6 Mary disclosed how she had faced multiple fears outside of therapy. Throughout the week Mary had a conversation with her Mother, talking about her past and subjects usually avoided due to fear. Additionally she shared a story of choosing a man to dance with her at a local dance, something that she was usually very scared of doing.

> I was really relaxed and enjoying…maybe my walls are crashing, I feel in some sections…I'm putting myself in different situations with risk…I wouldn't of two months ago...Now I have the possibility to be in charge of how my evening is going… (Mary, S6).

Both of these incidents perhaps illustrate a new found courage and ability to face fears within her life. She conceptualised this change with the image of walls crashing down, opening up new areas of herself and allowing her to take control of her life. This change was also apparent within our third improvisation. As I suggested the idea of playing a call and answer, both of us on the same piano, Mary asserted:

> Should I start…even though I don't want to? ... [We laugh together]…I'm being too honest, what is happening? (Mary, S6).

She was very assertive and took the opportunity to face her fear head on through music, afterwards commenting how she was very scared of playing piano but had the courage to overcome that fear (Mary, S6). Consequently Mary's fear of making mistakes and of what others think arose again within S8. As an important university presentation approached in her life, she deliberated approaching the situation with a curious excitement rather than nervous fear. As stated in the previous chapter, during S7 the idea of playing mistakes and listening to

them rather than rejecting them, was introduced and here Mary conveyed how such an idea and experience through the music had helped her to reach new realisations:

> Last week was a light bulb moment…when I tried to listen how my mistakes sounds, it was like a different aspect – when I play and I am curious of how every sound is sounding, then I am not scared of how I play, and can I transfer that idea in every moment of my real life? That I am not scared but only curious, how this moment is going, because I am afraid of everything…that's why I'm anxious, I'm scared of failing or looking stupid… (Mary, S8).

Mary reflected on her fear of mistakes and how by approaching situations with curiosity, whilst accepting her mistakes, the fear may be alleviated. Here she made the connection between the musical improvisations and the fears that she faces within therapy and those within her life outside of therapy. Furthermore as we began to explore Mary's fear through musical improvisations on the piano, and I asked her how she feels, she replied that she felt empowered (Mary, S8). Something within our improvisations together pushed Mary out her comfort zone, having an empowering effect on her. However when I suggested the idea of vocal improvisation she withdrew and commented how vulnerable that would be:

> It's like very scary…I don't why it's like that, is it because I'm showing everything? …. I can play wrong and do mistakes on purpose, but doing voice is…. (Mary, S8).

This was hugely important as the symbolic fears and empowerment through facing them within therapy gave Mary the ability to transfer her new insights into everyday life. Such conclusions are affirmed towards the end of the process within Session 11 as Mary reflected on the therapeutic process:

> I was thinking last week how much I've got courage…life is a bit easier…I've had to step out of my comfort zone…I'm not sure about fearless, I fear a lot but I don't want to that fear to stop me…I have more power to face the fears, they are not killing me… (Mary, S11).

Finally Mary's post therapy reflection also confirmed her progress made in coping and overcoming fear in her life (Mary, Post Therapy Reflection, 2015):

> I could ask man to dance with me at lavatanssi without being afraid of what they think of me

> To think that If I am afraid of something (like making mistake) I can change that feeling by thinking/doing in a more curious way

Mary also mentioned the terms "power" and "courage" throughout her reflection and affirmed her reduced fear in life.

In conclusion, it is evident that the issue of fear was a recurring and prominent theme within her process, one that was addressed within positive outcomes and self-realised changes within Mary's life. However the question still remains, how was such change brought forth? An answer to this question will be discussed in light of all four themes and pre-existing literature within the subsequent discussion. Perhaps the building of the therapeutic alliance and the 'favourable conditions' played an integral role in allowing Mary to self-actualise and acknowledge her fears. The idea that fears within Mary's life was a symptom of deeper issues shall also be discussed consequently in the discussion whilst the relationship between themes shall also be conceptualised.

6   DISCUSSION

Finally in this chapter the outcomes of this case study shall be concluded in light of the pre existing literature.

