

***Striking a Balance: Improving Practice as a  
Student Doing Group Music Therapy with Adults  
with Substance Abuse and Dependence***

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in partial fulfilment of the requirements for the  
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## Abstract

*An action research project was devised to help a music therapy student improve her practice in a group alcohol and drug treatment setting. The project initially focussed on improving practice by delivering more creative, sustained and holistic experiences. Four action cycles of one week each were carried out, each cycle comprising planning, action and reflection stages. Data sources were gathered in the form of clinical notes, a reflective journal and supervision notes from meetings and session de-briefs with counselling staff at the facility. The data was then woven into narrative accounts of each cycle, and key learning points for each cycle were identified. Cycles were also examined for common themes, and nine themes were identified. Findings show the student developing a deeper understanding of practice through the examination of structure and flexibility in facilitation style and musical interactions, and how and when to find balance between structure and freedom. Other key factors relevant to improving practice such as building confidence and working with the interdisciplinary team, are explored. Findings are discussed, along with ideas about the value of carrying out an Action Research project, and suggestions for future projects focussed on improving practice with this client group.*



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## Introduction

### Motivation for the Study

In my second year of training as a student of music therapy, I<sup>1</sup> had a student placement with one of New Zealand's leading Alcohol and Drug (A&D) treatment providers. The programme in which the project took place was an intensive outpatient programme for adults with either substance abuse or substance dependence. I delivered group music therapy as a secondary intervention, delivered alongside a group verbal therapy and education programme.

As far as I know at the time of writing, only two qualified music therapists are working in this field in New Zealand, and both are working with residential clients within the 12-step<sup>2</sup> treatment paradigm. Music therapy in the Alcohol and Drug treatment sector in New Zealand is therefore a new approach; however the music therapy work I was doing had become a regular part of this programme.

The work was still challenging to me and music therapy was not always embraced by the clients. I had met with and worked through some steep learning curves with the assistance of clinical supervision and support from the interdisciplinary team. At this point in my learning, I felt there was more to explore about my technique and process in this work. I felt that there was incongruence between the values I had as a student therapist and the treatment I was delivering as a student, and that the therapy I was delivering was held back by this. I found I was asking questions such as: How do I take my practice and understanding of my practice to a new level? What can I do to maximise my potential for growth in this context? How can I deliver my own level of 'best practice'? All of these questions arose from my experiences with clients, and my desire to facilitate experiences which would be most helpful to them in their journeys to wellness. Put simply, I wanted to feel like I was doing a good job, not by others' standards, but by my own standards. In order to answer these questions, I needed to define my values for what would be my personal concept of "best practice".

I had come to believe that the process of music making was the most powerful thing I could bring to this group. This concept lies closely to the idea my colleagues promoted of empowering clients to do their own work – or, as some counsellors say, become their own therapist. It was this process I decided to focus on, and I decided that finding ways of working which held creativity as a central ideal would be most helpful. I decided that my way forward was to find ways of keeping music at the

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<sup>1</sup> Due to the nature of the project and my theoretical orientation about research epistemology, this project will be presented in the first person.

<sup>2</sup> See glossary for definition.



centre of my sessions, in a way which allowed clients to be creative and me to keep my attitude towards the work fresh, and which would tend to all the needs of the clients.

At the time I started I was wondering what I could do to improve the way I deliver music therapy, and understand more about what influences my practice – what made me feel like a session was “good”, and what I could do to make more sessions feel “good”. I wanted to better understand the process of music therapy with this client population. I was also aware that reflecting on my work was empowering me to understand it more, and would be a key tool in answering my questions. I came up with the question “How can I, as a student, deliver my personal best practice in this field?”

“Best practice” is a neologism, a term often considered a “buzzword” used in the corporate and business worlds to refer to the most efficient and effective method of accomplishing a task. It is not a frequently used term in the context of music therapy, but I choose to use it differently: by using the phrase ‘my personal best practice’, I am allowing for the fact that my efficacy as a practitioner in relation to others is not a measurable thing, that regardless of how ‘effective’ my intervention may be, it is always subject to myriad influences, some of which can not even be named, let alone objectively studied. Whether I am a student of my profession or an experienced practitioner, I can hardly boast to be able to provide ‘best practice’, or even to define what is ‘best practice’ in the intangible field of therapy. My *personal best practice*, then, is a specific and achievable ideal which is unique to me. To achieve this requires me to find a way of viewing my work from new perspectives, and improving my work within the limits of my unique position as a musician, student therapist, and novice researcher.

There were two main concepts which seemed important in the formation of a schema of my personal best practice in this setting:

Firstly, I wish to work in a holistic way. My theoretical thinking is influenced by Gestalt<sup>3</sup> theory, and the predominant model of Māori wellness, *Te Whare Tapa Wha*<sup>4</sup> (Durie, 1998). I believe active music making is uniquely able to tend to all parts of a person - *hinengaro*, *tinana*, *whanau* and *wairua* - in some way.

Secondly, I had come to see music therapy in this context as most importantly a chance for clients to explore the ideas which are being presented in verbal education and therapy, and to develop new awareness in a creative, expressive and non-verbal way.

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<sup>3</sup> See glossary for definition.

<sup>4</sup> See glossary for definition.

I therefore identified the following area for initial enquiry: How do I bring active musical experiences to the forefront of my interactions with clients in a holistic, sustained and creative way?

## Overview of the Study

As my questions were about my practice, and I had specific values attached to those questions, an action research project - which allowed for the value-laden concepts which I already had, but within the framework of which I could empirically explore answers to my questions - appeared to be appropriate. I had often been told I was good at reflecting on my work, and I felt this would play to my strengths and help me to answer these questions. I also personally felt that learning from one's own reflections is a helpful way of learning.

My project comprised four short, intense action cycles each of one week in length, with one music therapy session per cycle. Data was gathered in the form of clinical notes, supervision notes, my planning for the next sessions, and my reflective journal. As both researcher and practitioner, I was the primary participant, however I sought and obtained informed consent from secondary participants to use my reflections of the interactions I had with them as data in the project<sup>5</sup>. The secondary participants were my clinical supervisor and the counselling staff who facilitated the outpatient programme.

A large amount of data was generated by this process. In the findings chapter the data is presented in narrative form, and themes and key learning points are drawn out. These ideas are discussed in the Discussions chapter.

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<sup>5</sup> See appendices for information and consent forms.

## Literature Review

This review of the literature is intended to give the reader a comprehensive introduction to the nature and knowledge of music therapy when used as a Substance Use Disorder (SUD) treatment in order to contextualise the research project, and the clinical work and reflections of the music therapy student.

A definition of substance use disorders is given, followed by an overview of addiction and addictions treatment in New Zealand. Alcohol and drug treatment methods are summarised followed by a description of clinical music therapy in Alcohol and Drug treatment from the existing music therapy literature. An appraisal of the literature, its strengths and weaknesses, follows.

### Substance Use Disorders

According to the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (American Psychiatric Association, 2000), Substance Use Disorders (SUD) have two main categories: *Substance Abuse* is a maladaptive pattern of substance use leading to clinically significant impairment or distress, sometimes resulting in a failure to fulfil major role obligations at work, school, or home; or leading to physically hazardous situations or legal problems. *Substance Dependence* is characterised by a high tolerance to the effects of a drug, often with withdrawals when the drug is not consumed; a persistent desire and/or unsuccessful efforts to cut down; and important social, occupational, or recreational activities are given up or reduced. Substance dependence may be diagnosed with or without physiological dependence.

