EXPERIENCING MUSIC THERAPY WITH CLIENTS WHO HAVE BEEN AFFECTED BY ADDICTION WITHIN THEIR FAMILIES

Emilija Puskunigytė

Master's Thesis

Music Therapy

Department of Music, Art & Culture Studies

24 June 2020

University of Jyväskylä

JYVÄSKYLÄN YLIOPISTO

Tiedekunta – Faculty Humanities	Laitos – Department Music Department
Tekijä – Author EMILIJA PUSKUNIGYTĖ	
Työn nimi – Title EXPERIENCING MUSIC THERAPY WITH CLIENTS WHO HAVE BEEN AFFECTED BY ADDICTION WITHIN THEIR FAMILIES	
Oppiaine – Subject Music Therapy	Työn laji – Level Master's Thesis
Aika – Month and year JUNE 2020	Sivumäärä – Number of pages 48

Tiivistelmä – Abstract

Research concerning music therapy in the field of addiction treatment is continuously growing. However, such work focuses mostly on the effectiveness of music therapy in helping the addict to recover, rarely investigating how music therapy is experienced and how it benefits the family members that carry a certain amount of the burden of their relative's addiction.

The current case study was conducted as an action research project with the purpose of experiencing group music therapy with the intended clients, following the action research cycle method of planning-action-reflection. Three participants were recruited for a group music therapy process of 10 one-hour-long sessions with a student music therapist.

A narrative description of one cycle (*Session IV*) is provided along with other findings revealing meaningful changes in group development and group cohesiveness. Music therapy interventions such as clinical improvisation and song discussions (song sharing) are discussed as means of creating a safe and supportive environment for the clients.

Asiasanat – Keywords

Music therapy, Group music therapy, Family burden, Codependency, Addiction, Action research

Säilytyspaikka – Depository	
Muita tietoja – Additional information	

Acknowledgements

It gives me great joy to express my deepest gratitude to:

My dear professor and supervisor, Dr. Jaakko Erkkilä, for he was and is always willing to assist in all situations: thank you for being amazingly understanding and kind, even when I did not deserve it. My gratitude goes as well to his colleague and our professor, Dr. Esa Ala-Ruona, who gave his time and attention to listen closely and to help me understand myself in my contexts.

My fellow music therapy students, wherever you are right now: thank you for joining me in the great and challenging, humbling and encouraging experience we had. I will always cherish it in my heart. Special thanks go to Angela, my ray of sunshine and a true friend, to Biran, for the many conversations we had and your help in data collection, and to Mikaela, my student tutor and inspiration – I know you will go far!

Lastly, to my parents who have given me the opportunity to study abroad and supported my endeavours all along the way; and to my sisters who never ceased to ask me how my thesis was progressing; thank you for encouraging me and pushing me out of my comfort zone when I did not know I needed it. I am so very grateful to you all.

CONTENTS

1 INTRODUCTION 5

2 LITERATURE REVIEW 7
2.1 Music therapy in addiction treatment 7
2.2 Codependency, family burden and possible coping strategies 9

3 RESEARCH AIMS 12

4 METHOD 13
4.1 Overview 13
4.2 Action research 13
4.2.1 Action research in the current study 14
4.2.2 Action planning 15
4.3 Music therapy group setting 16
4.4 Participants 16
4.5 Data collection 17
4.6 Data analysis 18

5 FINDINGS 19
5.1 *Session IV:* one cycle 19
5.1.1 Planning 19
5.1.2 Action 20
5.1.3 Reflection 26
5.2 Experiencing various activities within the music therapy group 27
5.2.1 Clinical improvisation 27
5.2.2 Receptive music listening 29
5.2.3 Mindfulness exercises 33
5.3 Music therapy support group 34
5.3.1 Group development 35
5.3.2 Group cohesiveness 36
5.3.3 Emerging themes 37

6 DISCUSSION 41
6.1 Limitations and further recommendations 43
6.2 Conclusion 44

References 46

1 INTRODUCTION

Addiction often has adverse consequences for the addict, including health and mental impacts. However, the addicts themselves are not the only ones who bear repercussions from their addiction; addiction also takes a toll on their family, relatives and friends. It appears that research on the family of the addict – examining their roles, experiences and coping strategies – may play a significant part in studies related to the development of the addiction and the recovery of the addict (Lutsenko, 2020).

Music therapy within addiction treatment has been practised by many music therapists, and it is also becoming a widely researched field. This is of particular importance because substance abuse and other addiction-related issues continue to be major problems in today's society. Support groups for addicts' relatives have been in existence for more than 70 years, in recognition of the fact that addiction is a family and community illness (Alcoholics Anonymous, 2001). However, music therapy in this setting has not been purposively studied. Therefore, with this action research I aim to broaden my understanding and knowledge about the effect that addiction may bear on an addict's family members, and to experience music therapy with intended clients in a group setting. Meanwhile, I also aim to explore the issues and challenges clients face in their everyday lives and examine how their overall wellbeing can be improved.

There were several motivating factors behind my decision to conduct this action research project. Firstly, over several years I have developed an interest in working with the intended people and gaining deeper understanding about both dependency and codependency. Secondly, back in my native country of Lithuania, I have spent time volunteering in rehabilitation and social welfare centres, meeting people who either suffered from addiction or were affected by it in other ways; this experience greatly increased my care and empathy for these people in their situation. A third factor was a wish to lead and experience music therapy in a group setting, improving my practical and theoretical knowledge along the way. A final step led me to combine these two interests in order to settle on my research questions and choose the action-oriented approach.

In this paper I first present a literature review focusing on music therapy in addiction treatment as well as an overview of codependency, family burden and coping strategies related to addiction. Next I briefly state my research questions, which are followed by the method section. The findings of this action research project are then described, mostly following the *planning-action-reflection* pattern, which is at the core of action research method. Finally, I discuss the findings and point out some limitations while making future recommendations for further research.

2 LITERATURE REVIEW

As far as I could establish, the available literature concerning the use of music therapy with clients who have been affected by relatives' addiction is sparse. However, it has been found, mostly through practice, that codependency issues can be addressed using similar methods to actual dependency treatment; often the 12-Step approach is incorporated in order to help the codependent person regain inner stability and independence. Thus, the focus is first shifted towards literature on research regarding music therapy and treatment of addiction. After this, a view is given into research concerning family burden in coping with the addiction of a relative.

2.1 Music therapy in addiction treatment

Dependence (or addiction) and related issues are, in their core, the same regardless of the source of the dependence. Yet when it comes to treating the addiction, various methods are applied: these include detoxification, treatment with medication, 12-Step programmes, psychosocial therapy and complementary therapies. Music therapy, as presented by Murphy (2017), is an example of a complementary therapy that is being incorporated into addiction treatment programmes. The array of studies that evaluate the efficacy of music therapy in helping individuals manage addiction is growing. In a systematic review, Murphy (2017) examines the current evidence on whether the practice should be included as a primary treatment protocol. The results are mixed: certain studies show that music therapy has significant effects on the treatment, while other studies indicate that it has limited effectiveness. There is a lack of consensus about whether music should be used as a primary treatment approach, as illustrated by Murphy (2017). However, previous studies on music therapy demonstrate that the approach is effective in helping addicts cope with the challenges that come with addiction. Several music therapy approaches (mainly lyric analysis and song writing) used in different phases of addiction treatment are more consistently described by Silverman (2009b, 2010, 2011, 2014, 2016). Other studies look into the regaining of coping strategies by recreating a situation similar to real life within a music therapy context, therefore providing distance for exploration (Dijkstra & Hakvoort, 2004), combining music and art therapy to achieve motivation for healing (Aletraris et al., 2014), and experiencing positive mood changes through music-induced emotions while avoiding substance use (Baker, Gleadhill & Dingle, 2007). In one of his earlier

studies, Silverman (2010) explores the usefulness of music therapy at specific points in the life of an addict, and also evaluates the use of music therapy practice during detoxification. The results found that most of the 118 patients in detoxification units involved in the study preferred music therapy over other approaches and noted that it was the most helpful therapy available at the unit. In their study Dijkstra and Hakvoort (2004) further elaborate on why the practice is effective, noting that music therapy helps addicts to regain coping mechanisms or learn better ones. A trained musical therapist is able to assist the addict in managing their struggles using music and help them to gain insights and practise coping styles and strategies. According to Dijkstra and Hakvoort (2004), music therapy offers the addict an alternative way – other than the use of narcotics – to deal with their issues. Baker et al. (2007) indicate that 87.5% of the participants in their study had successfully used music in the past to regulate their moods. As a result, participants reported a positive experience with music therapy, with 83.4% of those involved in the study reporting that the music therapy sessions were enjoyable.

Aletraris et al. (2014) demonstrate that complementary techniques, such as music therapy, are often overlooked in favour of evidence-based techniques. They report that, despite limited support for the approach, a combination of music therapy practice and other approaches such as the 12-Step programme proved to be successful. Music therapy was widely accepted among adolescents, while women in general preferred a combination of treatment programmes and therapies such as music therapy. Borling (2011) claims that in order to incorporate music therapy into addiction treatment successfully, it is essential to have a firm understanding of the 12-Step process that is often employed and supported by most treatment centres. In order to align music therapy process with the 12-Step programme, Borling summarises it into four stages: surrender (steps 1-3), honesty (steps 4-7), accountability & responsibility (steps 8-9) and stability (10-12). These ideas can be well explored during the music therapy process – for example, honesty with oneself and one's path to recovery can be addressed through lyric analysis (Borling, 2011) or structured imagery work (Brooke, 2009), whereas stability is sought in any therapeutic process as the last phase, ensuring a long-lasting recovery. The 12-Step programme emphasises the importance of the Higher Power (or God) and spiritual recovery. Borling (2011) sees a particular opportunity for music therapy here:

> The music therapist is in a unique position to assist with this developing relationship with one's own Higher Power. Music, by its very nature, has the ability to touch us very deeply and to call forward those aspects of our being that are ready for growth and healing. For some, the reclamation of feelings of

> human-ness, is spiritual in nature. I encourage all clinicians, when working with psycho-spiritual issues, to remain very open-minded and unbiased when this topic arises (p. 346).