6.1   Relationship Between Themes

Now I wish to address the relationship between the themes and my conceptualization of how they exist and influenced each other at various stages of the process. As stated within the therapeutic goals[8], helping Mary to be herself, accept and deal with her emotions, and reducing her fear of making mistakes were the underlying aims throughout the entire process. Mary came to therapy with a fear and anxiety concerning what others think of her, thus inhibiting her ability to reveal herself to others in fear of rejection. Such a fear of rejection may potentially stem from Mary's dysfunctional attachment bond as a child, arising from the death of her Father and later emotional detachment from her Mother, creating a dysfunctional working model that has carried on into Mary's adult life (McConnell & Moss, 2011). Likewise Shemmings & Shemmings (2011) state how child hood stress and attachment dysfunction leads towards dysfunctional internal working models in later life that hinders the ability to form meaningful and vulnerable relationships, stemming from a deeply disturbed view of oneself as unlovable and unworthy of affection. Therefore in the light of this case, Mary's skewed identity – a result of childhood stress/dysfunctional attachment, consequently manifesting in a fear of how she and others perceive her - may be at the crux of her problems and our work together.

Furthermore Bowlby's (1988) conception of a 'secure base' may also be applicable to this case as he affirms how the presence of a secure base in ones life allows the individual to explore the outside world with reduced fear, particularly within childhood. We can thus conclude that the concept of fear was potentially a symptom of Mary's skewed identity, lack of a secure base and maladaptive internal working models learnt from childhood. As a result it

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8 See 5.1.4 'Goal Setting'

became clear that the themes were integrated, influenced each other and connected intrinsically.

Nevertheless, the question is raised: how exactly does the therapeutic relationship and music (emotional expression/creativity) relate to her issues of identity and fear? Throughout the analysis process, and through extensive reading into the surround literature I concluded that the therapeutic relationship acted as the facilitator, providing a context and necessary environment for her development whilst the music (emotional expression & creativity) was the means or tool used throughout to explore and go deeper into ideas raised throughout; identity was therefore the underlying issue, remaining as the primary focus and goal of our work together; finally, deducing that fear was a symptom stemming from a dysfunctional identity and skewed perception of herself. In other words the music acted as a means of emotional expression and exploration, whilst the relationship facilitated the entire process of facing fears and self-discovery, one that lead towards a more functional internal working models and conception of herself. Fears were thus reduced as Mary's identity strengthened and she learnt to accept herself fully, the good and bad, as a result of the therapeutic process.

6.2   Thematic Discussion

I now wish to discuss further the outcomes of Mary's therapeutic journey, the four prevailing themes and the conceptualization of the process in relation to the literature.

6.2.1   The Therapeutic Relationship

As stated above the therapeutic relationship provided a necessary context and environment for Mary's process, acting as a facilitator for the therapy. Such a conception of the therapeutic relationship in this specific case relates heavily to Roger's (1951) 'favourable conditions', in which the primary objective for the therapist is to create the optimal psychological conditions for the client to flourish. The three fundamental components of the conditions are as follows: unconditional positive regard, empathy and genuineness/congruence (Tan, 2011). Such favourable conditions are sought after with the intention of obtaining a deepened therapeutic relationship and ability to *be with* the client. As Mary experienced a non-judgmental attitude

from the therapist and acceptance of her fears and pain, this allowed for a strengthening of the therapeutic relationship and a deepening of trust leading towards therapeutic change.

The strength of the therapeutic relationship was witnessed during session 6 during a moment when we sat in silence together for five minutes as Mary struggled to play out her emotions through music. In this instance by accepting her struggles and inability to play at that specific moment, our relationship deepened and Mary may have experienced what is it like to be accepted and *with another* even in the toughest parts of her life. Such a holding/containing and accepting stance is one that reflects the relationship between child and parent; the provision of a safe environment for emotional expression (Finlay, 2015). Such an ability to contain the client's projected self and pain, such as a long evocative silence, is deemed essential for the client mental survival and development (Miller-Pietroni, 1999), as the therapist brings a musical environment that can hold the client, containing, binding and shaping their chaotic expression (De Backer, 1993). Moreover through the mirroring of Mary's thoughts and feelings, verbally and musically, a degree of empathy was conveyed by acknowledging and accepting her pain. Empathy in this case allows the client to remember that they are not alone (Bohart, 2003), as the therapist enters deeply into the client's subjective reality. Thus Mary experienced being accepted and understood by another person through empathy, meeting a deeply human and intrinsically therapeutic need, one perhaps lacking throughout her childhood.