Substance abuse or dependence can lead to *Substance Induced Mental Disorders* such as delirium, dementia, psychosis, mood disorder, anxiety disorder, sexual dysfunction, and sleep disorders.

Although many contrasting theories exist as to the etiology of addiction, it can best be described as a bio-psycho-social disorder, meaning that a complex range of physiological, psychological and social factors has led to the development of abusive or dependent patterns of behaviour (Brook, Pahl, & Rubenstone, 2008).

## Substance Use Disorders in New Zealand

It is estimated that around 13.8% of New Zealanders are likely to suffer from a substance use disorder at some point in their life (Browne, Wells, & Scott, 2006). The New Zealand government has developed many ways of resourcing and researching this issue. Research in the mental health arena has recently become a priority, and the Mental Health Research and Development Strategy has included projects researching such aspects as the models of practice in Alcohol and Drug treatments services (Ridder & Mohr, 2003); the models of practice specifically used in Māori treatment (Sullivan, Penfold, Goulding, Cook, & Phillips, 2004); treatment outcomes (Deering, Robinson, Adamson, Paton-Simpson, Robertson, & Warren 2004); and strategies for developing more research in the field (Adams & Hodges, 2004). The *National Drug Policy 2007-2012* explains that the government has three main goals for this area in line with a harm minimisation approach: they wish to take measures to control or limit the availability of drugs (supply control); to limit the use of drugs by individuals, including abstinence (demand reduction); and to reduce harm from existing drug use (problem limitation) (Ministry of Health, 2007). The third is where services such as the one in which this study was conducted come into play.

In New Zealand in 2004, 65% of clients receiving treatment for a SUD were male, 32% were Māori. The mean age of these clients was 34 years (Adamson, Sellman, Deering, Robertson, & de Zwart, 2006). Alcohol is the most commonly used recreational drug in New Zealand, and many New Zealanders exhibit risky drinking behaviours. Six in ten people who drank alcohol in the year 2007-2008 had consumed enough alcohol to feel drunk at least once in the past year, while one in ten had done so on a weekly basis. Alcohol-related harm continues to be a social and health issue in New Zealand (Ministry of Health, 2009).

In 2006, 47% of those in treatment for a SUD were seen for alcohol-related issues. Cannabis accounted for 24%, opioids for 15%, and amphetamines for 10% - this last is a dramatic increase from nearly 0% in 1998 to 10% in 2006. Māori youth, both men and women, were more likely to be in treatment for cannabis use, and were younger. (Adamson et al., 2006). The development of addictions treatment services for Māori appears to be an expanding part of the sector in New Zealand at present, and there is a growing responsiveness to the needs of Māori in SUD treatment (Cave, Robertson, Pitama, & Huriwai, 2008).

## Substance Use Disorder Treatment<sup>6</sup>

Many verbal treatment modalities are used in psychological SUD treatment: the psychodynamic approach, the 12-step approach, cognitive behavioural therapy, group therapy, family therapy, and motivational enhancement therapy are among the most prominent<sup>7</sup>. In the literature, consensus does not exist regarding the effectiveness of any one treatment approach. Miller and Hester propose that there is no need to prove that one is better than others, but instead treatment models can be shaped to individual needs (Hester & Miller, 1995).

Cognitive-behavioural therapy<sup>8</sup> (CBT) treatments are among the most well-defined and rigorously studied psychotherapeutic interventions for substance use disorders (Carroll, 2008). Motivational Enhancement therapy concepts are often used in conjunction with CBT, as it is vital that a client is motivated to change before entering treatment, and is then less likely to relapse (O'Connor & Stewart, 2010). Epstein and McCrady (2009) describe a programme with the three core elements of Motivational Enhancement, Functional Analysis and Relapse Prevention. Some core cognitive behaviour elements include identifying triggers, identifying dysfunctional thoughts and emotions, changing thoughts and feelings, and changing behaviour (Epstein & McCrady, 2009).

## Music Therapy in Alcohol and Drug Addictions Treatment

The possibilities for musical interventions in the field of addictions treatment have been considered since the 1970s when three anecdotal articles by non-music therapists outlined the potential of music therapy as a treatment modality in the addictions field, all of which appeared in the then titled *Journal of Music Therapy* (Brooks, 1973; Miller, 1970; Stone, 1973). Since then, it appears that music therapy has been practiced in the field of addictions treatment with increasing regularity, with many important articles being published in the last ten years.

### Music Therapy Methods

Although many writers have advocated one method as more useful over others, music therapists have reported a wide range of therapeutic activities employed in clinical music therapy with this population.

Bednarz and Nikkel (1992) recommend tailoring activity choices at levels to suit clients in each stage of recovery; however many facilities can not always afford to cater to each client's particular stage of recovery. The diverse methods used by music therapists in the literature show that each music

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<sup>6</sup> The following information includes international research and literature. The Alcohol and Drug treatment sector in New Zealand is generally informed by international research and trends.

<sup>7</sup> For definitions of these therapy models, see the glossary.

<sup>8</sup> For definition see the glossary.

therapist develops a way of working which will particularly fit in with his or her training and facility, and the unique needs of the clients.

Songwriting is a method widely used by music therapists to facilitate creativity and self expression (Baker & Wigram, 2005). The expression of emotions is a goal for which many therapists have used songwriting with this population (Baker, Gleadhill, & Dingle, 2007; Freed, 1987; Gallant, Holosko, & Siegel, 1997; Murphy, 1983). Group songwriting in addictions treatment can help to establish group identity and meet other social goals (Ghetti, 2004). Songwriting is popular with A&D clients (Gallagher & Steele, 2002), and having a final product to take away from therapy sessions can lead to increased self esteem (Freed, 1987). Songwriting can offer clients further insight and understanding of addiction issues, and offer both empathy and confrontation in a safe environment (Murphy, 1983).

Receptive methods encompass techniques in which the client is a recipient of the music experience, as opposed to being an active music maker, encompassing listening, relaxation and lyric analysis activities. It is not widely practiced as a music therapy method in all countries and varies greatly between countries (Grocke & Wigram, 2007). Listening to music and lyric analysis with this client population encourages the expression of feelings and thoughts (Abdollahnejad, 2006), and is a non-threatening way of engaging resistant clients in treatment (Dougherty, 1984). Lyric analysis activities can help clients to identify for themselves some cognitive distortions characteristic of addictive patterns (Ghetti, 2004; Treder-Wolff, 1990), and can positively influence participants' perceived locus of control (James, 1988a).

Active music making through improvisation is reported to help elicit clients' emotional states and encourage the non-verbal expression of emotions, and can be used as a tool to confront resistance (Murphy, 1983). It is a useful tool to facilitate peer interaction (Bednarz & Nikkel, 1992), and to challenge habitual cognitive patterns (Soshensky, 2001). Ghetti states that "the creative process inherent in improvisation allows individuals to transcend their everyday selves and experience other aspects of being – often healthy, vibrant parts of the self that have lain dormant." (Ghetti, 2004, p.88)

The physioacoustic method<sup>9</sup> has been applied by Punkanen. In his work in Finland, he uses the method for clients experiencing acute withdrawal symptoms. He also combines physioacoustic methods with listening to music and discussing experiences, which provides the client with an

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<sup>9</sup> For definition see the glossary.

holistic experience, and can open new perspectives and help modify old addictive behaviour (Punkanen, 2006, 2007).