Furthermore, Borling (2017) illustrates that music therapy helps the patient move beyond the first stage of recovery and towards the second stage. According to Borling (2017), the practice of music therapy helps addicts move beyond the bio-physical stage of recovery as the approach aids in addressing psycho-emotional and psycho-spiritual growth, which is the second phase of recovery. Music therapy achieves this goal by helping patients develop other life-affirming approaches. Borling (2017) further argues that through music therapy, the individual is able to adopt a life driven by values and ethics. Ghetti et al. (2017) also support the same point of view. They show that music therapy is effective in helping patients transition from the first stage of recovery to the second stage, and that the approach was preferred by patients in detoxification units working towards recovery or avoiding relapse. In a recent study, Carter and Panisch (2020) also note that music therapy is a promising alternative to established approaches because it helps to reduce the stigma associated with treatment regimens offered to substance abuse addicts. Therefore, the chances that an individual will resist treatment are reduced. Furthermore, Carter and Panisch (2020) illustrate that music therapy strategies such as lyric analysis help patients to evaluate the harmful effects of their behaviours, as illustrated by the lyrics of a popular song. Harrison (2019) also subscribes to the assertion that the practice works well in helping addicts cope with addiction problems; music can help individuals connect socially, and it could work well in reducing dependence on drugs.

The available literature on music therapy in addiction treatment examined here shows that there is some consensus that the approach works in aiding recovery. The process of recovery should include the whole family, as its members are also affected by the addiction of their relative, and may exhibit similar behaviour and suffer from serious issues. Thus, a deeper understanding of how music therapy is utilised and experienced in addiction treatment can inform the practice when it is employed in addressing the associated needs of the family members.

2.2 Codependency, family burden and possible coping strategies

According to CoDA (Co-Dependent Anonymous), codependency can be defined as “being overly concerned with the problems of another to the detriment of attending to one’s own wants and needs” (Center for Substance Abuse Treatment, 2004). When their personal needs are not

addressed due to taking care of the abuser constantly, the codependent person may exhibit several patterns of maladaptive behaviour. These may include constant controlling due to a belief that others are not capable of self-care; low self-esteem; excessive complying and denial of their own values to avoid anger; oversensitivity towards disruption and disappointments; and undeserved loyalty to those who do not deserve it (Center for Substance Abuse Treatment, 2004). These behaviours and related challenges are often addressed in support groups for family members, in which a change in one's regard towards the issue of addiction is sought. For example, the Al-Anon Family Group is formed by following the 12-Step programme: during this process, various aspects of the programme are addressed in order to provide attendees with insight into what their addicted family members are going through. The main purpose of the support group is to provide a safe and confidential environment for those who attend, so that they may "share their experience, strength, and hope in order to solve their common problems; [it is believed that] alcoholism is a family illness and that changed attitudes can aid recovery" (The Twelve Steps, 1996). It is essential to note that family members or friends affected by the addiction of their close one might not necessarily exhibit signs of codependency, yet they will almost always experience the effect, and feel burdened by it to a certain degree.

Research into addiction and family burden acknowledges that addiction becomes the family's priority, rather than the relationship between the members of the family (Choate, 2015). Similar findings are evident in a study completed by Shyangwa et al. (2008), where it is reported that addiction puts significant strain on the relationship between the addict and the caregiver. Parents who are addicts place their children at risk of depression, poor academic performance, social isolation and anxiety (Usher et al., 2015). Children are also affected when pregnant women abuse alcohol; the rate for this has been found to be about 3.5% in the USA (Bohrman et al., 2017). The families of addicts also often have to deal with costs associated with the addict's rehabilitation and are frequently on the receiving end of irrational behaviour induced by drug and substance abuse. Research has been undertaken to measure the impact that addiction has on the family of an addict and to investigate strategies that can be used by the addicts' family members to cope with their behaviour.

Support programmes, such as Al-Anon, have been found to be effective in enabling the family of the addict to cope with the emotional impact of the addiction. These programmes often involve therapy and lectures that offer counselling to the codependants. Al-Anon processes are

often similar to those of AA because codependants exhibit the same behaviour as the addict; this arises from their inability to recover from their frustration through drug and substance abuse like the addict (Cohen, 1990). It is effective for the addict's family members to seek therapy and counselling, as this makes them better able to deal with the stressors associated with the addiction. However, the benefits do not cover all domains. Timko et al. (2016) found that newcomers to Al-Anon reported more benefits associated with their own personal gains than gains associated with the addict. The Al-Anon programme offers coping techniques that enable the codependant to deal with addictive behaviour, but it does not guide the codependant on how to encourage the addict to reform, or foster an improvement in the relationship between the codependant and the addict. Personal gains, however, enable the codependants to respond adequately to the stressors brought on by the addiction. Additionally, the coping techniques used by the codependants are more effective if they are adaptive, as opposed to maladaptive. The codependants were found to seek maladaptive coping techniques naturally, as opposed to adaptive techniques (Moore et al., 2011); this points to the need for therapy to encourage the use of adaptive techniques that produce more positive outcomes.

While most programmes that are researched involve counselling of the codependant, it is recommended that mixed methods be used in order to report better outcomes (Usher et al., 2015). The programmes that have been investigated to enable codependants to cope with addiction focus on prompting the clients to speak about their previous situations with the addict and providing advice on how to cope with future situations. Music therapy has also gained popularity as a means through which people with mental health conditions or addiction can cope. Further research of alternative therapeutic approaches, such as music therapy in dealing with the repercussions of addiction, should be continued to provide more possibilities for codependants.

3 RESEARCH AIMS

The aim of this case study, based on an action research approach, is to experience, review, analyse and describe the music therapy process in a group context when participants of the group are in some way affected by addiction in their families.

The research question that led to this study was: What are the *experiences* of people attending music therapy when they have an addicted relative? The emphasis is put on *experiences* because of the underlying sub-questions that this study attempts to explore:

1. What are the experiences within the music therapy process in a group setting that bring about change, if any?

2. How can the group music therapy experience relate to a typical support group experience? Where does group cohesiveness come into play?

3. How can I, as a student music therapist and researcher, improve my own practice while conducting an action research project in group music therapy?

4 METHOD

4.1 Overview

Due to the exploratory nature of the research question and aims, I have chosen to conduct an action research project, which in itself serves to gather rich qualitative data. Aldridge (2005) gives a compelling argument for choosing the qualitative research approach, which is something that many novice researchers in music therapy may find attractive:

> A strength of qualitative research for music therapy is that it concerns itself with the interpretation of events as they occur in natural settings and, therefore, has a resonance with the very processes involved in music therapy as the therapist tries to understand his, or her, patient. (p. 35)

The chosen research project served as an opportunity for me as a student music therapist to plan and carry out group music therapy sessions with the intended client group, in order to reflect on, analyse and interpret my own work, therefore gaining new insights about my field of interest. I chose to work in a group setting to mirror commonly existing support groups for the relatives of people struggling with addictions. Participants were gathered through an open invitation. 10 one-hour-long sessions were planned, carried out and reflected upon. Audio/video data was gathered and transcribed; along with my reflective notes, these form the database for the findings.

4.2 Action research

Action research is usually designed to diagnose issues and develop practical solutions that address them effectively. Due to its nature, research can be carried out in a circumstance where it is a challenge to use other research methods (Snoeren et al., 2012). Action research needs a working environment that encourages a collaboration due to its supportive nature.

Action research is essential because it involves the problem-solving skills of professionals within their service centres. As Winter & Munn-Giddings (2001) describe, in healthcare, nurses can analyse problems and devise programmes and activities that are designed to solve problems or to improve standards, thus learning a lot about research in the process. The high levels of practical relevance are used alongside qualitative and quantitative data to help health

practitioners develop knowledge about various diseases. This makes nurses more reflective within their situation and gives them the ability to be more helpful to the patients. Additionally, action research helps to sharpen the practitioner's reasoning abilities and helps them improve self-monitoring measures towards the effectiveness of performance (Stringer, 2013).

However, action research also has various disadvantages when used in research. The results of action research cannot be used in a generalised model; they are only used for the population studied and the exact system. In addition, there is a challenge in the validity of writing and the presentation of the final report (McNiff & Whitehead, 2010). It is likely that the correct information may not be given, leading to issues that may not favour the profession. The practitioner may also not state all details in the final report, thus giving doubt to the story.

However, action research is usually considered to be essential in group therapy since evaluating their local intervention enables practitioners to make use of findings to enhance their practices.

4.2.1 Action research in the current study

Considering that my primary research query was to experience music therapy with the clients and to reflect and improve my own practice, action research appeared to be an appropriate method to frame my project. McNiff & Whitehead (2010) propose a way to understand action research:

> Action research is about two things: action (what you do) and research (how you learn about and explain what you do). The action aspect of research is about improving your practice. The research aspect is about creating knowledge about your practice. The knowledge created is your knowledge of your practice. (p. 21)

As a novice researcher and student in music therapy I understood the need to create knowledge about the music therapy field, both in theoretical and practical learning. Yet I was most interested in *action* i.e. "doing music therapy" and *reflection* on the action in order to improve with every cycle (session). During my previous clinical internship, I received feedback that my reflective skills were adequate, yet needed more practice. Supervision and regular meetings with my tutor helped to improve my reflective view on my own practice. However, the ability to reflect deeply on one's actions is essential in this type of research, and I was concerned that my skills of reflective thinking were still underdeveloped. Therefore, I made sure that

throughout the therapeutic process I could continue discussing the sessions with a student colleague who recorded the sessions; I reflected on my notes after every session and reviewed the videos before planning the next session.