Therefore as the relationship created throughout this case potentially shares a parallel of that of a mother, such an environment created through our relationship and the secure connection between us was potentially therapeutic in creating the necessary holding environment of safety, acceptance and trust for Mary and every other aspect of the process to flourish. This conclusion reiterates my previous summation of the role of the therapeutic relationship in this case study:

    1. To serve as a facilitator and secure base for Mary's development, creative expression and consequently therapeutic change

    2. Providing a *corrective emotional experience* through the provision of a stable attachment bond and accepting relationship.[9]

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[9] Page 33.

It is stated that the lack of a secure base in ones life, such as in Mary's childhood, may lead towards a lack of stability to explore the world, a disturbed view of oneself and difficulty in forming meaningful relationships in adult life (McConnell & Moss, 2011). However Ainsworth (1991) states that therapists may act as an attachment figure and in some way provide a 'secure base' for the client to depend on and grow through. Likewise Bowlby (1988) explicitly defines the role of a therapist in providing a secure base for the client to safely explore themselves and their life and to work on dysfunctional internal working models. This is particularly apt in the context of this case as she affirmed within her post-therapy reflection how our relationship provided her a secure, "…healthy reliable man model" (Post-Therapy Reflection, Mary, 2015) and provided a secure context for her many other self-reflections. Therefore the stability of the therapeutic relationship potentially provided a 'secure base' for Mary at this point in her life allowing Mary to explore life with confidence rather than anxiety and fear (Bowlby 1988), a symptom in her life and the fourth theme of the analysis.

Correspondingly the therapeutic relationship may of also formed a strong attachment bond, one lacking from Mary's childhood and relationship with significant others. In light of Mary's potential lack of stable attachments throughout childhood Shemmings & Shemmings (2011) assert how the effects of disorganized attachment may even be reversed through warm, responsive and predictable relationships. Accordingly through the use of music within the context of the therapeutic relationship and the attachment bond therein, painful and/or dysfunctional aspects of Mary's thinking were approached – such as her fear of others, making mistakes and dealing with her emotions in a healthy way. As evidenced in her post-therapy reflection (Mary, 2015):

> ... to express my feelings more with other people (especially sad and angry feelings … I could ask man to dance with me at lavatanssi without being afraid of what they think of me…

This help to demonstrate how the therapeutic relationship may of provided the right context for Mary to express her feelings, face her fears outside of therapy, potentially reversing the negative consequences of dysfunctional attachment. Therefore it is evident that the relationship throughout the process potentially provided a safe and reliable context for a therapeutic attachment bond, creating a secure base for the client to explore the world thus leading towards change and a reworking of her dysfunctional internal working models.

Finally, the therapeutic relationship may have been a tool in of itself in bringing forth therapeutic change. Aside from providing the necessary context, holding environment and secure base for the client to work from, the therapeutic relationship and it's effects in this context may also of provided a vital *corrective emotional experience* for Mary through the attachment bond and secure base created. Alexander and French (1946) who first defined the concept concluded that conflicts within the client are resolved with a new ending. Such new endings allow for dysfunctionality to be released and functionality regained, and is identified within successful therapy processes (Hartman & Zimberoff, 2004). Therefore the relationship may also of acted as a necessary attachment bond for Mary at this time in her life, providing a corrective experience within her life:

> Almost last time…three months has passed very quickly, all the semester is finished also… [it's been a long journey, things seem different than at the start]…very much different, I was thinking last week how much I've got courage…so it's good to notice that I am going forward, life is a little bit easier now…thank you that you lead me to this, out of my comfort zone… (Mary, S11)

To conclude, the therapeutic relationship provided a facilitator for the process, through the presence of the necessary favourable conditions, at times contained/held Mary's emotions, providing safety and acceptance. Mary's learned behaviour from childhood has inhibited her from sharing in adult life due to a life of rejection and shame. Thus through the establishment of as secure and trusting relationship, a secure base was provided allowing Mary necessary security and safety to approach her life, thoughts and emotions with reduced fear. This potentially allowed Mary to feel accepted, supported and as a result, empowered to live her life and be herself out side therapy, all amalgamating and facilitating a powerful corrective emotional experience for Mary. All in all, a very therapeutic piece of work.