One notable commonality in most accounts of clinical music therapy (MT) with alcohol and drug addicted clients is that most interventions are group based. It is almost taken for granted that music therapy should be delivered in group sessions. This could perhaps be due to the limited resources of many treatment providers, however group music therapy will address many of the social issues experienced by substance dependent people. Some authors do however mention the decision to provide group or individual therapy specifically, and in fact Punkanen suggests that a music therapist should very carefully decide whether to provide group or individual treatment based on the individuals' stage of recovery (Punkanen, 2007). A 2009 study of twenty-five music therapists working in the addictions field found that most participants did not provide one-to-one therapy but delivered group therapy instead (Silverman, 2009).

Music therapists have written about the importance of group process (Murphy, 1983; Treder-Wolff, 1990a), and the development of group identity and cohesion through music activities (Bednarz & Nikkel, 1992; James, 1988). Music therapy can also enhance and complement other therapies (Adelman & Castricone, 1986). Kapteina (1989) strongly supports the idea of group music therapy being integrated with and delivered alongside group verbal therapy interventions for people with addictions.

### **Clinical Objectives and Therapeutic Outcomes.**

The literature indicates that the therapeutic goals chosen to be addressed in therapy vary depending on the facility and the music therapist's theoretical orientation on the nature of addiction. Certain goals are clearly defined, however.

In terms of social outcomes, music therapists perceive that music therapy can reduce impulsiveness (Silverman, 2003); facilitate modification of harmful behaviour (Ghetti, 2004); reduce feelings of isolation (Miller, 1970; Murphy, 1983; Treder-Wolff, 1990); help clients to engage more fully in treatment (Dingle, Gleadhill, & Baker, 2008; Gallant et al., 1997); and provide a safe environment for taking risks (Murphy, 1983).

Music therapy can help a substance dependent person to express emotions (Baker et al., 2007; Gallagher & Steele, 2002; Ghetti, 2004; Kapteina, 1989); experience more emotions (Dougherty, 1984); reduce negative emotions (Ghetti, 2004; Murphy, 1983); manage frustration tolerance (Ghetti, 2004); and to stabilize emotions. (Bednarz & Nikkel, 1992).

Music therapy offers clients in recovery a chance to experience alternative activities which can help them break habitual and distorted cognitive patterns. Soshensky (2001) uses individual case studies to demonstrate this, using the premise that healing occurs through the inherent transformational qualities of creativity.

On a cognitive level, in an empirical study, music therapy with addicted clients was shown to internalise perceived locus of control in adolescents (James, 1988a), and other music therapists have anecdotally expressed this also (Bednarz & Nikkel, 1992; Ghetti, 2004). Music therapy can help with practical skills to stay abstinent (Gallagher & Steele, 2002). It can help to challenge automatic thinking (Ghetti, 2004), and enhance mindfulness and insight (Ghetti, 2004; Wheeler, 1985); and can help clients to develop coping strategies (Dijkstra & Hakvoort, 2004).

Silverman in 2009 found that the most frequent clinical objectives for this client group, as determined by 25 music therapists practicing in the field in the United States, were communication, coping skills, emotional expression, decision making, self-esteem and insight. Other popular goals included socialization, stress management, leisure skills, self-image, relationships and relaxation (Silverman, 2009).

Some evidence purporting the use of music in addictions treatment comes not from music therapists, but other professionals working in the field. A 1986 article describes discussing song lyrics as a method for encouraging adolescents to talk about issues around drug use, and to help them in examining defence mechanisms (Mark, 1986). Anthropologist Winkelman describes and evaluates the use of drum circles in recovery, suggesting that drumming is a valid therapy for clients who have repeatedly relapsed and for whom other treatment modalities have failed (Winkelman, 2003). The helpfulness of songwriting to address personal issues and to buoy clients through recovery was studied in a qualitative manner by a social worker in the addictions field, with reference and recommendations to music therapists and counsellors alike (Gallant et al., 1997).

Music therapy is described as being a good alternative for those resistant to other therapies (Gallagher & Steele, 2002), increasing engagement in treatment (Bednarz & Nikkel, 1992; Dingle et al., 2008; Wheeler, 1985), and has the advantage of being less threatening to clients (Ghetti, 2004).

Music therapy is an holistic treatment for clients with SUD (Hedigan, 2005; Punkanen, 2007), which can attend to all parts of a client's welfare where other therapies may fail to do so. James (1988) states that *"given that many researchers emphasize the need to treat the 'whole person' as opposed to 'their addiction', the adaptability of music therapy is particularly valuable to interdisciplinary treatment teams"* (p.66).



Music therapy is described by many practitioners as being very flexible, and can be tailored to a variety of facilities, clients, diagnoses, and stages of recovery (Bednarz & Nikkel, 1992; Ghetti, 2004; Soshensky, 2001; Treder-Wolff, 1990; Walker, 1995). Music therapy has been shown to elicit emotional change in a single session, which is no doubt attractive to financially stretched services (Dougherty, 1984; Jones, 2005).

### **Music Can be Friend and Foe.**

One important challenge in the field is that music can be a powerful facilitator for negative and uncomfortable experiences as it can be for positive therapeutic change.

If a client hears music which he or she associates with using their drug of choice, they can experience severe cravings, and sometimes physical discomfort. The experience can re-traumatize clients and lead to relapse. Walker (1995) describes having witnessed clients shaking, sweating and showing anxiety when listening to music which they associate with their drug use (Walker, 1995). Many clients have had traumatic experiences in their past and some music interventions can re-traumatize a vulnerable client. Punkanen (2006) recommends knowledge of trauma-psychotherapy as important for a music therapist in this field, and suggests techniques such as anchors, safety places, and body awareness to assist in this process.

Horesh (2006) has described her work with this client population as 'rehabilitating music-listening habits', helping clients to learn what music is dangerous or destructive for them and their continued abstinence, and what music they can incorporate into their lives to enrich and empower them. Horesh also made a qualitative study of the meaning of music in the lives of people recovering from drug addiction. She noticed that her clients often had a very strong connection with their music and this can be used to help or hinder wellness, and promotes the concept that this can be used to help enrich clients' lives (Horesh, 2006a).

In a qualitative study, Abdollahnejad (2006) found that clients reported that their music choices had negatively affected their continued abstinence in recovery, and prompted cravings to use. In contrast to this, a study of which the current author has only been able to access an abstract indicates that clients who listened to clinical applications of music of their own choice showed significant improvement in mood compared to a control group (Horvath, 1998). This would indicate quite different recommendations than those of Abdollahnejad.

Kapteina in 1989 proffers the view that active and creative music making is the most therapeutically helpful method, and that receptive techniques are contra-indicated for this population. He claimed that listening to familiar music was not only a trigger, but could lead to hallucinogenic type episodes,

and times where a client can escape reality and find themselves in the all too familiar fantasy-relationship with the world around them, which is unhelpful to their long term abstinence from mind-altering substances (Kapteina, 1989).

While many writers have observed the potential danger for this vulnerable client group in music, many have deemed it most important that the therapist must use the therapeutic opportunity in both 'good' and 'bad' musics, and deliver a treatment which is tailored not only to the clients' needs and the facility, but to his or her own strengths and training.