4.2.2 Action planning

Inspired by Yearsley (2010), whose study follows the *action planning* procedure by answering critical questions as proposed by McNiff & Whitehead (2010), I attempted to find my own answers as well, in order to increase the transparency of my initial stance as a novice researcher and student music therapy practitioner. Here I provide an excerpt from my research planning notes:

> What is my concern?
>
> I would like to experience more of music therapy in real life. I wonder what it is like to lead a music therapy group; also, what I will discover about the people who feel affected by addiction in their family. I would like to learn more about them and practise music therapy to get better at it.
>
> Why am I concerned?
>
> I personally haven't experienced the effect of addiction in the family, but I know many people, friends, who did. I know something about their experience and I empathise with them although I cannot relate totally. I believe I want to learn more about these issues, to understand them on a deeper level.
>
> What experiences can I describe to show why I am concerned?
>
> During the summer [of 2017] I volunteered as a music-making (using therapeutic methods) activity leader in a rehab centre. I used some therapeutic techniques from music therapy and I could see some positive and negative changes in some members who attended the group. They were recovering addicts. I could also observe the open support group meetings for adult children of alcoholics/drug abusers. This made me question what it would be like to experience music therapy with these people.
>
> Which participants?
>
> I will simply invite people who feel the effect of addiction in the family on themselves. I will not screen the participants in any way, expecting that they will know what they are participating in. I won't distinguish between different sources of dependence (alcohol, drugs, gambling etc.) because, at its core, dependence is the same. [Research Project, 2017]

I was encouraged to attempt an action research-based approach by yet another definition of it, as proposed by Winter & Munn-Giddings (2001):

> Action research is the study of a social situation carried out by those involved in that situation in order to improve both their practice and the quality of their understanding. (p. 8)

I decided to involve myself in a group music therapy setting with the intended clients, in order to practise and improve my skills as a novice music therapist and in turn gain deeper understanding about the situation.

4.3 Music therapy group setting

I chose the group music therapy setting for a number of reasons. Firstly, offering the intended participants the chance to come to a music therapy support group appeared to be similar to the most common method for helping people deal with addiction in the family (i.e. attending free support groups for family members). Moreover, it seemed that a group setting was appropriate for creating a safe environment in which participants could share their experiences amongst people who would empathise, understand them and give support for each other. As proposed by MacKenzie, one important therapeutic factor is *support*, which reveals itself in a group therapy setting through the instillation of hope, acceptance, altruism, universality and cohesion (Davies et al., 2014). With regard to the current study, *altruism* and *cohesion* were regarded as important factors to foster during the process. According to Koelsch, music-making may help to bring people into contact, create shared empathic states and motivate people to cooperate and connect (Bruscia, 2014, p. 152). Pavlicevic (2003) suggests that group bonding, a feeling of belonging and confidence enhancement can be viewed as ‘secondary aims’ in a group context, alongside established ‘primary aims’ such as exploration of emotional/relation issues, addressing trauma or conflict, and enhancing self-expression, among others. In the context of this study, the ‘secondary aims’ relating to the concept of group cohesiveness were regarded equally as important, or even more important. Above all, I preferred the group setting because of my previous experiences working with a group in a rehabilitation centre, observing support group meetings for codependants and seeing the benefits of group work in this population.

4.4 Participants

I brought participants together by distributing paper posters around the city of Jyväskylä, Finland. In the poster there was an open invitation to participate in group music therapy sessions for people who have relatives with addiction. It was clearly stated in the invitation that the

sessions would be conducted by a student music therapist. I also created an online version of the invitation which was forwarded to other students and selected organisations in the city.

Three young women agreed to join the group by writing an email. To maintain strict confidentiality, their names have been changed.

Meg, the first participant to sign up, wrote in her email that she needed some support to face her feelings regarding her father's alcoholism. She expressed eagerness to meet people from a similar background. In addition, she stated a wish to find some energy to survive her everyday life as well as help to deal with anxiety symptoms.

Eve, a young mother, wrote that she was willing to be more open about her family situation, in which she was affected by her relative's drug abuse and violence towards the family; she expressed her interest in finding support to deal with it.

Jess, the third participant to sign up, expressed her curiosity towards music therapy as a tool to help people with their emotional struggles. She openly shared information about addiction to alcohol and narcotics in her family and states that she had already accepted the situation a long time ago. She was about to start attending psychotherapy sessions but still had an interest in the music therapy group.

After the initial contact via email, we agreed on a common time for weekly meetings according to everyone's availability. It was implied that the group would be a 'closed' one.

4.5 Data collection

Before the first session, all three participants received and signed an informed consent paper for their participation in the group music therapy sessions within the University of Jyväskylä, along with associated audio and video recordings and further research purposes. The consent forms, together with the video recordings, are securely stored and protected at the Music Therapy Clinic for Research and Training.

A total of 10 group music therapy sessions were conducted at the Music Therapy Clinic for Research and Training, University of Jyväskylä, between March and May 2018. This therapeutic process was part of my clinical internship, which is compulsory for all music therapy students. The duration of each session was 60-70 minutes. Every session was semi-structured, starting with a verbal check-in before continuing with free or thematic musical improvisation, pre-recorded music listening or another activity, and processing and sharing within the group, before concluding with a verbal check-in at the end.

Although all 10 sessions were supposed to be recorded, due to some technical difficulties three sessions (the third, sixth and seventh) were lost. Moreover, the cameras in the music therapy clinic had a limited number of angles, therefore making it more difficult to record and observe some reactions or body language cues.

The main data used for this study were the video recordings, separate audio recordings and written *verbatim* transcriptions of the music therapy sessions, together with my pre-/post-session reflective notes and conversations with my student tutor and fellow music therapy student. I must note that due to one client's sporadic attendance at the music therapy group sessions, her data is scarcely used, and only when necessary.

4.6 Data analysis

The data analysis took place in a few phases. As a first step, due the nature of action research, I embarked on an ongoing analytical reflection about the process. After this, I transcribed the gathered recordings, forcing myself to go through the data piece by piece. Subsequently, I revisited the transcriptions and my notes more than a year later; this gave me a different perspective on the process and may have decreased the potential for bias, which is almost always unavoidable in action research. I then attempted to apply the inductive qualitative content analysis method, in order to establish what kind of themes emerged from the data. In the following chapter I will present and explain the findings of this research project.

5 FINDINGS

In presenting my findings I shall first single out one particular cycle, providing narratives and explanations of the planning, action and reflection stages in that cycle. Furthermore, I briefly describe the main therapeutic interventions (*action*) used throughout the process, along with their *planning* and *reflection* stages. Finally, I give an overview of the music therapy group development with regards to group cohesiveness, as well as some themes emerging from the data analysis.

5.1 Session IV: one cycle

I chose to present this particular cycle (Cycle Four) because of its importance for the overall group music therapy process. It was during this cycle that we experienced what I termed 'a meaningful change' – a turning point in our process.

5.1.1 Planning

When planning the session, I returned to my reflections on the previous sessions. I noted to myself that the group dynamic was quite fragile; this was possibly due to one client, Jess, not being able to participate in the first session. Her later joining seemed to have disrupted the already existing dynamic between Meg, Eve and myself, and therefore *Sessions II-III* were more difficult. In addition, I noticed myself thinking that "some clients take too much space" whereas "some want to open up but do not trust the environment yet". During *Session III* I had experienced some negative feelings towards the process we were in, and constantly questioned myself whether I was doing anything correctly. Upon reflection with my assisting student colleague (who recorded the session and was familiar with it), I even said "I feel like I have to say something… cool" which to me showed a certain lack of confidence in my approach as a therapist. However, a thorough reflection reminded me that I should instead work on developing skills to become a better listener. I also expressed a wish to see myself becoming a facilitator, rather than a leader of the group, and to see "support for each other within the group" which I related to my knowledge about how most support groups for recovering addicts and/or codependants appear to function. At the end of *Session III,* I asked the clients to send me the title of a song (or up to three songs) "that has great importance to them", explaining that we

would all listen to them together during the upcoming sessions. The clients sent me their songs via email, with Meg choosing only one and both Eve and Jess each sending three songs. When planning the session, I could not assume that we would listen to all the songs, yet I had a flexible plan to do so. Just before the session, Jess informed me that she would not be able to participate.

The planned action was inspired by several things. Chiefly, I wanted to try the commonly practised therapeutic activity of listening to client-chosen music and processing it within the music therapy group. Moreover, I presupposed that it could be a meaningful tool to allow space for individual clients within the group due to my previous experience of utilising this activity. Finally, I hoped it could help in eliciting deeper sharing.

I decided to follow structure similar to that of previous sessions: verbal check-in, free improvisation, verbal processing, improvisation with some instruction, verbal processing, listening to client-chosen music and reflection.

In summary, my aims for *Session IV* were thus:

- *Establish a safe, cooperative environment by improvising in the group and, for myself, by being more "there" for the clients and listening while avoiding asking too many questions;*
- *Experience listening to client-chosen songs and verbal processing within the context of the group.*

5.1.2 Action

When describing the action, I mostly used the *verbatim* transcription of *Session IV* video recording, along with my notes, to create a thorough narrative. Direct quotations from the transcription are included to give the reader a glimpse into our reality.

Ahead of the session, I prepared three mats on the floor, remembering that the clients had felt quite comfortable on the mats during the previous session. With Jess absent, Meg and Eve came to the music therapy clinic, immediately removed their shoes and sat down on the mats. Meg

appeared to be less tired than usual, therefore I began the verbal check-in with her. “You seem to be more… fresh today?”, I asked. Meg firstly disagreed by shaking her head, before stopping to reflect and replying “Yes, maybe I am. I like the warmer weather”. Eve joined in the conversation by telling about her baby being fussier because the weather was becoming warmer and sunnier. “I may have to go for long walks more often”, she said giggling, while Meg nodded in agreement: “Yes, me too, I’ve been going to the nature around town, camping, making fire […] it’s nice”. Eve looked distracted, starting to pick up dust from her clothing and gazing downwards. I tried to focus her attention back on the circle by asking about her own sleep. She replied, giggling, that is had been very hectic, “waking five or six times per night, but that doesn’t matter, I have a baby…”. When Meg’s phone rang, she apologised and went to turn it off. After she returned, Eve was already looking around the room, so I invited them both to select an instrument for the improvisation. Eve stood up right away and went to take the kalimba, while Meg stood up slowly, mumbling “what do I choose?” She spotted a couple of mallets left next to the djembes, and asked if she could play the djembe with the mallets. After confirmation, she brought back the instrument to the circle.