6.2.2   The Music – Emotional Expression & Creativity

The music (emotional expression and creativity) used throughout the process will now be discussed in relation to therapeutic change and the process therein. As previously concluded, the music was a tool used within the context of the therapeutic relationship for emotional exploration and the working through of issues raised. It is apparent from Mary's post-therapy reflection that the music - the emotional expression and creative activity - had a huge effect on her emotional capacity, courage and presence, playing an integral role in our work together. Bruscia states (1998) how music therapy focuses on beauty and creativity, and it is

affirmed that the connection between therapist and client through music brings forth therapeutic change (Pavlicevic, 2002). Thus creativity is a crucial aspect of music therapy and Mary's development and change during the process. Nevertheless, what role did music and the creative process play in Mary's process? And how did this assist in facilitating the working towards of the goals? As stated within the initial goals, helping Mary to live in the moment, deal with her emotions – good and bad and the expression of these -, and to empower her to be herself, with less fear and the ability to improvise in music and life were the aims of our work. Accordingly Mary's (Post-therapy Reflection, 2015) reflection provides strong evidence that musical activity was important and effective in meeting the goals:

> The music helps me be more present in that moment … Improvising helped me to be more who I really am. I have done changes in my life so that my life more suitable for me … To express my feelings more with other people (especially sad and angry feelings) … To accept that sometimes I am sad and sometimes I am very happy. My life will never be boring because these ups and downs make life very interesting … Trying different instruments gave my courage to try more things … I have found the passion to play the piano again. I am defined starting to play the piano again after my school has finished.

Theories of creativity affirm that by engaging in artistic activity, such as musical improvisation, one can understand reality and learn things otherwise not understood (Ruud, 1986). Therefore perhaps through the use of musically improvisation Mary obtained an alternative understanding and view on her life, her emotions and who she is. Furthermore during session 4 Mary used drawing to illustrate and objectify her inner world; allowing her to transform and process her experience through the medium of art (Kim, 2011). Additionally McNiff (1981) states that art may provide order in expressing the chaos that lies within individuals. Therefore art can a powerful tool to order human experience, particularly if an individual has experienced trauma and/or emotional conflict in their life, such as within Mary's life. Moreover Alridge (2003) affirms how creative expression can bring meaning out of illness/difficult situations, restore identity and empower clients. Conclusively, the creative activity and musical improvisations throughout Mary's journey may have provided a way for her to objectify, understand and transform her experiences; particularly the painful ones surrounding her breakdowns, dysfunctional attachment and anxiety.

Moreover empowering Mary to be herself and strengthening her identity was a principle aim throughout and this was achieved partly through the use of music. It is stated how music therapy can be beneficial for the restoration of identity (Aldridge, 2003), as through music

one can perform a personal identity (Ruud, 1997) leading towards a deep psychological empowerment (Zimmermann, 2000). Such empowerment and building of Mary's identity through music was witnessed within her post-therapy reflection (Mary, 2015), "…Improvisation helped me to be more who I really am…the music helps me be more present in that moment…I have the power to be myself and respect that I am also precious." These comments reflect the psychological empowerment that Mary experienced and her strengthened identity through musical improvisation. Furthermore one of our main goals for the process was to assist Mary in dealing with and expressing her emotions. After one musical improvisation during session 6, a session that began with Mary disclosing personal feelings and crying, Mary commented on her experience of the music:

> It's nice to notice how easy it is to laugh and cry at the same time, or in the same meeting, it's odd and positive. Life should be like that, and express your feelings (Mary, S6).