### **Suggestions Made about Being a Good Music Therapist in the Field**

Many professional music therapists have included their thoughts on important qualities for a music therapist in this field. This is relevant in the context of the current study which is focussed on improving practice.

Adaptability, flexibility and insight are key therapist qualities according to James, and a current knowledge of addiction and addictions treatment is important for any practitioner in the field (James, 1988).

The therapist is required to have faith in the process and take risks, to use the strengths of clients, and to work collaboratively with other professionals (Gallant et al., 1997).

Openness, sincerity, courage and self-knowledge are recommended by Freed (1987), along with a willingness to fit into the facility.

Bonny demands a music therapist to be a 'strong, accepting and available person' (Bonny & Pahnke, 1972); and Soshensky speaks of the entering into a partnership with clients (Soshensky, 2001).

A 1986 article describing a method for complementary addictions treatment using techniques from art therapy, psychodrama and music therapy emphasises the need for music therapists to work collaboratively in an interdisciplinary team with substance abuse clients (Adelman & Castricone, 1986).

### **Critical Evaluation of the Existing Literature**

Calls for more empirical evidence in this field have been made consistently by many music therapists. As early as 1988 James voiced a demand for music therapy as a profession to become more active in addictions and the theoretical development of music interventions for addicted clients (James, 1988a). Although there was a paucity of literature on MT and SUDs in the 1990s, the

last decade has elicited a large number of studies in the field, many of these including quantitative evidence in support of music therapy for addictions treatment.

One article published in 2003 includes both a literature review and a pilot study. The literature review includes a table which shows that out of 23 studies in the field, only 7 included quantitative data. The pilot study revealed that music therapy helped to reduce impulsiveness for clients, and that clients perceived music therapy as the most enjoyable and clinically effective intervention offered. The author made more calls for evidence supporting the use of music therapy in the addictions sector (Silverman, 2003).

A quantitative study was carried out in 2005 to measure the effectiveness of two different music therapy methods in eliciting emotional change in a single session. While music therapy was found to significantly increase feelings of acceptance and happiness, and to significantly reduce feelings of guilt, regret and fear; the researchers found no difference between results from the songwriting activity or the lyric analysis activity. This may indicate that music therapy can elicit therapeutic change *irrespective of technique* (Jones, 2005, p.94). Another quantitative study of 2005 would appear to corroborate these findings: following a session, music therapy resulted in a decrease in symptoms associated with depression, stress, anger and anxiety; yet no significant differences were found in the measures between movement, rhythm and game interventions (Cevasco, Kennedy, & Generally, 2005).

New Zealand has produced one piece of research in this field, a mixed methods study exploring individual music therapy with women in substance dependence treatment. Multiple case studies were used to gather both quantitative and qualitative data. Results showed that clients were able to achieve the majority of their set goals in music therapy and that other subsidiary benefits arose from music therapy sessions (Savage, 2006).

Two studies have been published by Australian researchers in the last three years. Baker, Gleadhill and Dingle designed a study to determine whether music therapy programmes delivered within a CBT framework facilitated the exploration of the emotions of clients. A self-report questionnaire generated both qualitative and quantitative data, and results indicated that music therapy sessions facilitate the experiencing of predominantly positive emotions to a moderate or high degree. Clients reported that music therapy was beneficial in allowing them to experience emotions without the need for substance use (F. A. Baker et al., 2007).

Another study conducted at the same time and by the same researchers explored the possibility that music therapy would further engage clients in treatment. Attendance and participation was

uniformly high, and analyses of patient surveys showed that music therapy was able to engage clients regardless of their age group. 46% of clients reported that music therapy helped them to feel more a part of the group. The conclusions state that “music therapy is a promising approach to improving engagement in substance abuse treatment groups” (Dingle et al., 2008, p.195).

A non-controlled non-randomised pilot study which took place in New York in 2008 sought to investigate how participation in a music therapy programme affected treatment outcomes for people with dual diagnoses of mental illness and a SUD. Quantitative measuring tools were used to analyse data which indicated that music therapy is a useful motivational tool for this client group. While the study had limits including no control group, a positive outlook on the use of music therapy as a motivation enhancement tool for clients with dual diagnoses was expressed, once again identifying a need for further studies, and also suggesting that should evidence prove reliable, then a manual for music therapy for motivational enhancement could be developed and delivered alongside verbal treatments (Ross, Cidambi, Dermatis, Weinstein, Ziedonis, Roth, & Galanter, 2008). It is encouraging to see a widely respected expert from the addictions field, Marc Galanter, credited as a co-author in this article.

Most recently, a descriptive study published by Silverman examines music therapists working with clients in treatment for substance abuse with a view to the profession being able to design better research and also to know what to expect when working with this population. Quantitative analyses of survey results revealed a significant relationship between years as a practitioner and perception of the positive impact of music therapy, and a significant relationship between the music therapist's enjoyment of clinical practice and their perceived positive influence on treatment (Silverman, 2009).

The quality and frequency of studies in this area appears to have been improving greatly in the last decade. As ever, there have still been calls for more evidence, and evidence of empirical quality in the sector.

The issue of the validity of some of the quantitative research is challenged in an article published in 2007, originally presented as a conference paper by Hakvoort and Dijkstra. After specifying the increasing demand for evidence based treatment modalities from health authorities, Hakvoort and Dijkstra go on to give examples of how the age, methodology and findings of many major studies are insufficient to provide music therapy with any truly rigorous evidence to support its use in addictions care. Hakvoort and Dijkstra's concern and passion in their argument demonstrate that the music therapy profession is actively engaged in exploring ways of collaborating with addictions care (Hakvoort & Dijkstra, 2007).

In 2008, funding for a systematic review of the literature concerning music therapy for the treatment of patients with addictions was granted by a mental illness research authority in Pennsylvania, USA. The researchers were specialists in the mental health research area and not affiliated with the music therapy profession (perhaps most evident in the derisive title of the article: *Treating Addiction with Tunes*). Some music therapy studies were not found by the researchers' search methods for this review, such as those of James in 1998; Cevalco, Kennedy and Generally in 2005; and Baker, Gleadhill and Dingle in 2007. The review reported that few studies exist which quantitatively assess music therapy in this area, and that no consensus exists regarding the efficacy of it (Mays, Clark, & Gordon, 2008). The fact that there was a call for a review of this subject matter indicates that the fields of SUD treatment and MT are increasingly working together, and are interested in providing clients with a broader range of therapeutic interventions.

It is important to acknowledge also that the problem of creating evidence for practitioners to work in an evidence-based way is not only present in the music therapy field, but in the addictions treatment sector also. Moos (2009) in raising the issue of the addictions treatment sector adhering to a scientific paradigm states that "we should recognise that efficacy trials provide only one specific context for observation and are not necessarily the royal road to a divine blueprint of revealed truth." (p.551). With this vulnerable client population, there are many variables which cannot be isolated, making quantitative study designs very complex.

In conclusion, therefore, it appears that there is an increasing body of literature which supports the use of music therapy within addictions treatment, much of which has appeared in the last decade, and which indicates that more SUD treatment professionals and SUD clients are calling for more treatment options. And, as some respected music therapists stated, "the absence of evidence of effectiveness is not the same as evidence of the absence of effectiveness." (Pavlicevic, Ansdell, Procter, & Hickey, 2009, p.5)

### **Rationale for the Current Project**

The current study utilizes the Action Research methodology. Some examples from the literature about the value of action research projects in the music therapy field follow.