I gave the instruction to “try creating small dialogues: listening to each other, hearing their ideas and trying to respond to that…let’s start whenever we’re ready”:

> Eve starts right away. Plays the kalimba in a rhythmical pattern, Meg observes her, while the therapist observes both, starts holding Eve’s playing. Meg joins in, and the Eve looks up for the first time. Then she starts looking up more often, looks at how Meg is playing, while Meg keeps a steady rhythmic pattern. The therapist then prompts them to intensify by adding more complex rhythmic figures. They respond very quickly, intensifying their rhythmic patterns, too. But this doesn’t go on for long – in a few seconds, Eve raises her head, finished. Meg looks like she has stopped too, but the therapist continues by “scratching” the djembe with energy. Eve imitates, while Meg looks surprised, giggles and right away joins in with her djembe, actively playing with the mallets. The three play intense rhythms for half a minute. A moment of silence. Then Eve gives a clear single “slap” on the frame of the kalimba, the therapist responds with a similar “slap”, and Meg responds too. They play the “slapping” game for a few times, mostly taking turns in the small circle, while giggling. Then Meg starts to fill in the slapping pattern with some rhythmic playing, and the other two join in. Eve looks quite pleased, looks more often at the others. After some moments it seems like they’re about to stop, but Meg continues with a different pattern, while the therapist starts accompanying her idea. Eve starts to respond to Meg’s idea, and there is a short musical dialogue between them while the therapist tries simply to contain them. This final playing goes on for a couple of minutes before fading away to silence. While coming out of the improvisation, the women appear to be very intentional with their playing being a “form of communication” – they no longer concentrate so much on the instruments, but look at each other, smile at each other, nod and giggle. [Session IV, transcription]

I asked them “how was that?”, and Meg responded that she thought the musical stops were interesting – she could notice that there were sections, like “taking a new direction every time … not stopping but changing”. Eve agreed with her, stating that she had also liked the pauses,

directly after expressing that it was difficult for her to know how to create dialogues among three people, and how to "respond to one when another is following you".

I decided to continue with their idea about pauses and gave an instruction before the next improvisation to "not be afraid to pause if you feel like it … we don't have to play at the same time, we can take turns". I suggested they could pick different instruments, but both Meg and Eve kept theirs while I took a simple wood block, about which Meg curiously enquired. After briefly saying a few words, I proposed that they start whenever they wanted to (purposely not looking at any of them). Meg showed her willingness and started improvising while Eve smiled at her with a hint of encouragement:

> Meg starts with a regular rhythmic pattern on her djembe, plays it for 20 sec. She intensifies some moments of her playing and then stops. Eve and the therapist respond in a similar way; the therapist tries to recreate some more intense moments, too. Suddenly Meg decides to join in again, starts playing her djembe quite loud and moving her upper body to the rhythm. She explores different spots, sounds on the drum, suddenly laughs out loud and keeps playing with a smile. Eve seems to be content with accompanying Meg's leading. Finally, after another 20 sec. Meg looks like she is ready to finish and slowly fades away with her playing whereas Eve and the therapist keep the containing response in case Meg decided to come back to leading. Meg, seeing that the others still keep their accompaniment, starts to play again but in a moment sees that Eve is taking over the leading of the improvisation, therefore she gently stops playing. Eve intensively plays the kalimba for about 30 sec. and then stops and lifts her head to see what the others will do. Meg starts off by playing the djembe with the stick part of her mallets and then even starts to play with the ropes on the djembe which creates a similar sensation to that of the kalimba. The therapist plays her wood block with fingers instead of a mallet. Eve listens for a while, especially focusing her regard at Meg's playing. Eve is listening for the whole duration of the response, not joining in. The response slowly stops. [Session IV, transcription]

We started discussing how everything went, and Eve expressed that even though she found it confusing working out how to respond to an idea, she enjoyed seeing what the others "made of her question". Meg tried easing in to her reaction with "it was nice…yeah…the playing" before quickly stating "I don't know what to say". I asked her about the noticeable force in her playing. Meg responded again "I don't really know", while laughing nervously. Then Eve added that she, too, had noticed how Meg "said with her with music *blah blah blah,* to which we said *blah blah blah,* but then you said *no, BLAH BLAH BLAH*". They both giggled and then Meg said "well, maybe it's something like…trusting…I enjoyed it".

I noticed Meg using the word "trusting" but thought that we might elaborate on that at a later point. Instead we moved on to music listening, which began with me thanking them for sending me the titles of their songs (which I then found and collected on Spotify). Neither of the clients volunteered to have their song played first; Eve said to me "you choose". I suggested listening

to Meg's song first, thinking that it might take time for Eve to choose between her three songs. Both Meg and Eve lay down on their mats, with Eve on her front, with arms supporting her resting forehead, and Meg lying on her back with her arms and legs relaxed on the ground. Before listening to the song, I invited them to relax, saying "let the music come inside you…then maybe after Meg could share why the song is important to her".

Throughout the song, *Catch the Wind* by Jonathan David Helser & Melissa Helser, I sat calmly and observed the clients. I later noted that in that moment I had felt quite unsure about the subsequent processing. Meg was very still, apart from bringing her hands under her head in the middle of the song. Eve, meanwhile, kept moving her feet to the beat of the song. After the song ended, neither client sat up; they both remained lying on the floor, only turned on their sides. I sat next to them in a relaxed manner and asked:

> T.: Can you share something about this song?
>
> M: It's telling about freedom. It became (*lifts herself and sits on the mat*) an important song for me during last year when I was abroad […] It's [about] how I used to have a lot of fear in my life, and I was so insecure and the story how like God made me free and how I had my confidence. And every time I feel afraid, I listen to this song.
>
> T.: Afraid of what?
>
> M: It's the fear of being…myself…yeah… (*sighs a couple of times).*.. I just had a lot of fear to…speak up…I had a lot of fear that I would be…rejected. And I didn't want…others to see me. It's funny because in a way I wanted, but, yeah, I felt so insecure about myself, and the future… […]
>
> T.: How did you experience feeling more secure?
>
> M.: For me, with my faith and with God, like knowing that…ah… my security is in God, and like, I am not alone. Trusting even with the bad things. […] Really during my time there [abroad] I finally started to learn to trust people 'cause I had this feeling that I was alone, believing that nobody is for me and really didn't trust people. So that was really the first [time] I tried to open up myself, it was really hard. That's why I felt so insecure and open my things to other people. I started to learn that I can trust people. But it's still a journey (*sighs*). [*Session IV*, transcription]

At that moment I sensed that this was a window of opportunity for Meg to share something about her experience, and that it may also prove to be meaningful for Eve, too. Therefore, I gently continued the conversation:

> T.: Where did this mistrust, inability to trust people come from before?

> M.: Yeah, I think from my home. I felt like my parents didn't really care. We didn't really talk about things if I had some problem. We didn't really… I didn't talk about it with them. Well…now I am learning (*laughs nervously*), they have changed, still it's more like I don't really want to call them especially if I am sad. I don't want to call them. But I have opened up a bit more, but still I don't about my things with them. *She paused for a few seconds, during which Eve sat up.*
>
> T.: Coming back to the song, is there one word or line that is particularly important to you?
>
> M.: Heh…there's so many… maybe "your faithfulness will never let me down". It reminds me that I'm not alone, my faith gives me security. I also am learning that when I know people more, trusting is better; when I can open up with them. [*Session IV*, transcription]

I then looked at Eve, who appeared to be wanting to say something. Therefore, I asked her:

> T.: Eve, you have been listening a lot…do you want to ask something?
>
> E: I was thinking about what you (*to Meg*) said about trusting. Maybe trusting was difficult to you because you experienced that people disappoint you? And with the community that you got to know, maybe you started to see that not everyone disappoints you, that they can actually be there for you, and you can have good experiences, something like that?
>
> M.: I think so, yes. Maybe before I have experienced that people when they said something, they didn't mean it or betrayed my trust. [*Session IV*, transcription]

I noticed that Eve was very empathetic in the way she enquired about Meg's experience with disappointment; I sensed that she might be open to sharing later along the line. However, I continued by asking Meg about her finding her faith.

> M.: I found it myself (*smiles).* Two years ago I felt like I wanted to go to a church. It was the time when I felt kind of depressed, thinking that there's no sense in this world and I felt this emptiness… then started to open my things (*Meg quickly wipes a few tears from under her eyes, while Eve looks at her with supportive and empathetic posture*).
>
> T.: It is a courageous journey, going from this loneliness, emptiness to opening up to other people… (*Meg sighs and nods).* Thank you for sharing.
>
> M.: Thank you for listening. *(Meg appears calm, still brushing off a few tears, gently smiling.)* [Session IV, transcription]

After a pause, I glanced at Eve, who appeared to be more present than before, and less distracted. I asked if she was willing to share her experience while listening to the song:

> E.: Yeah, for me the song felt really powerful. I am not religious at all, so I didn't listen to it in that sense. But for example, the line "I'm confident, I see your goodness now" – I can really relate to that, in like, people [and] relationships *(Meg agrees, nodding and turning towards Eve*). Also, trusting in other people and being confident, […], I realised, and that you can never really know what other people can do. And that I have to be confident in myself and believe that I am worthy of love […] it spoke to me about trusting

> other people and seeing goodness in them, which I believe also comes from being confident in myself. I also had the same problem of being afraid to be myself, to say things out loud […], being afraid that people will disappoint and not accept me for who I am. [*Session IV*, transcription]

I noticed her mentioning "seeing goodness in other people" and suggested the group share more about that.

> M.: After I became a believer, I worked things out with my Dad, now I can…heh…can love him. Before I wasn't thinking like that. Sometimes I was hating him […] but now I can understand him […] My mother is doing better, of course, sometimes has hard times. My Dad got help two years ago. I think my Mom respects herself now more. It's a long journey. [*Session IV*, transcription]

I asked if Eve felt like she could relate to what Meg shared and straight away she started telling us about her experience of having an addict relative whom she was once very close to. She shared her great difficulty in trying to combine two different images of the same person before and after the addiction and violent behaviour took their toll, and explained how she came to feel afraid of someone she had known all her life.

> E.: I kind of want to hope that he'll get better and everything turns out fine but at the same time it's really hard for me to, at this moment, see much good in him (*sighs*). I also feel a lot of pity […] At the moment I have to think about my family, my safety and the safety of my child, so that's my number one thing at the moment. But at the same time, I feel very sorry for him. I feel sad that I am not able to help him in his situation, and at the same time I know that I have to put my family first right now. […] [*Session IV*, transcription]

After Eve finished sharing, we all sat in silence for a few moments, and then I noticed that the time allocated for our session was about to end. I sensed that it was better to stay in silence rather than attempt another activity, thus I suggested that we sit in stillness for a few minutes and each of them should find one word that they wanted to bring with them to the outside world. I also thanked them for their sharing, to which they both smiled in agreement. As we sat in silence, Meg closed her eyes for a minute, appearing both shaken and relieved, and Eve looked downwards, with her facial expression appearing sad yet calm. They both looked right into each other's and my eyes and said a quick "thank you" while standing up. After agreeing that next time it would be Eve's turn to share a song (with which she appeared pleased) and saying good-bye, I sat for a while in complete stillness, before going to the piano thinking "something has happened" and playing to process my own inner state.