This realisation helps to highlight Mary's growing acceptance and ability to express her emotions in life and music, particularly at this half-way stage of the process. This new level of awareness may be conceptualised as insight, an outcome resulting from engaging with the expressive arts (Rogers, Tudor, Tudor & Keemar, 2012). Kim (2010) also reiterates this strength of the expressive arts as she ratifies how art in itself is a process of discovery, leading to a deepened understanding of oneself, and it is stated that our art can even communicate back to us if we take the time to listen (Rogers, 1998). Therefore through engaging in musical improvisation and drawing, Mary may have been able to for the first time experience her world through art leading towards an emotional acceptance. This experience and learning through art ultimately lead towards the acceptance and ability to release emotion, a specific goal of the process. Mary could learn about herself in a new way and have the time to reflect and listen to what her art, drawings and musical improvisations have to say.

The music was also used throughout as a symbolic representation and 'playing out' of thoughts, ideas and emotions. One theory of musical improvisation places the emphasis on music in facilitating the relationship between client and therapist (Pavilcevic, 2000), however musical improvisation can also be used for its power to symbolise and objectify intangible thoughts and feelings (Wigram, Pedersen & Bonde, 2004). During session 5 we attempted to play out Mary's drawing [made in S4] of the light and dark forces in her life, leading to her breakdowns and pulling her out of them. We played the dark force twice as I encouraged her

to express how it feels to be there, but then as we attempted to play the light force we sat in silence for 5 minutes as Mary attempted to access those feelings and symbolise the light force. In that moment perhaps the silence was what needed to be heard. Her silence as she attempted to play music, potentially spoke louder than music could in that moment. As Huxley (1931) affirms how after silence music can express the inexpressible, we must not ignore silence within music therapy and what it has to say. Accordingly in the following session we tried again to symbolise her concept of a 'mummy bear' – power and warmth -, representing two sides of herself, this proved to be a pivotal moment where together through the music within the relationship between us we got to symbolise Mary's view of herself and her different sides.

> You are getting easily what I mean – like the bear, when you played softness – nice to feel that you are being understood so quickly…maybe I'm not so hard to understand… (Mary, S6).

Furthermore, the idea of reorganising Mary's way of thinking through music played a pivotal role in addressing her fear of mistakes in life and how she perceives herself. During S8 we began to play the idea of "mistakes" and used a jazz music as an illustration of how free and curious music can be. Upon reflection Mary commented,

> Amazing idea about jazz…trying to do mistakes…the mistakes are their music…listening to how mistakes sound…when I am curious to how every sound is sounding, then I'm not scared of how I play…Can I transfer this to everyday life? That I'm not scared, only curious to how this moment is going, because I am afraid of everything…I think that's why I'm anxious – I'm scared of failing or looking stupid…when I repeated my mistakes they actually sound pretty good and I was wondering is everything I do a mistake? In my life and when I play, are they only in my head? I don't think they are mistakes, it is only that I am different in my own way. (Mary, S8).

Here the music provided a safe way for Mary to experience a new way of being in the world (Trondalen, 2008) and potentially provided a corrective experience for Mary to learn what it's like to approach life with curiosity and with less fear.

Finally the music may also of acted as a support, providing a third entity within the therapeutic process and was a tool in deepening the therapeutic relationship. It is stated how within music therapy the music acts as a third entity working in a role as that of a parent, providing a source and object for support within the triadic relationship (Bruscia, 1998). Thus in light of this case, the music at times was a resource and a 'third person' to be accessed throughout the process. When asked within session 6 if she wants to continue playing music Mary replied, "…yeah, I don't want to end this kind of feeling, it's not good to stop in there,

in bad feeling" (Mary, S6). In that moment Mary want to continue playing and experiencing herself in the music, perhaps because the music became a source of safe and power for her at this time. Furthermore the music also assisted in strengthening the therapeutic relationship, which is reference by (Pavilcevic, 2000) as Mary disclosed,

> …it was nice to play with you, and in some section I thought that I could even play with you, hearing what you are saying… (Mary, S6).

Not only did we connect verbally but connection was also established musically. This proved to crucial, especially as the client and myself share a different mother tongue. As music is a from of communication that can often go deeper than words (Alvin, 2003), our dialogue musically at times spoke more than words could allow. The music therefore allowed for Mary to express all different shades of her emotions and experience what it is like to accept how she feels and have this also accepted by another. The improvising therefore assisted Mary in confronting herself and learning to exist in a healthier way with others.