Action research is considered a helpful way of generating new knowledge. Reflecting on one's actions in a studied way can generate new learning (McNiff & Whitehead, 2006), and projects of this type are a helpful addition to the body of music therapy literature (Rickson, 2009). In a world where there is great demand for evidence-based practice from healthcare professionals, reflective learning processes can bridge the gap between formal qualitative study and personal learning (Welch &

Dawson, 2006). Research designs utilizing qualitative methods are increasingly popular in the music therapy field in New Zealand. Projects such as those by Chiang (2008) and Potter (2007) have created new knowledge using Action Research methods.

Reflexive journal writing, such as that carried out in the process of action research, generates new ideas which are valuable to the profession of music therapy as well as helping the practitioner to understand his or her development and professional value (Barry & O'Callaghan, 2008).

Wheeler (1995) states that the building of evidence of any kind is good for the profession of music therapy. In spite of calls for more quantitative data in the addictions field, the current student of music therapy chose to use a reflective and qualitative methodology as it suited her initial research questions as well as her philosophical stance and current stage of development. This is of importance because, as Bruscia states, there are fundamental paradigm differences represented by positivistic or non-positivistic research methods (Bruscia, 1995). There is currently little in the existing MT literature which focuses on techniques and processes of working with this client group, and considering the expanding amount of work with this population, it seems appropriate that this be addressed.

## Background

### The Setting

For my second year of training, which I was undertaking as a part-time student, a clinical placement was set up for me with a company providing treatment for alcohol and drug issues in a city in New Zealand. The company had an office and clinic in the centre of the city and four to five satellite clinics in outlying regions of the city. Initially, I began by observing the therapy in an Intensive Outpatient Programme (IOP) in the city clinic, which was run three evenings per week for three hours each evening. After several weeks of observation and orientation in the company, I began facilitating group music therapy for 40 minute sessions on one of these evenings each week. I initially attended the whole programme for the first three months, and thereafter attended only on the evening music therapy was offered, but I was always present for the whole three hour session. Four months into the placement, I started delivering music therapy at a similar IOP run in one of the satellite clinics during the day. Music therapy continued at both groups for around ten months, and then I ceased working at the central clinic and continued work at the satellite clinic for a further six months. It was during this time - after around a year of delivering music therapy as a student within this context - that I started this research.

During this time I had also spent one day each week for six months observing treatment and facilitating music therapy at a drug treatment unit in a women's prison. Treatment there was based on the concept of a Therapeutic Community<sup>10</sup>, and was designed specifically for rehabilitating substance abusive and dependent offenders in preparation for their return to the community. Although the nature of this work was very different to the outpatient work in the community, through this work I came to understand a lot more about the role of addiction in the lives of people with SUDs, and what I could do to support them in recovery.

The programme in which this study is orientated ran for three hours three mornings per week; and usually had between 8 and 12 clients enrolled at any one time. Membership was rotational: new group members joined whenever they were ready to, and each member attended for 8 weeks before graduating from the programme, although some chose to attend for a longer period of time, in order to support their peers and keep their own recovery on track.

The clients on the programme were male and female adults of any age who were in recovery from substance abuse or dependence. Clients were referred to the programme by many routes, some of the most common being from Community Probation Services (for substance abuse issues

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<sup>10</sup> See glossary for definition.

accompanied by offending behaviour); Land Transport New Zealand (for 'drink-driving' offences); concerned whanau or employers; or self-referrals. Most clients were of NZ European or Māori descent, some were Pacific Islanders. While most clients were in treatment for addiction to a particular drug or alcohol, they were asked to abstain from any alcohol or drug use for the duration of the course.

At the time of the action cycles, the programme being offered drew from a wide range of verbal treatment models, in keeping with current research and the philosophical guidelines of the treatment provider. Some of these included Motivational Enhancement Therapy, Rational Emotive Behaviour Therapy, and Dialectic Behavioural Therapy. Cognitive Behavioural Therapy<sup>11</sup> was perhaps the most emphasised of these treatment approaches. Two counsellors were the main facilitators of the programme, student counsellors and I also helped to deliver parts of the programme.

Educational sessions were designed to inform the client about the nature of addiction and help enhance their understanding of and motivation to change. Some typical session foci included: dealing with urges and cravings, *Te Whare Tapa Wha*, understanding personal needs, and recommitting after a lapse. Practical therapeutic and skill building sessions included: mindfulness, understanding and identifying core beliefs, understanding and identifying cognitive biases, emotions, self-esteem, communication, managing criticism, anger management, and problem solving. The programme was geared to help clients to understand that they are the only people to ultimately control their addictive behaviour, and empower them to assume accountability and responsibility for their actions. Focus on 'mindfulness' as a foundation for changing habitual thinking was one of the main tenets, and the concept that thoughts influence feelings and feelings influence behaviour underlined most of the therapy being delivered.

### Music Therapy Within the Setting

Music therapy was a part of this programme for one hour each week. On a typical music therapy day, the programme would start at 9.30 with a 'feelings check' – each client was asked to share his or her emotional state and energy levels. The next two hours (usually with a 15 minute break) would be spent in addressing the topic for the day, and clients were often involved in interactive activities such as small group discussions, writing up posters about the topic, role play, and brainstorming. While the main part of the session appeared to be educational, a lot of therapeutic intervention was implemented by the facilitators during the sessions, such as challenging core beliefs and cognitive biases, Socratic questioning<sup>12</sup>, and developing social skills through working together in groups.

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<sup>11</sup> See glossary for definitions.

<sup>12</sup> See glossary for definition.



One of the group rules was that everyone must participate in some way, and even though some clients were more hesitant to share, every client was heard and observed by the facilitators in every session. I was often involved in delivering parts of these sessions, which I enjoyed, and perceived this important to help establish a working relationship between myself and the clients. This was necessary as the concept of music therapy was often very new and potentially intimidating to clients, and helped to dissolve some of the ambivalence which they felt towards music therapy. A break was had before music therapy started, and at least one of the facilitators would participate in music therapy.

All clients enrolled in the programme were expected to participate in music therapy, which took place in the same room as the rest of the programme. Clients were provided with an information sheet about music therapy in their first session, and also required to sign a form provided by the treatment provider stating that they were informed that I was a student, and including the statement that I would adhere to ethical and supervision guidelines like any fully qualified practitioner. The facility did not have any musical equipment, so I would provide a selection of small and large percussion instruments, two guitars, a keyboard, xylophones, an autoharp and a stereo on a day-to-day basis.

The methods of music therapy which I used included listening for relaxation, song lyric analysis, body percussion, group song writing/lyric substitution, and group improvisation. I would, where possible, design a plan for the session around the focus of the verbal therapy session, in order to keep the learning for each day as congruent as possible. Long-term projects were hard to implement because of the rolling group membership, so music therapy activities were generally contained in one session. Occasionally, a 3-4 week project such as songwriting could be undertaken when group membership was projected to be steady. Although I always had a prepared session plan, I did not always follow it completely, in keeping with what I felt the needs of the group were on a particular day. I facilitated verbal discussion at the end of most musical experiences, encouraging clients to use the mindfulness and communication skills they were developing in verbal therapy. I had established a stone passing activity for the start of each group and a 'reflective check-in' with each client to end with. Often the other facilitators were involved in this final part and reflections were of the whole day's work, not just the music therapy part.