5.1.3 Reflection

As with every cycle, the reflection process followed similar steps: immediate reflection with a fellow music therapy student, and then writing up my clinical notes and reflections, combined with video reviewing.

Upon reflection, I was both pleased and surprised with how the session had gone. “Wow, this is real, something important has happened”, I wrote in my reflection. “A meaningful change, could it be?” I was not surprised that listening to a client-chosen song had brought out personal stories, and yet I was astonished by the extent of it. “Maybe it was time for it”, I reflected. “They trusted each other enough to be able to share their stories.” *Trust* was the key word that I noted from this session. I could sense that the group, and Meg in particular, had not been pushed into sharing against their wishes (which I feared could have been a possibility if I had not had the determination to avoid any such pushing). Meg confirmed this by expressing verbally that she felt able to trust the group. I noted that Eve was likely inspired to start sharing her experience because of Meg’s self-disclosure and vulnerability. I believed that the group’s *cohesiveness* may have contributed to the outcome. The experience of this session became a stepping stone for the rest of the therapeutic process.

I also reflected on my role as therapist – particularly aiming to assess whether I would be able to improve my being “there” for the clients while also reducing verbal interaction. Upon reviewing the video, I noted a small positive change: I was calmer than I had been during previous sessions, my movements and breathing were slightly smoother and slower, and I was able to maintain eye contact. I still asked what I considered to be too many questions; some of them may have been ‘too leading’ but they were less complicated – i.e. one sentence instead of a few. This gave me the confidence to continue “to strive at becoming a better listener and letting them ask each other questions if they wanted to” (*Session IV*, Notes). I also decided that during the next session we would continue with song sharing while observing whether the positive change in group *cohesiveness* and mutual *trust* would be sustained.

In the following sections I do not present other sessions as cycles; instead I describe the most frequently occurring interventions, outlining the activities that seemed to be meaningful along with how I planned for them and reflected afterwards. Furthermore, I outline some observations

and themes that emerged from the data analysis, relating to the overall group music therapy process.

5.2 Experiencing various activities within the music therapy group

5.2.1 Clinical improvisation

Throughout the therapeutic process clinical improvisation was the most frequent intervention of all. There was not a single session that did not include improvisatory activities.

Throughout the process, but particularly during the initial stage, improvisation was included to help in fostering the "environment of trust and support established to meet the needs of clients" (Wigram, 2004, p. 37). The clients were relatively keen on exploring the music therapy clinic with all the different instruments in it, and they increasingly seemed to understand different roles when improvising, such as *leading*, *following*, *responding*, *taking turns*, *supporting*, *accompanying* etc., which gradually led to musical cohesion. Initially they were, as expected, slightly hesitant at improvising freely, preferring to play rather defined, static rhythmic patterns (with Eve expressing that "life is nicer when there is rhythm"); they often observed how I was playing and noticeably imitated my playing. At one point in *Session III* Meg asked if she could play "anger and fear", which we attempted to do together, although she did not appear to be content with the outcome. I sensed that she may have felt that the others did not share her emotions, and therefore was left unsupported. However, Meg stated at the end of the session that she could "now play the happier emotions".

Once we reached the working stage, from *Session IV* onwards, the improvisations became increasingly longer and more independent from me as a therapist. Once I noticed this, I tried to foster and gently ground and/or hold the musical interaction between the clients. I realised that the clients were gradually improvising more with each other; once one started to lead the improvisation, the others supported her. After an improvisation had finished, they remained focused on each other's verbal processing, sharing in a similar supportive way. I observed how their eye contact became more natural and sustained, how they would lean in when listening to others and maintain a relaxed body posture when sharing themselves. During *Session VIII*, once improvisational music making became more "natural" to the group, I suggested that we could

record an improvisation together. We discussed which instruments everyone wants to play, brought them to the circle, decided to develop several episodes (sections), and agreed to "take turns" in who is leading (after a section was finished by the leader, she could pass her role by cueing musically or with a gesture) while the others supported their "musical sharing" by "being there and listening without judgment…musically". The leading role was passed on to the next person, and we did this twice. This resulted in an improvisation lasting for nine minutes and 22 seconds. Another suggestion I made was to explore different intensities of volume, and possibly change the instruments when they felt it was appropriate. This resulted in an improvisation full of contrast, with "ups and downs", as Jess expressed; Meg, meanwhile, appeared to be very content with the improvisation ("oh, this was quite beautiful"). Finally, we listened back to the recording during the next session; the clients also expressed their wish to receive copies in order to keep the recording as a memory from our time together.

Planning and reflection

Throughout the therapeutic process I focused more on reflecting how the improvisatory interventions unfolded, rather than planning them. However, most often the reflection process led to the formation of ideas for the next session. After *Session II* I experienced a slight confusion and lack of certainty on how to proceed with the clinical improvisation. This was, as I noted, due to being something of a novice in the role of the music therapist. Therefore, I revisited Tony Wigram's *Improvisation* (2004) and was relieved to find a section, amongst all the different methods for improvisation, called "Dialoguing". Within our music therapy group we immediately started, upon my initiation, referring to the improvisation as a dialogue or conversation, regardless of what technique (suggestion, instruction) had been given in concrete situations. Wigram (2004) defines *dialoguing* as "a process where therapist and client/clients communicate through their musical play" (p. 97). Moreover, he describes two forms of *dialoguing*: "turn-taking" (making pauses and giving space for each other) and "free-floating" (playing "more or less continuously and simultaneously" (p. 98)). I noted that we used both forms of dialoguing musically, relating 'turn-taking' to points when someone was sharing while others listened, and 'free-floating' to a freer conversation, or discussions on a common theme. Wigram's comparison of dialoguing with real-life conversation provided me with a number of ideas on how to expand our improvisations during the upcoming sessions.

5.2.2 Receptive music listening

Throughout the process the group experienced several different receptive music listening methods: pre-recorded music selected by the therapist, songs selected by the clients, and listening to a recorded improvisation.

Pre-recorded music listening

In the second part of *Session I,* after active improvising and warming up with each other, I invited the clients to listen to a piece lasting eight minutes and 40 seconds, giving a simple instruction ("just relax, close your eyes if you want to and let the music in […]") before we listened to *Piano Concerto in G-major: II. Adagio assai* by Maurice Ravel. After the music stopped, I gently asked them to share their experiences ("any feelings, thoughts, ideas that came to you"). Meg appeared quite calm and shared that she had simply enjoyed the music and was excited to continue the process of music therapy; she appreciated that there were many possibilities here and it is a "nice way to give time for myself…to concentrate […]". Eve, on the other hand, shared that she had found it difficult to concentrate – her mind tended to wander off a lot, and yet she still liked listening to the music ("it's been such a long time since I listened to classical music"). She also briefly mentioned that the music reminded her of the reason behind her joining the group:

> And there was this more intense part in the song which reminded me the situation why I'm here for, so I was thinking about that for a moment, and, yeah, I was trying to think about this (*gestures at the room),* how it's going to move forward but I still don't have any idea how it's going to go… [*Session I,* transcription]

I noticed her mentioning the "why I'm here" but I assessed that I could not ask her to elaborate any further at that stage as my approach was to let them share at their own pace rather than pushing them into disclosing personal experiences. We finished the activity, as well as the session, with my final line: "It seems that you both need to have quality time for yourself and experience being in the here and now."

Planning and reflection

The choice to listen to a piece of classical music during our first session came from a rather simplistic place: when I planned the session, I decided to choose something quite 'universal' and we would listen to it if I sensed that it was appropriate. After the first session finished, I

reflected in my notes that the choice to listen was “not bad” even though the clients spoke of their lack of concentration. Upon reviewing the video recording, I observed their body language cues more closely:

> Meg was very still, listening with her eyes closed, head slightly raised and arms resting on her thighs while Eve, also with closed eyes, was more restless, looked very tired, kept holding her head by hand and yawning. Towards the end Eve opened her eyes and started looking around the room. [*Session I*, Notes]

Their body language reflected in their sharing, which made me want to be more aware and attentive to these cues during these sessions, in order to notice subtle changes and respond accordingly. I surmised that if we proceeded by listening to client-selected music rather than my choices, this would possibly elicit *self-disclosure* and *trusting* conversations.

Song sharing

At the end of *Session III* I asked the clients to select songs that are “somehow important” to them, and to send me the titles in advance. Before the start of *Session IV* I had already listened to all the songs they sent me, in order to familiarise myself with them. During *Session IV* it was Meg who shared her song (see section *Session IV – One Cycle*); later in *Session V* it was Eve’s turn and finally during *Session VII* we listened to Jess’ song. In all three cases, listening to the songs within the group elicited *self-disclosure* and *empathy*; this activity supported and improved group *cohesiveness.* The clients disclosed their experiences in dealing with the addiction of their close ones, expressed what kind of associations these songs have in their lives, listened to others sharing and consequently shared things that resonated with them. Every time I could sense and observe that they regarded each other’s song sharing with *care*, *support* and *confidence*. I interpreted these interactions as the high points of the whole therapeutic process.

Planning and reflection

I had not prepared a detailed plan for the song-sharing activity in *Session IV*: I simply trusted my previous practical experience that this, to put it simply, “works”. The outcome of Meg’s *song sharing* surprised me, and therefore I decided to read more about the method in order to plan the subsequent cycles more thoroughly.