> …usually I've been discussing my problems and what has happened but this music therapy is forcing me to think in a different direction about my life and my experiences. (Mary, S6).

6.2.3   Identity

As stated earlier identity was acknowledged as the foundation of Mary's issues surround anxiety, fear and skewed perception of herself. Identity issues are often a result of those arising from dysfunctional attachment and trauma during childhood, as in this case such theories align with Mary's history and discussions throughout the process. Within this chapter the conceptualization of how identity was worked upon will be summarized again in relation to literature and how the therapeutic relationship and music influenced identity change will be concluded.

It was our goal throughout to strengthen Mary's identity as witnessed within our therapeutic goals: be more herself, good and bad, less afraid and empowered in life.[10] Rendering identity as a key theme within our work. Within S5 Mary stated how after sharing she feels shame and doesn't let people close because she is afraid of what they might think, especially as she does not know who she is or have a strong sense of personal identity. Her learned behaviour form

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[10] See Goal Setting 5.1.4

childhood makes Mary anxious as she discloses her real self to others as she is afraid of their rejection. Therefore she requires a lot of reinforcement in life, relies on the opinions of others and explains her need to "weak a mask" (Mary, S5) outside therapy. In order to address these issues it was crucial for a strong therapeutic relationship and bond to exist between Mary and I, characterized by safety, acceptance and a strong sense of collaboration (Messer & Gurman, 2003; Wampold, 2001). The presence of such a relationship may have been a corrective experience for Mary, to exist in a vulnerable relationship and at the same time experience acceptance and safety, instead of Mary's fear of rejection and abandonment. As Alexander & French (1946) affirm how a corrective experience is one where conflicts are resolved with new endings. Therefore through the relationship and the corrective experience Mary learnt that others can accept her, thus allowing her to realise that she can be accepted, and that her true self is okay, thus strengthening her sense of identity and ability to be herself around others in life. Furthermore, as mentioned within the previous chapter, the use of musical improvisation can be a means of celebrating identity (Ruud, 1997) and exploring oneself through an alternative lens (Trondalen, 2008). Therefore as we improvised together, particular within S5 as we played the 'Mummy Bear', this allowed for Mary to work out and more so, experience her, including her identity, through music and creative expression.

Thus empowering Mary and helping her to accept both sides of herself – the good and bad – was a seminal part of our work and was a part of strengthening her identity and acceptance of herself. Again through music and the playing out of 'mistakes', this allowed her to challenge her preconceptions of herself and what it is to make a mistake. Through musical improvisation within the context of the secure relationship, Mary was given the opportunity to work out her thinking and experiment musical with a new way of being. Daykin (2003) asserts how individuation through the music therapy process can help patients to reflect their individual uniqueness, leading towards empowerment and creativity. Moreover through musical improvisation, is it stated how the therapist and client constantly renegotiate themselves in relation to one another (Pavlicevic, 2000), and gives each individual a way of being recognized in the world *with another* (Trondalen, 2008). Thus through the playing out of 'mistakes' together, this potentially facilitated the process of renegotiating her thinking and ability to be in the world in a less dysfunctional way. Such a healthy new experienced for Mary may of lead towards new ways of thinking and empowerment, such as being okay to

show weaknesses around others and having more courage to face scary situations in life. As echoed within her post-therapy reflection (2015):

> I could look at my teaching videos without being so anxious about how I look and sound. I could see me more positive way…I could do damacting in my teachers studies and it felt good…to notice that I have the power to be myself and respect that I am also precious…to accept that sometimes I am sad and sometimes that I am very happy. My life will be never boring because these ups and downs make life very interesting…improvising helped me to be more who I really am. I have done changes in my life so that my life is more suitable for me

These concluded reflections suggest that Mary found a new positive way of viewing herself, accepting her mistakes and her "ups and downs", and learning to be who she is. As a result, through the use of music within the context of the therapeutic relationship Mary, Mary's identity and perception of herself was strengthened through the corrective experience and the working out of particular thoughts musically. Therefore meeting the second and third goals, being herself and learning to deal with and accept her emotions.