My clinical objectives for the group were mainly socially oriented goals. With most activities I was aiming to encourage and develop good communication skills, group cohesion, listening and mindfulness of others. As part of these goals I also was thinking of individual goals to encourage the expression of emotions through creative activity; and to enhance self-esteem and self-reflection

skills. Some sessions were designed with relaxation or stress reduction in mind, others focussed simply on having fun without the need for mind altering substances. For a client group who often feel as though they have little control over the world around and the world within, I felt music therapy helped clients to internalize their locus of control. For example, by simply increasing the speed of a steady drum beat, a client can notice that others musiking around them will follow – cause and effect. Another of my clinical objectives was to help develop decision making and coping skills, which can be empowering to a person who has lost much both materially and emotionally to addiction. I and my colleagues agreed that music therapy also became a safe environment in which clients could step out of their comfort zones. Using a mind-altering substance can be understood as an escape into a world which, in dependence, becomes more comfortable than the ‘real’ world. Often in recovery there is resistance to stepping outside of what is known and familiar. To ask a client to do something ‘a bit different’ such as play a maracas in front of others can be a real challenge, but my colleagues and I agreed that to stretch a client in this way is very important in their journey to wellness. The inherent ‘holding’ nature of music allowed this kind of activity to happen in a safe and contained environment, where clients’ actions can and often are affirmed by others in the group.

During this placement I had off-site supervision with a registered music therapist who practiced music therapy mainly with disabled children, disabled adults and the elderly. I also had regular support meetings with tutors and other students of music therapy at the university music therapy department. There is no how-to manual for music therapy, but students can often look to qualified professionals for clinical ideas and advice – I was often able to do this within supervision. However, music therapy was a new approach to all the counselling staff I worked with, and due to the limited number of music therapists who work with this particular population, I often felt isolated within the context of this specific population. Some of the challenges of this work included:

- Group membership was rolling – this meant that a therapist could not tailor a programme or activity especially for the needs of a client in a particular stage of rehabilitation. It also meant the stability of group cohesion and trust would change every week.
- Time constraints – music therapy was most often the last part of the day’s work, and so often there was less than an hour in which to deliver a session. Although I and the counsellors worked very hard to keep to planned time schedules, the nature of this work means that even the best-laid plans could go awry and often did!
- Music therapy was a new concept – none of the counsellors I worked with during the course of this placement had seen music therapy in practice before, and so had varying

expectations of how it would be. Music therapy was also a new idea for many clients and was sometimes met with varying degrees of ambivalence.

- Clients attended the programme in varying stages of wellness – some had been in recovery for months, some had only been in hospital for detoxification the day before, so cognitive functioning was variable within a group, and it was hard for a new therapist to establish goals and develop suitable activities.

### **My Developing Understanding of the Nature of the Work**

When I first began doing this work I attempted to work from an evidence-based perspective; allowing myself to be guided by the existing literature about music therapy with this client group, and my training. I had the advantage of working with a variety of counsellors from a variety of backgrounds and who were influenced by a variety of different models. Sometimes this was a challenge and eventually I realised it was important for music therapy to complement the type of verbal therapy being delivered to clients. I had to find ways of using music therapy to enhance the verbal therapy.

The first IOP programme I worked on was perhaps more suited to my understanding of how music therapy could be helpful for an adult population. The approach in verbal therapy was very much one of carefully listening to clients, exploring ways to help heal the old hurts which perhaps had led to their drug use; and the client-centred approach meant that often in music therapy sessions I could choose experiences which would affirm clients and help them to sit with their grief and anger and pain, as well as their hopes and successes. For example, on one occasion I used the song *Everybody Hurts* by REM to help clients feel a sense of solidarity with the group – that they were not alone in the emotional pain which may have led to or perpetuated their drug use.

The approach used in the IOP programme setting in which this study took place was very different, and while affirming a client's sense of loss, was more focussed on active and immediate change, emphasizing the importance of developing new thought patterns and positive behaviour. As a therapist I had to find a different way of providing music therapy which would be congruent with this approach. For example, if I had used the song *Everybody Hurts* in this context, I felt it would have taken away clients' sense of autonomy and enabled them to externalise locus of control, which would have been very incongruent with the verbal therapy approach being offered.

### **My Beliefs and Values**

I have a strong belief that music therapy can be an important and instrumental intervention with this population when delivered alongside verbal therapy. I believe that positive change in the thoughts,

feelings and behaviours of people in recovery from alcohol and drug addiction can be stimulated, complimented and even initiated by creative acts. I hold the assumption that the act of creation, both planned and spontaneous, reflects the whole self. It is the act of creating something unique and personal that I think is instrumental in music therapy in this programme. Therefore, my main choice of music therapy method is group improvisation, and also song and lyric creation. I also believe that the very act of engaging in a new activity outside of the 'comfort zone' is a healthy way of engaging in recovery from addiction.

I came to music therapy from a background of having trained as a classical musician for several years. I hold the belief that being flexible and spontaneous with music making does not always come naturally to me; and my knowledge of non-classical music, while good, is not always as thorough as needed in this environment.

I believe that my conduct with clients at all times needs to model the type of behaviour which is being taught in the programme: that is, I need to listen attentively, to participate with assertion, to communicate with clarity and to be aware of the needs of those around me. I am aware that as a person I often bring enthusiasm and passion to group environments, and that sometimes this has the potential to make others feel like they can not 'speak up'. I am aware that by being grounded I can bring some moderation to my enthusiasm, therefore being true to myself without negatively affecting others in group and social situations. Being grounded to me means feeling relaxed and being deeply aware of the present both physically and cognitively.

I understand my role in music therapy group experiences to be important in shaping and moulding musical experiences to help encourage creativity in a safe environment for clients. It is important for me to place clear boundaries in the group environment, and to help clients feel comfortable and validated in the group.

These values and assumptions are central to my practice in the field of alcohol and drug treatment, and have clearly had a large part to play in the direction of this research which aimed to improve my practice in the field. With these in mind, we now move on to outline the chosen methods for this study.

## Methods

### Methodology

When considering how I might go about researching my area of enquiry, Action Research (AR) appeared to be an appropriate method to apply in order to explore answers to my queries. The framework of AR was appropriate because it has been developed specifically for researchers to find ways of improving their own practice. AR requires a lot of reflective thinking, and I had received feedback in the past from tutors and supervisors that I was able to reflect well on my experiences. Early reading into action research as a research method also equated with my non-positivistic views on the creation and nature of knowledge.

One form of AR is succinctly described by McNiff & Whitehead:

*“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.”* (McNiff & Whitehead, 2010 p.21).

Action Research acknowledges a practitioner’s value base and the influence this has on their practice (McNiff & Whitehead, 2010) – this is in line with my understanding of clinical music therapy practice – that while I adhere to standard methods and ethical and theoretical underpinnings of what music therapy is and how to deliver it, I cannot leave my own values and understanding, my own unique musicianship and listening skills, my own filters and sometimes vulnerabilities at the door of the therapy room. Were I to do this, I would not be able to be properly present in a therapeutic capacity, to deliver ‘my own personal best practice’. To take this further, in researching my practice these factors are unavoidable, I simply cannot achieve complete objectivity. I can, however, by using AR, develop a deeper understanding of these things, and use this knowledge to develop my practice in both theoretical and practical ways. My values influence my actions and my learning, and action research acknowledges this.