In planning *song sharing* during the later sessions, I re-examined the process from the previous session as well as reading key chapters from *Receptive Methods in Music Therapy* by Grocke

& Wigram (2007) – particularly Chapter 6, which is dedicated to song lyric discussion. Reading this chapter had a double effect: on the one hand, I could confirm that the process I had moderated was in fact, mostly "correct"; on the other hand, it also provided me with an even clearer idea about the purpose and facilitation of the song discussion. Amongst the objectives of this method were these, which I regarded as necessary to follow:

> To promote music as a catalyst for discussion of issues pertinent to the client(s)
>
> To encourage insight by discussion of the song's lyrics
>
> To provide opportunities for choice and self-expression (Grocke & Wigram, 2007, p. 164)

I could see that during *Session IV* the shared song definitely acted as a "catalyst for discussion of issues", yet I wanted to make sure that my objective to "encourage insight" was not accidentally too invasive – i.e. I could observe that some questions I had previously asked may have been "too leading". Therefore, I carefully studied the three levels of questions as presented by Grocke and Wigram (2007) and attempted to better incorporate the neutral tone in which they are formulated, in order to improve my facilitation during the discussion. As the clients were already familiar with each other, and the group members were seemingly becoming more confident to process and share on a deeper level, I noticed that we quickly moved on to second- and third-level questions:

> Are there particular lyrics that stand out as being meaningful to you? In what way?
>
> Is there something about the song that relates to your life [...]?
>
> How does the song make you feel?
>
> What images or thoughts came to you when you were listening to the song? (p. 166-167)

Upon reflection, my effort to improve verbal interaction during song discussion by both reducing it and simplifying it – i.e. asking one question at a time, while also encouraging respectful and supportive enquiring from the other clients – gradually shifted the interaction to *client-client*, rather than *client-therapist*. It seemed to me that this too was a meaningful change.

Listening to an improvisation

During *Session IX*, I had prepared sheets of paper for Meg and Eve, the participants that attended the session; these were placed at the centre of the circle along with crayons, pens and pencils. I invited them to listen and use the paper to reflect on "what the music will bring up: images, feelings, thoughts…" Both Meg and Eve seemed to be involved in the task at hand; after the music had finished, they continued drawing for another two minutes. Finally, after they both raised their heads, I asked if anyone wanted to start sharing their reflection. Meg volunteered:

> M.: It reminded me about the ocean. A lot of times I think that in life… I wrote here that "Life is like an ocean, sometimes the waves are big and stormy but there can be joy", sometimes, yeah, you can feel like, oh, it's so stormy, and I think but it can be calm and I can just live in the moment. And there is like different colours and joy in the waves in our lives, and the in the end, I think…this is…why did I do this red colour in the end? (*Meg reflects for a moment*) I think it's my emotions that sometimes they take control over my life…yeah…it felt good to kind of like express this. And I thought also that drawing and doing some kind of arts would help me to express my feelings in a good way. [*Session IX*, transcription]

We then elaborated on the image of the ocean, with its storms and waves, and also discussed how to keep calm even when anxiety – "the storm" – is taking over, relating this to the first part of the session, where *anxiety* was the main theme during verbal check-in and the first improvisation. Eve also shared a response to the image of the ocean, yet stated:

> I really do love the ocean, water…I thought I would hear more of it in the music, because that's what I was thinking when we did it…but I didn't. For some reason I heard more things. I did hear the ocean but not as much, I thought it would, you know, be more of it. [*Session IX*, transcription]

She remembered that she was the one playing the ocean drum, and expressed that listening to the recording afterwards was a very different experience to playing the same music at the time. We discussed further about our changing perception of things between when they happen and how we later remember them. Eve also shared that she had colours in her mind rather than specific images, and that she enjoyed listening how the colours, or moods in the music, changed. I enquired about the unpainted white space in her paper, and she referred to it as "things that are unknown", elaborating that these were areas where she wished "to build a little bit more tolerance". When I asked what kind of things these might be, she smiled, "well, that's the thing – they are unknown". This caused laughter throughout the group.

Meg expressed that she had not really been able to listen to the music because she was concentrating on drawing; therefore, it seemed appropriate to suggest listening to the recording again. Playing it a second time, I invited them to "just focus on the music itself, without any

papers". They lay down on the mats, closed their eyes and listened to the music in stillness. After the music stopped, Eve smilingly shared that she had remembered a very positive memory; she recounted the memory, prompting laughter from the rest of the group. Meg simply shared that she had imagined a waterfall, where she was at the top and could just let go of her emotions, her anxieties. She appeared to be in a peaceful state of mind. I shared that I could not stop noticing how much "water" was in that day's session, and encouraged them to take the image of "waters" away for their week.

Planning and reflection

When I planned to use papers and crayons for the reflection, I did this because of my previous experience in carrying out similar tasks while processing the music. I assumed that this method might encourage the clients to practise using another means to process their thoughts, feelings and experience. Upon reflection, I was interested to hear that concentrating on the drawing had caused Meg to lose focus on the music; Eve, on the other hand, reported "following the music all the time". It appears to have been a good decision to listen to the recording again at the end of process, in order to give the clients an opportunity to process their reflection even further or simply to enjoy their music, which it seemed that they did. I noted towards the end of our therapeutic process that it had been good to observe the clients' increasing levels of self-confidence and sense of worth after creating "quite beautiful music". Whilst reflecting on the process and planning the final session I realised that our short-term process of ten sessions was not enough for this group; given further time, we could have explored more deeply.

5.2.3 Mindfulness exercises

During the planning stage of the overall therapeutic process, I made the decision to try leading mindfulness exercises during every session within the timeframe of the therapy. I believed that this could provide a chance for the clients and myself to become more aware of ourselves, particularly our bodies and inner states within the context, to experience being "present" ("here and now"), and to practise focusing on and accepting our "inner track" as it is. Yet after trying a couple of exercises in the early stages of the process, I noticed myself feeling somewhat uncomfortable when leading them. I kept hearing my thoughts (saying "what are you doing?") and my inner voice told me that it would be better not to force this activity if I was not confident with it. Therefore, after two sessions, the exercises dedicated primarily to mindfulness were left

as ideas to be revisited if and when necessary. Upon reflection, I found myself both relieved that I was not supposed to achieve everything I had planned, and disappointed that I could not work through these uncomfortable feelings. It appeared that I had learned to be more accepting of my inner state and lack of experience; these factors meant that I would not always be able to do everything I had planned, although the situation would likely improve as I gained further knowledge and experience.

5.3 Music therapy support group

At the start of this action research within the music therapy group, I had a plan to combine different interventions and elements from both music therapy and support group frameworks. A support group, as briefly defined by Cambridge Dictionary, is "a group of people who have had similar experiences, especially difficult ones, and who provide help to each other". By inviting clients that share a background affected by addiction in the family, I hoped that they would be encouraged to open up to each other, share and listen in confidence and experience various activities together. Thus the primary defined goal for the group as a whole was:

To foster a safe environment for 'musicking', reflecting and sharing within the group

- *by encouraging musical cooperation and dialogue between the clients;*
- *by providing various means to process their experiences, past and present;*
- *by facilitating cohesive group work through moderated conversation.*

I did not find it appropriate to define more than one clear group goal due to the short-term process that had been planned. I regarded the defined group goal as a direction to follow, although it seemed to be important to remain flexible within every session. Therefore, although I planned every session with the goal in mind, I was ready to adapt to any changes that may occur.

Conscious that everyone was aware of the common background they all shared – i.e. the burden of addiction in the family – I decided not to lead purposely to this subject, but rather to let the clients take their time to open up and process it. This decision on my part as the therapist proved to be of use: once an appropriate level of group *cohesion* was achieved and the clients felt able

to trust the group, they started functioning as a support group for each other, providing a space to listen, share and relate.

5.3.1 Group development

Throughout the process, I noticed several changes in group development. As Pavlicevic (2003) suggests, I reflected upon Tuckman's Group Phases model in order to better understand the developmental stages the group was going through. In contrast to many groups, the development was rather linear and, in the main, did not move back and forth between different developmental stages. *Session I* started as expected with Phase One – *forming.* I understood that this was a time for the clients to get to know each other and take the initial steps to becoming a cohesive group, and therefore it was disappointing to find out that Jess would not be able to participate. However, both Meg and Eve, despite showing signs of slight discomfort and shyness because of an unfamiliar situation, were very receptive to the activities I proposed, and therefore it seemed that we could all sense the appropriate atmosphere forming for future meetings. However, the next sessions quickly jumped forward to Phase Two – *storming.* There appeared to be a higher level of discomfort here; upon reflection, this can be explained as a reaction to both internal factors (as I noted at the time, this is the "normal nature of group formation") and important external factors. These include Jess' late entrance to the group, Eve bringing her baby to *Session III*, and Meg's intense emotions, which she wanted to fully express and but found it uncomfortable to do so. *Session IV* was a turning point for the whole process as well as the start of Phase Three – *norming.* Upon reflection, I attributed the shift in group dynamics not only to the natural arrival of Phase Three but also to the return of the initial group setup, which was limited just to Meg, Eve and myself. This group continued for the next two sessions (*Session V* and *Session VI*) and it became "able to tolerate and manage difference" (Pavlicevic, 2003); therefore, when Jess attended *Session VII* and *Session VIII,* the group remained relatively cohesive and the clients kept trusting in each other. My opinion is that Phase Three occurred simultaneously with Phase Four – *performing*, with the group able to maintain its function relatively well since the turning point. *Session IX* showed again that the particular dynamic between Meg and Eve was a meaningful, fruitful one. Finally, the last session was intended to serve as Phase Five – *adjourning,* which meant closing the process. After the session, I noted that the ending felt "forced" ("because we were supposed to close", *Session X*, Notes) and not natural. This may be attributed to the short-term process we had; all three clients

expressed that they valued their experience here, and one felt that "we were only starting to really talk" (*Session X*, Notes).

5.3.2 Group cohesiveness

One of my research aims was to observe the formation of *group cohesiveness* – i.e. to notice and analyse both the obvious indicators of a *cohesive group* and the more subtle ones. Yalom and Leszcz (2005) summarise this here:

> "By definition, cohesiveness refers to the attraction that members have for their group and for the other members. [...] The members of a cohesive group are accepting of one another, supportive, and inclined to form meaningful relationships in the group. [...] In conditions of acceptance and understanding, members will be more inclined to express and explore themselves, to become aware of and integrate hitherto unacceptable aspects of self, and to relate more deeply to others. [...] Cohesiveness favors self-disclosure, risk taking [...]" (p. 100).

I found that this particular group within the music therapy context was able to reach an adequate level of *cohesiveness*. Every client exhibited willingness to participate in various activities, and to explore their feelings, thoughts and experiences while trusting the safety of this environment; they increasingly showed their acceptance of each other by listening more attentively, and expressing *support* verbally, musically and with their body language. I purposely attempted to facilitate such interactions where the clients shared and played with each other, rather than with me. They could eventually relate to each other on a deeper level, as they shared a similar background of family burden with addiction.