6.2.4 Fear

As aforementioned fear was ultimately a symptom, one arising from a skewed identity, fear of rejection form others and a lack of acceptance of the self. It was therefore a particular aim to reduce Mary's fear and anxiety in life and facilitate a healthier way of being in the world with less fear. As stated within Mary's amendment of the therapeutic goals in S6, helping her to be less afraid and to empower her through the therapeutic process was central to our work together. Mary's fear of showing herself and being free was evidenced within her music playing, as he improvisations were initially very short, and her stated anxiety concerning playing the piano (S1). However over time and within the safety of the relationship, Mary faced her fears and within S6 she actively chose to play first on the piano during a 'call and answer' improvisation. This was evidence that Mary was becoming more courageous and not allowing herself to be controlled by her fear within the sessions. Therefore, what helped and assisted in reaching this new state of empowerment and courage?

It has been discussed that Mary's fear is a result of a deeper issue, her identity and lack of a secure base in her life. Therefore as her identity was strengthened through the process and the therapy provided a secure base for her to explore the world from (Bowlby, 1988), perhaps the summation of both these factors lead towards the ability of facing life with reduced anxiety

and fear. Also when security is reached through the provision of a secure base it is noted that the individual is now able to engage in the world around them with increased confidence (Ainsworth, 1991). Therefore, fear was potentially reduced through the provision of a secure, reliable and stable relationship, thus providing a secure base for Mary to explore herself and the world around her without fear and anxiety. In light of this Mary noted within S8 (Mary, 2015) when asked after one improvisation about how she felt, she replied, "…like I have the power, I am empowered…". Additionally within S11 Mary (2015) reflects on her growth and ability to handle her fears:

> I was thinking last week how I've got courage…life is a bit easier now…I'm not sure about fearless, I fear a lot but I don't want that fear to stop me…I have more power to face the fears, they are not killing me…

Her growth and reduced fear in life was also finally witnessed within her post-therapy reflection:

> I could ask man to dance with me at lavatanssi without being afraid…to think that if I am afraid of something (like making mistake) I can change that feeling by thinking/doing in a curious way…trying new instruments gave me courage to try more new things (Mary, 2015).

Therefore through the corrective experience and/or secure base of the relationship and the strengthening of Mary's identity, a new sense of courage was manifested and translated across into multiple areas in Mary's life. Mary learnt throughout the music therapy process to face her fears and to develop an increased courage and confidence in how she approaches life. Mary's identity was strengthened, dysfunctional ways of thinking about 'mistakes' were corrected through music and Mary also got to experience herself and the art of 'making mistakes' in a new and safe way.

7   CONCLUSION

Throughout this case study the aims have been, to document the uniqueness of Mary's process, identify therapeutic change and finally to examine and conceptualize the role of the therapeutic relationship and the role of music in bringing forth therapeutic change. Through the documentation and analysis of the therapy recordings, my clinical notes and Mary's post therapy feedback, I have sought to illustrate Mary's journey and her milestones. Within the discussion therapeutic change has been conceptualised and the role of the therapeutic relationship and the music discussed, illustrating the following conclusions.

Throughout Mary's process it is concluded that the therapeutic relationship was an essential facilitator in bringing forth the provision of a secure base, leading towards the strengthening of her identity through a corrective emotional experience of acceptance and understanding. The environment created allowed Mary to explore her issues surrounding identity and fear in a secure and empowering way, providing a corrective emotional experience of being accepted and exposed without rejection. Such a corrective experience was a catalyst towards the reduction of fear/anxiety in her life and the ability for Mary to accept herself, and her emotions to a greater extent. The experience of a secure base and an accepting relationship consequently facilitated an evident reduction of fear in Mary's life. Her fears were faced throughout the process through musical improvisation and within the therapeutic relationship. Musical expression was accordingly used as a tool within the relationship to explore and symbolise Mary's feelings and thoughts. Also, musical improvisation and the creative process allowed Mary to objectify her pain, her struggles and gave her the opportunity to process painful aspects of her life. Therefore, this study has furthered understanding of the therapeutic relationship and the role of music within music therapy.