“Knowledge generated through action research is about both practice and theory”. (McNiff & Whitehead, 2006, pg 149) As a relatively new practitioner of music therapy, I need to develop knowledge about practice and theory. As a researcher, I am attempting to develop knowledge which contributes to the theory of practice both as a student of music therapy and as a practitioner working with adults in Alcohol and Drug treatment.

## Action Plan

An action plan was devised after considering these specific questions posed by McNiff and Whitehead in 2006 (McNiff & Whitehead, 2006). An updated version has since appeared in their 2010 book on the same subject (McNiff & Whitehead, 2010).

### *What is my concern?*

There is current incongruence between how I wish to practice and how I am practicing – I am finding it hard to sustain creativity in my practice; I wonder if I am delivering holistic practice in line with *Te Whare Tapa Wha*; I wonder how to get better at what I do within the context of my own influences and ethos as a musician and therapist?. I would like to understand the processes of my practice in a deeper way.

### *Why am I concerned?*

I had received feedback about valuing my work more, and building my confidence in my work. I experienced creative blocks both during sessions and in planning sessions. I felt that sessions were not music centred enough, and I felt that I could find ways of changing this.

### *What experiences can I describe to show why I am concerned?*

A few months previous to the inception of this project, I had had a very difficult time with some clients feeling that music therapy was not helpful and one lyric analysis activity in particular was in fact harmful to their recovery. While this issue was dealt with and resolved within supervision and with good communication between myself and the counselling staff and the clients, the feedback severely affected my confidence and I lost faith in my ability to deliver music therapy. I even started to wonder about the efficacy or appropriateness of music therapy with this client population. I believe this contributed to my feeling creatively 'stuck', as I had lost faith in my musical and facilitative instincts when I was in a session.

In an assessment I had also discussed with my assessor the possibility of increasing musical interactions and decreasing verbal interactions –clients were receiving intense verbal therapy already, and music therapy was intended as an alternative to this.

I was also made aware by my colleagues and supervisor that my verbal interactions were often unclear and ambiguous; therefore I knew this was an area to improve in. One colleague felt I could improve my practice by allowing the group to have more choice about what to do and allow sessions to flow more freely, and to not 'lead' so much as 'facilitate'. I felt that this was a valid point and I sought to understand the nature of facilitation in terms of finding a balance between giving

structure to sessions and activities within sessions, and allowing freedom within sessions and encouraging the clients to be more participative.

*What can I do about the situation? What will I do?*

On a practical level, I will think about creating new ideas in planning sessions, I can become more mindful of bringing active music making to the forefront of my interactions with clients' and I can start to develop more concise ways of communicating verbally in sessions. I will use careful reflection on my experiences to develop an understanding of my practice and therefore identify ways to improve it. By keeping my goals of sustained, creative and holistic practice in mind I can find ways of aligning my practice with my values and schema of music therapy with this population.

*What data will I gather?*

Three main data sources will be gathered clinical notes; supervision and session de-brief notes; and my own reflective journal.

*How do I explain my educational influences in learning?*

I will influence my own learning by examining my actions, reflecting on them, evaluating their impact, and using them to inform future action. This in turn can influence the learning of others by showing how reflective practice can help to modify practice for the better, and by developing ideas which may influence the experiences of other students and other music therapy practitioners in the alcohol and drug treatment sector.

*How do I ensure that any judgments I make are reasonably fair and accurate?*

By having a strongly defined sense of what my values are and what my estimation of 'my personal best practice' is. Also, by using the input and feedback of counselling colleagues and supervisors, I can know that the aspects of my practice on which I am focusing are ones which will indeed improve my practice. Once the data is collated, I will ask a fellow music therapist to peer-review each cycle to assure that the judgements I have made are fair.

*How do I modify my practices and ideas in light of my evaluation?*

As my placement at this facility and my journey as a student is nearly at an end, I will not be able to apply any practical learning at the end of the project to this specific setting. I will however have a deeper understanding of the development of my clinical practice and how I can achieve certain goals. Most important will be the overriding concepts which emerge, which can continue to be developed by myself through professional development and reading literature. After all, my learning and that of other music therapy professionals is a continuously evolving and living action which can only change, and hopefully, develop, with time.

## Action Map

**Pre-cycles:** Gather data to show issues and areas of concern.

### Cycle One:

- Plan a specific session with actual activities and goals for facilitation
- Carry out session
- Debrief on session with counselling colleagues
- Reflect on session and debrief alone, including reading any appropriate literature

Repeat above pattern for four cycles in total. The findings from each cycle will contribute to a cumulative understanding of what actions I took and what ideas I explored in aiming to improve my practice.

**Post cycles:** Gather data together and present to show both practical and theoretical learning.

## Ethical Considerations

In keeping with the Code of Ethics for the Practice of Music Therapy in New Zealand, I needed to be careful to deliver therapy with the needs of my clients in the forefront of my mind, and to make every attempt to minimise any affect that the research might have on the value of the therapy that clients received. In practice this meant staying very 'present' with the issues and feelings for the clients while running the sessions, and reflecting separately on my work and actions as a therapist *after* the sessions, when I was conducting the action research.

## Participants

Because I am studying my own process, I am the primary participant. In order to help me examine my work in a more objective way, I requested secondary participants to be involved. Secondary participants were my clinical supervisor, and four different counselling facilitators with whom I worked during the action cycles. I am only using my notes and reflections of what they said<sup>13</sup>.

## Peer Debriefing

In the process of analysis of data, I showed the steps in my action research cycles to a student colleague, who checked my ideas and verified my analysis, or asked for further clarification.

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<sup>13</sup> See appendices for sample information and consent forms.



### Approval

A proposal was submitted to the facility in question, which gave permission for the study to take place on their premises. Ethical approval was sought and obtained from the Central Regional Ethics Committee.

## Findings

In presenting my findings I shall use a modified version of the *descriptive reality approach* described by Dorothy Valcarcel Craig in her 2009 book (Craig, 2009). For each cycle I shall present a narrative description of the planning, action and reflection, integrating all data sources, and using examples from data sources where appropriate. At the end of the narrative, I shall lay out the conceptual themes which I draw out relative to the development and understanding of improving my practice, and also précis key practical learning points.

In the interests of precision, and also in completely protecting information about clients, I have been selective about which parts of a session I talk about in each cycle, and have only briefly visited parts of the sessions which had no bearing on my goals for the research or were irrelevant to demonstrating the development of learning.

Cycle One	Cycle Two	Cycle Three	Cycle Four
17/06/09-24/06/09	25/06/09-01/07/09	02/07/09-08/07/09	09/07/09-15/07/09

## Cycle One.

### Planning

The first cycle began at a time when I had embarked on a songwriting journey with the group. We had spent the last three sessions working on composing songs in small groups of two or three, which would morph each week into something new because of the changing group membership.

Nevertheless there had been some good creative teamwork in the group in the last three sessions and there were at least two songs which had both lyrics and some music composed for them. I always began these sessions with a stone passing song to set up the group feeling – I would lead the singing of a simple rhythmic song and as a group we would pass a selection of crystals and small rocks around in time to the music. I always ended groups with some form of ‘reflections circle’: sometimes verbal, where everyone in the group could comment on their thoughts and feelings about the session; sometimes musical, where each person could play for a short while on an instrument of their choice.