It seems that the outcome of *group cohesiveness* can be attributed to several different factors. One major factor was the common reason why these clients had chosen to participate in the group: they wanted the opportunity to explore their issues while being together with people who have similar experiences. Meaningful music-making contributed to eliciting a *sense of belonging*, while song-sharing evoked *self-disclosure*; moreover, the clients prompted each other to share personal experiences and reach greater depths simply through being their authentic "selves". The group was able to understand the concept of *dialoguing* when improvising and could reflect together on their common activity. Over time, they learnt to give feedback with care. I also noted that the most *cohesive* relationship seems to have been formed between Meg and Eve; I attributed this to their being present at all sessions, while Jess was only able to attend a few sessions. An important turning point occurred within *Session IV*, when Meg

could *self-disclose* in confidence and Eve was prompted to share too; this continued through the following session, serving to increase the *supportive* nature of this group and of their relationship. Towards the second part of the process, group *cohesiveness* remained stable, facilitating meaningful experiences inside the music therapy group.

5.3.3 Emerging themes

Confidence

Confidence is an important theme that unfolded throughout the therapeutic process. During the analysis, *Confidence* appeared to encompass instances related to *self-confidence, having confidence in others, trust, sense of worth* and *"grounded-ness"/presence.* At the beginning both clients that attended exhibited signs of an initial lack of confidence, which I regarded as 'normal' for the start of such a process. Eve expressed a few times that she is "shy to do these things", how "this is scary"; however, at the introduction of every new activity she did not resist. In fact, she was frequently first to be prepared for it, quickly choosing an instrument, able to take on the leading role during an improvisation, and willing to change her playing in the middle of any improvisation. Despite initially playing in the most careful manner in terms of the volume and variety of sounds, this gradually shifted to a more confident, freer style of musicking towards the end of the process, with greater exploration of the instrument. During the first sessions, Eve did not maintain direct eye contact, and nor did her body language cues exhibit willingness to open up; however, her posture drastically changed when she was fully listening to Meg's personal sharing.

During the processing of the first client-selected song, both clients were able to share about their struggle with *self-confidence* and *trust* issues in their lives, which they related to their experience of dealing with addicted relatives; in addition, they also expressed that they were now able to "trust this environment" (i.e. the music therapy group). Having one member share a very personal story prompted another to share her story, too.

Meg often expressed her feeling of "being present" during the sessions, particularly directly after an improvisation; this feeling gradually increased throughout the process. Often this was clearly noticeable by how the clients' body language changed. Meg became more relaxed and was able to sustain direct eye contact; she was more intentional with her playing and appeared

able to process her emotions. Eve was usually more distracted, with her body language displaying her detachment; she often shared that her mind was occupied with other things.

It appears that *confidence* was one of the most important outcomes of the therapeutic process; not only for the clients, but also for my role as a therapist. I constantly attempted to remain more aware of my full presence, keeping myself "available" for the clients at all times, in order for them to be able to trust the group and to experience supportive response from the members, bearing in mind that one of those members was myself.

Care

Throughout the therapeutic process it became apparent that the clients were keen to *care* for and *support* each other, practice *self-care* and listen *empathically.* During my analysis I titled the encompassing category as *Care.* The clients stated that they saw the choice to join the music therapy group as the opportunity for their "time for myself". At the end of a session, they sometimes felt as though the hour had passed too quickly, expressing that it felt "weird to come back to the world outside"; sometimes they described a change in their state from "tired" to "fresh", from "anxious" to "calmer", from "feeling happy and sunny" to "wanting to rest".

The *empathic listening* process gradually expanded, although there was a distinct positive shift during the turning point in *Session IV* and *Session V.* Previously, the clients had seemed more easily distracted, focusing their attention and gaze on the music therapist or extraneous subjects (things outside of the music or the group), and sometimes directly commenting on what the others shared, seemingly in a less empathetic way. After the turning point, when one client was telling and processing their personal story, the other clients would remain very still and invested, listening without commenting and only sharing with *care* in a sensitive manner, when they found something that resonated with them. Going onwards, the direct eye contact, open relaxed body posture, and subtle touches such as leaning in when others shared, appeared to become more prevalent.

The clients shared their different experiences with *caring for others* and *care for oneself.* Eve shared multiple times that she "always cares for the others", while at the same time realising that she needs to take care of herself, too. For her, a pivotal moment was understanding that even though she is worried and afraid, and wants to help both the addicted person in the family

and everyone else affected, she must take care of her own family first. Meg expressed how she felt that during her childhood her family "did not really care", that they could not talk about things, and even now she was not keen on communicating with them about her problems. Discovering faith and her church community brought about a positive change in which she started learning to open up to other people more. However, she was encouraged to share more openly within the music therapy group after listening to an important song that she had selected. Her sharing prompted Eve to share more deeply as well, and this continued into *Session V* where she brought her "important song". After listening to it, the clients were able to continue sharing personal stories.

Coping

I chose to frame another prominent theme as *Coping*, having observed several instances of possible coping strategies that the clients appeared to be already using or developing in their lives. This included *emotional awareness, coping with emotional issues/states, sources of strength, sense of belonging* and *security.*

It seems that attending the music therapy group has challenged the clients to revisit within themselves the effect their relative's addiction had (or still has) on them, and how they deal with it. For example, I noted that for Eve, a young mother, having someone to *care* for (her baby, or her husband) was both a *source of strength* ("but I have to take care of my family first, be there for my child") and a way to avoid *coping* with her plethora of feelings towards the situation. Throughout the therapeutic process she was able to tell her story and be vulnerable, yet often I noted that she was rather distracted and constantly talked about her baby (although this is understandable). However, practising free improvisation within the group may have helped her increasingly to let go of her "perfectionism", even for a short time, and process her emotions. It was during *Session IX* that she shared about her recurring anxiety issues; she was willing to process them through improvisation as this helped her to relate meaningfully and, as she expressed, "release her anxiousness". It seemed that those feelings had been all but forgotten by the end of the session, when her posture was relaxed, and she was calm, concentrated and less distracted.

I was also interested to observe how Meg may have been inspired to use music to increase her *emotional awareness* and process her *inner states.* During *Session III* she wished to improvise

"anger and fear", but this appeared not to unfold as she expected it. Her body language showed more tension, with her face becoming slightly red after she had finished leading the improvisation. Her playing seemed quite "angry", and she appeared unsatisfied with the other clients' responses to her playing. However, this may also have been a sign of a struggle with group *cohesiveness*, which is normal during the *storming* stage of group formation. She experienced *sense of belonging* during the very first session, and continued to refer to it both verbally and musically later on. It seemed that her experience with discovering faith and her community greatly increased her *sense of belonging*, which I interpreted as her way to *cope* with her burdens. She shared information about her insecurities and how "having security in God" led to more openness to other people and an ability to trust them, especially when they have not done "anything wrong".

In this chapter I have presented some findings of this action research project; I believe it is necessary to acknowledge that some data went unnoticed or escaped the analysis. This can be ascribed to a number of reasons, which I will outline in the next chapter.

6 DISCUSSION

In this chapter I provide the summary of the findings, discuss their meaning within the context of music therapy and addiction-related family burden, point out the limitations of this research and make further recommendations before concluding the paper.

The findings suggest that experiencing music therapy in a group setting can be meaningful to people who have been affected by a relative's addiction. It seems that through attending the music therapy sessions, the participating members were able to develop into a relatively cohesive group that may have contributed towards achieving the therapeutic objectives. The group experienced at least one major turning point during the process; this brought about a change in the way they shared with each other and listened. A trusting and supportive relationship between the clients was progressively developed, and may have contributed towards building their confidence, care and possible coping strategies. Client-selected song listening and sharing seems to have been the most meaningful experience for the participants, prompting them to share about their burdens; clinical improvisation has also been observed as a useful tool for creating a safe, cooperative environment in which the clients could increase emotional awareness and process their experiences.

Aspects of sharing client-selected "important songs" with the group, along with some lyric analysis, and processing the experience that brought about a meaningful change all seem to reflect literature on the subject. Pavlicevic (2003) suggests music sharing as tool for members to get to know each other, especially in a new group; Grocke & Wigram (2007) describe the song discussion as an intervention that may assist in building the therapeutic relationship, based on trust and encouragement to disclose; and Silverman (2009) finds that lyric analysis within group music therapy conditions has a higher mean treatment eagerness and working alliance in recovering addicts. It appears that in this setting, after they shared and reflected on their songs, the clients were also enabled to disclose personal stories in relation to how they were affected by addiction of their relatives, and to share how they try to cope with their experiences; the disclosure in confidence seemed to contribute to a better working alliance and greater cohesion within the group. As with the findings of Timko et al. (2016), the group music therapy experience functioned as a common support group (like Al-Anon) in terms of gains for the clients: it created a safe environment in which to share and process their experiences with

people from a similar background, rather than gaining knowledge on how to improve their relationship with the addict. I could only speculate on whether the participants had indeed changed something in that relationship, and yet I could observe that they may have attempted to increase their emotional awareness and self-care while going through the therapeutic process. Coming back to the definition of codependency by CoDA ("[…] being overly concerned with the problems of another to the detriment of attending to one's own wants and needs" (Center for Substance Abuse Treatment, 2004), it is important for people with this burden to adopt better coping techniques and attend to their own needs. It appeared that all three participants had already acknowledged some of their needs and were coping with their experiences in some way; thus the music therapy group may have been another contributing tool to help them to process their emotions and give time for self-care, while also increasingly gaining confidence through exploring their past and present within the music therapy context. The cyclic use of active music-making – i.e. clinical improvisation in every session – may have contributed in building their self-confidence in improvising by allowing them to experience the "sense of belonging" and the feeling of being "present", and therefore increasingly making it easier to relate this experience to their real-life situations, feelings and thoughts. In turn, this created a more cohesive relationship among the group and the music and led towards the group's directional therapeutic goal.

The action research method, with which I approached my research questions, proved to be both an asset and a challenge. On one hand, its cyclic pattern, as described by Winter & Munn-Giddings (2001), allowed me to be flexible within every session and to reflect on the process continually, in order to change something in my practice if I deemed it necessary. Conversely, it required serious consideration of the presence of "other ways of understanding this experience", which proved to be very difficult. Thus, making judgments about the process and data that I had collected – the evaluation – was also challenging: when I attempt to improve my practice, how can I be sure what has been "effective"? (Winter & Munn-Giddings, 2001). Discussing the sessions with my student peer provided different perspectives, while reviewing literature and trying to incorporate what I learned in the following sessions also seemed to be quite effective.