This study also highlighted certain limitations and raised a number of problems throughout. Ethical issues were raised, as at times it was difficult to remove myself completely from the research, as a therapist who was intimately involved within the process from the beginning. Moreover allowing the analysis and research to be predominantly inductive, presented difficulties at various stages. This was due to my preconceptions as a theoretician and clinician, potentially hindering an objective view of the process with. Yet in spite of these

limitations, the qualitative and subjective nature of this study was capitalised on, due it's capacity for a rich and intimate documentation, focusing on the experience of an individual (Patton, 2002). Procedures were put in place, such as allowing a two-month break between the termination of the therapy process and the beginning of the analysis and issues were discussed thoroughly with my thesis supervisor. Furthermore additionally readers were employed upon the completion of the research to test the inner logic and transparency of the study.

Hitherto this study has provided an in-depth insight towards on how music therapy may be implemented in treating clients suffering from identity and/or attachment disorders. In the future further more rigorous studies may be beneficial to explore specifically how music therapy can address the particular needs of such clients and what interventions may be most beneficial for them. However as an initial study perhaps this has provided a new frame of thought regarding music therapy and it's implementation within psychotherapy. Conclusions have been drawn conveying music's capacity for allowing an individual to experience himself or herself in a new way and to perform a new sense of identity through music (Ruud, 2007), and the therapeutic relationship's potential to bestow a secure base in an individuals life, facilitating an empowerment and the reorganisation of dysfunctional ways of being (Bowlby, 1998).

In conclusion, by our very nature we are musical beings (Darnley-Smith, 2003) and the music itself and the creative process are said to bring order to the chaos within us, exalting life, bringing order to our experience of the world around us (McNiff, 1981; Nietzsche, 1968). Therefore through this study I hope to have furthered insight into how music can enhance and aid our lives. Music is still a phenomenon that remains an enigma to us all (Storr, 1997), yet it's capacity to stir emotions (Alvin, 2003) and influence every aspect of human live (Denham, 1997) must provoke thought and serious consideration towards music. Yet, I trust this study has provided a glimpse, perhaps by taking a further step, in documenting and seeking to explain how music can be used. As a clinician and a researcher I have learnt a tremendous amount through the therapeutic process with Mary and my subsequent analysis. I trust this research will provoke and inspire further clinicians and professionals from all areas of health and social care towards implementing and regarding music as a fundamental component of our lives as human beings. This remains a principle objective of music therapy,

to bring music to people, giving them the tools and the space to awaken their intrinsic desire, ability and need to music (Small, 1998). As music therapists, this we must do.

> Music is so naturally united with us that we cannot be free from it even if we so desired (Boethius in Storr, 1997, p. 1).

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APPENDIX A – Mary's Post Therapy Reflection

I have learned:

Not to take myself so seriously.

I could look my teaching videos without being so anxious about how I look and sound. I could see me more positive way.

I could do dramacting in my teacher-studies and it felt good

I could ask man to dance with me at lavatanssi without being afraid or what they think of me

To express my feelings more with other people (especially sad and angry feelings)

To think that if I am afraid of something (like making mistake) I can change that feeling by thinking/doing in a curious way

To notice that I have the power to be myself and respect that I am also precious

To accept that sometimes I am sad and sometimes I am very happy. My life will never be boring because these ups and downs make life very interesting

I have to eat, sleep, sport, regularly and I have to balance work and free time well

The music helps me to be more present in that moment

For me it is good to see health and reliable man model because I haven't had that kind of experience so much in the past

Trying different instruments gave me courage to try more new things

Improvising helped me to be more who I really am. I have done changes in my life so that my life is more suitable for me

I have found the passion to playing the piano again. I am definitely starting to play the piano again after my school in finished.

APPENDIX B – Mary's Therapy Application

I am ******** and I am interested in participating in free music therapy sessions, because my biggest emotional problems are anxiety and stress-sensitivity. Anxiety and stress cause sleeping problems and tensions. Sometimes if anxiety and stress go out of my tolerance, I have depressive feelings. These symptoms and problems are caused by painful past experiences in childhood and youth. I also want to get to know myself better, because I think that I really don't know who I am, what my limits are and what living is. At the moment I get psychotherapy too, but I think that music therapy could help me also because music is very important element for me.

I am ** years old. I am *********. Now I am studying ******** and to be a teacher of health sciences in University of Jyväskylä. My phone number is *********. I am using this email-address. I can do the therapy in English