In addition, I found further affirmation in my interest for the field of addiction and/or codependency treatment: my own understanding about the targeted client population was enhanced and therefore I am considering continuing to work in this field.

6.1 Limitations and further recommendations

One of the limitations was the short-term nature of the therapy process, which only encompassed 10 sessions. I believe that for this client population – moreover, this particular group of participants – a longer-term process may have proved to be more beneficial. The level of cohesiveness, although quite adequate, could have developed further over time. In the case of this study, it was not possible to organise more sessions due to conflicts within the busy schedule of the music therapy clinic.

Throughout the process, one of the clients was only able attend less than half of the sessions, leaving a group consisting of two clients and the music therapist. Although I, as a novice practitioner, found the group size to be rather manageable, the level of cohesiveness fluctuated, and I could observe different levels of personal motivation in the clients as the two constant members appeared to be somewhat more invested in the process. Thus, one of my suggestions is to form larger groups (possibly 4-7 members), which would also better reflect the setup of regular support groups. While setting up the sessions, I had only a relatively short time to gather participants, and therefore I may have inadvertently missed opportunities to reach the intended client group, thus making my group quite small and homogenous in age and gender. In the future, I would also consider it worthwhile to have an open group, which is something frequently seen with support groups; the process and outcome of such a group might be somewhat related to community music therapy.

Unfortunately, three sessions do not have video recordings, as these were lost or a session was accidentally unrecorded; this left both the reflection process and later analysis much more limited. I could only reflect on the process right away with my student colleague and write my notes (although these processes were also very helpful). This situation influenced my choice not to present all 10 cycles, but instead to focus on the one I found to be the most meaningful while also drawing additional data from the other recorded sessions.

Choosing the action research method was, as I have previously mentioned, a challenge. This method in itself has some relatively unavoidable drawbacks such as the validity and reliability of the findings, which depend solely on how the researcher carries out his/her work. Throughout the process I was able to reflect on my work and immediately discuss the sessions with my peer colleague; however, while looking back over the process with my supervising student tutor and professors, I found that it had been influenced by my being a novice music therapist as well as first-time researcher. Moreover, with regard to the data analysis, I was the only person to review and make conclusions about the data, thus making the findings even more subjective. However, when carried out as thoroughly as possible within the situation, this type of research does benefit the practice of the practitioner and his/her understanding of the research in the field, providing practical knowledge on what to do, and what not to do, for the future (Winter & Munn-Giddings, 2001). It should be noted that the findings cannot be generalised, and therefore have little use in expanding universal knowledge within this particular field.

I do hope that the body of research in music therapy and addiction – and the associated family burden – will continue to grow, providing more insight and tools to cope with issues arising from the addiction, as well as co-occurring diseases.

6.2 Conclusion

Experiencing group music therapy with clients who have dealt with the burden of a relative's addiction seemed to have been a meaningful process for all the group members. As it was an action research project in a form of a case study, findings should not be generalised, and yet they could be used to inform my own understanding about the intended client group. Several important considerations had to be taken into account when organising the process: finding the intended clients; agreeing on the short-term group music therapy process and signing a consent form; fostering a safe environment for the process; planning, reflecting and writing notes about the action, adjusting to the process; having reflective conversations with a peer and/or supervision; and learning to become more of a facilitator in order for the group to develop its supportive purpose. I was able to observe the changes in group development and group cohesiveness, and reflect these factors in relation to emerging themes – such as confidence, care and coping – as well as noting therapeutic interventions that may have led to these changes. The cyclic process of planning, action and reflection with every session helped me to develop

my reflective skills, my own style and my confidence in facilitating music therapy within the context; this has all contributed to my future aspiration to practise my studied profession and to ceaselessly improve my practice along the way.

References

Alcoholics Anonymous. (2001). *Alcoholics Anonymous, 4th Edition*. New York: A.A. World Services.

Aldridge, D. (2005). *Case study designs in music therapy*. London: Jessica Kingsley Publishers.

Aletraris, L., Paino, M., Edmond, M. B., Roman, P. M., & Bride, B. E. (2014). The use of art and music therapy in substance abuse treatment programs. *Journal of Addictions Nursing*, *25*(4), 190-196. http://doi.org/10.1097/JAN.0000000000000048

Baker, F. A., Gleadhill, L. M., & Dingle, G. A. (2007). Music therapy and emotional exploration: Exposing substance abuse clients to the experiences of non-drug-induced emotions. *The Arts in Psychotherapy*, *34*(4), 321-330. doi://doi.org/10.1016/j.aip.2007.04.005

Bohrman, C., Tennille, J., Levin, K., Rodgers, M., & Rhodes, K. (2017). Being superwoman: Low income mothers surviving problem drinking and intimate partner violence. *Journal of family violence*, *32*(7), 699-709.

Borling, J. (2011). Music therapy and addiction: Addressing essential components of the recovery process. In A. Meadows (Ed.), *Developments in music therapy practice: Case study perspectives* (pp. 234-249). Gilsum, NH: Barcelona.

Borling, J. (2017). Stage two recovery for substance use disorders. *Music and Medicine*, *9*(1), 59-63.

Brooke, S. L. (2009). The use of the creative therapies with chemical dependency issues. Springfield, Ill: Charles C. Thomas.

Bruscia, K. E. (2014). *Defining music therapy*. Gilsum, NH: Barcelona Publishers.

Carter, T.E., Panisch, L.S. (2020). A Systematic Review of Music Therapy for Psychosocial Outcomes of Substance Use Clients. International Journal of Mental Health and Addiction. https://doi.org/10.1007/s11469-020-00246-8

Center for Substance Abuse Treatment. (2004b). Substance abuse treatment and family therapy. TIP 39. Rockville, MD: U.S. Department of Health and Human Services

Choate, P. W. (2015). Adolescent alcoholism and drug addiction: The experience of parents. *Behavioral Sciences*, *5*(4), 461-476.

Cohen, L. (1990). Addicted to the addict: treating addiction's other victims. *CMAJ: Canadian Medical Association Journal*, *142*(4), 372.

Davies, A., Richards, E., & Barwick, N. (2014). *Group music therapy: a group analytic approach*. London: Routledge.

Dijkstra, I. & Hakvoort, L. (2004). How to deal music? Enhancing coping strategies in music therapy with clients suffering from addiction problems. *Music Therapy Today 5*(5) Retrieved from https://pdfs.semanticscholar.org/bd64/38a03539a554139d9e2e11531561085aa9dd.pdf

Dingle, G. A., Gleadhill, L., & Baker, F. A. (2008). Can music therapy engage patients in group cognitive behaviour therapy for substance abuse treatment? *Drug and Alcohol Review, 27*(2), 190-196. doi:10.1080/09595230701829371

Ghetti, C., Chen, X. J., Fachner, J., & Gold, C. (2017). Music therapy for people with substance use disorders. *Cochrane Database of Systematic Reviews*, (3).

Grocke, D. E., & Wigram, T. (2007). Receptive methods in music therapy: Techniques and clinical applications for music therapy clinicians, educators, and students. London: Jessica Kingsley Publishers.

Harrison, K. (2019). The social potential of music for addiction recovery. Music & Science. 2. 205920431984205. 10.1177/2059204319842058.

Lutsenko, A. M. (2020). Coping strategies and personality profile characteristics of people whose parents were alcohol addicts. *Behavioral Sciences, 10*(1), 32.

McNiff, J., & Whitehead, J. (2011). *All you need to know about action research*. London: Sage Publications.

Moore, B. C., Biegel, D. E., & McMahon, T. J. (2011). Maladaptive coping as a mediator of family stress. *Journal of social work practice in the addictions, 11*(1), 17-39.

Murphy, K. M. (2017). Music therapy in addictions treatment: A systematic review of the literature and recommendations for future research. *Music and Medicine: An Interdisciplinary Journal*, 9(1), 15-23. Retrieved from https://mmd.iammonline.com/index.php/musmed/article/view/556

Pavlicevic, M. (2003). *Groups in music: Strategies from music therapy*. London: Jessica Kingsley Publishers.

Shyangwa, P. M., Tripathi, B. M., & Lal, R. (2008). Family burden in opioid dependence syndrome in tertiary care center. *JNMA: The Journal of the Nepal Medical Association, 47*(171), 113-119.

Silverman, M. J. (2010). The effect of a lyric analysis intervention on withdrawal symptoms and locus of control in patients on a detoxification unit: A randomized effectiveness study. *The Arts in Psychotherapy, 37*(3), 197-201.

Silverman, M. (2009). The effect of lyric analysis on treatment eagerness and working alliance in consumers who are in detoxification: A randomized clinical effectiveness study. *Music Therapy Perspectives, 27*. 115-121. 10.1093/mtp/27.2.115.

Snoeren, M. M., Niessen, T. J., Abma, T. A. (2012). Engagement enacted: Essentials of initiating an action research project. *Action Research*, 10(2), 189–204. https://doi.org/10.1177/1476750311426620

Stringer, E. T. (2013). *Action research*. Thousand Oaks, California: Sage Publications.

The Twelve Steps (1996). Retrieved from http://www.al-anon.alateen.org/the-twelve-steps

Timko, C., Laudet, A., & Moos, R. H. (2016). Al-Anon newcomers: Benefits of continuing attendance for six months. *The American Journal of Drug and Alcohol Abuse, 42*(4), 441-449.

Usher, A. M., McShane, K. E., & Dwyer, C. (2015). A realist review of family-based interventions for children of substance abusing parents. *Systematic Reviews*, *4*(1), 177.

Wigram, T. (2017). Improvisation: Methods and techniques for music therapy clinicians, educators, and students. London: Jessica Kingsley Publishers.

Winter, R., & Munn-Giddings, C. (2001). *A handbook for action research in health and social care*. London: Routledge.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. New York: Basic Books.

Yearsley, S. (2010). Striking a balance: Improving practice as a student doing group music therapy with adults with substance abuse and dependence. Retrieved from: http://researcharchive.vuw.ac.nz/handle/10063/1473