After reviewing my clinical notes from the last few weeks of work, my goals concerning improving my practice for this week were quite straight forward:

- I wanted to encourage group singing during the stone passing activity, which was in keeping with my goals for delivering holistic practice. I believe singing is a very holistic activity, and I wanted to encourage this within the group.
- I planned to give clients clear choices about the main session activity today, and be careful to deliver clear verbal interactions.
- I wanted to remain mindful of my role as facilitator, not dictator, and to allow clients to have choices about the activities. I had been mindful of this in the last few sessions, and had discussed with my supervisor a feeling of being redundant in sessions as the clients worked on the songwriting task with little input from myself. My supervisor had pointed out that in fact if I found that I was not needed to help groups, that this was fulfilling some of my goals for the clients, including group cohesion and internalising locus of control. I wanted to keep being mindful of how much structure and freedom I was giving in the group, as I felt this was an important part of developing a deeper understanding of my practice. I also realised that being less active in the process would enable me more time to listen to the clients, and I planned to be more mindful of listening to individual clients’ interactions whenever I had the opportunity.

My session plan for this session was quite free. I planned to start with our usual stone passing activity, then to give the group three choices for a main activity for the session. The choices I planned to give were either group improvisation, or to continue refining the songs they had written, or to move on to another group songwriting activity. I had basic ideas for what to do should they choose any one of these activities. I felt that in keeping the plan open and having many possibilities for the session, I would be providing activities with creative and holistic possibilities in keeping with my aims for improving practice.

### Action

The group for the session was quite large, there were 10 clients, and besides myself and the two counsellors there was a family member of one of the clients and two student observers in the group also. I felt that a change of energy in the room was required, so although it wasn't planned, I started my session by leading some physical stretching and breathing exercises, which the group readily participated in.

It had been mentioned by one of the facilitators during verbal therapy that the three best ways of secreting endorphins in the brain were exercise, laughter and singing. This gave me a great segue into introducing more active singing into the stone passing. Instead of simply moving into the stone passing, where I usually lead the singing and sometimes clients join in after a time; I started by simply singing each phrase of the song and asking clients to sing it back. I was surprised at the response: most of the group sung the phrase back. In order to encourage this further, I changed to leading in chest voice which helped the men to feel a bit more confident and took the whole song down a key the third time round. By this time everyone was singing and the group sound was quite strong. I then passed out the stones and we sang and passed the stones around in time with the song. As the singing was sounding so strong and confident, I decided to try to develop this activity further, something I had never done before. While keeping the singing going I used body language to get everyone to walk around the circle, then led some call and response style body percussive moves, and when these were going well, I added some vocal call and response ideas also. At this point, it would have made sense to lead in singing the original song again and finishing by slowing down and getting softer, as often happened towards the end of this activity when we had done it before. Instead, I finished abruptly without giving any musical cues that the end was coming. Clinical notes state about the activity that *"...they replied with enthusiasm and matched my examples."* My reflections state that *"I ended the activity rather abruptly"*, and my feelings were that *"I don't have enough ideas to make this fun"* I worried that my stopping the activity abruptly *"perhaps made clients feel a little unsure or unsafe"*. I wondered if I could have extended the activity further and

that perhaps I could try keeping activities going for longer to allow clients to feel more comfortable with them.

Giving clients clear choices about what activity to do elicited a positive response from one client which the others agreed with.

So the main part of the session was spent in working on finishing off and recording the songs which had been begun in the last three sessions. Because there were three new clients in the group today, I needed to assign each of them to existing groups. I found this part quite difficult, and reflected that had I been more directive here, clients might have felt more at ease. Although I had aimed to be more *concise* in my verbal interactions, perhaps what I needed to do was to be more *assertive* with the verbal facilitation.

During the session, some groups were working on lyric creation, one group was working on music creation and I mainly worked with the group who had finished their song and were recording it. The group who were doing music creation had a client who played some guitar and they were working well together. The other two groups were writing lyrics as individuals and sometimes in groups.

I was using some basic software I had downloaded from the internet to record the song straight onto my laptop. Unfortunately I was only versed in the basic recording properties of this software, and when the group asked if they could layer track upon track I explained that I didn't know how to do this with this software. There appeared to be something wrong with the microphone also, meaning the playback was very soft. I asked if we could try to record it again next week, but because three of the four clients who had written this song together were going to be graduating this week, this was the last opportunity for us to work on the song. We did however get a reasonable track together which I could put onto CDs to give the group the following week. Not knowing enough about the recording programme made me feel *"guilty"* and I felt it *"fed into my insecurities about not being into the modern music scene in an active way,"* which in turn made me wonder if I was able to connect with my clients musically when my experience of music has been so different to theirs.

I called the group back together to share all the ideas and work which they had done. One client shared the lyrics they had written with the group, which were very funny: they told a story about the consequences of waking up in the morning with no idea of what happened the night before.

Although this was very funny and the clients enjoyed it, I was concerned that it included lyrics which displayed an externalised locus of control. I had had a previous experience a few months back where clients wrote a song in group in a similar vein, and after talking to the team about it, I realised I needed to challenge them on the underlying meaning in the lyrics which showed unhelpful thinking

patterns. It was hard to do but I knew I should ask the clients about what core belief was exhibited in the lyrics of the current song, because I felt it was important to reinforce these concepts which were such a vital part of the therapy being delivered. Discussion on this issue was not forthcoming, and I felt a little out of my depth in discussing this. I was able to refer to my colleague at this point who helped facilitate that part of the conversation and we were ready to move on.

Another client shared lyrics with the group, themed around the value of having family notice and support positive change in recovery. In spite of being very nervous about sharing his ideas, the client spoke his verses and sang the chorus he had worked on in a small group. It was positive to see that there was enough trust in the group for him to feel comfortable to do this.

In keeping with my aims to give clients clear choices, I asked the group what main activity they would like to do next week. One client answered that they were interested in doing all of the activities I offered, and the others agreed.

I closed the group by asking every client to choose an instrument and play individually for a short while, using the sounds of their instrument to show the group how they were feeling in the present moment. I outlined the basic sound qualities they could make, fast, slow, loud and soft or any combination of the four. My clinical notes state that *"the new clients played without hesitation or any of the physical or verbal cues which most clients exhibit when they are faced with this task"*. This struck me as good because clients, especially those who have not been in MT before, often make excuses for their playing or physically demonstrate disinterestedness during this activity. Perhaps by this time in the session there was a level of trust between myself and them which allowed this to happen.

### Reflections

An important idea which developed while reflecting on my sudden ending of the stone passing activity was that maybe *"I need to push my own comfort boundaries a little further"*. I wondered how much more smoothly the activity would have ended had I allowed it to continue and shown more leadership to bring the activity to a close. This was something I could perhaps look at in the next cycle.

I was concerned that not all the material created in the songwriting activities had been turned into a finished product. During de-briefing, input from one counsellor helped me to put some perspective onto this and encouraged a move to new activities next week. I remembered that *"process is more important than product... even if some of the songs are not completely finished the process was the helpful thing"*.

I also reflected that the rolling group membership is what makes an activity like songwriting over more than one session a real challenge. This led to some wider reflections about the challenge of rolling membership: *"I have developed a way for dealing with this, but it will never be easy"* and *"if the group had consistent membership songwriting would become a much more prevalent part of my tool-kit"*.

In reflection about giving clients choices, I realised that perhaps asking the clients what *activity* they would like to do gave the impression that I might not have clear objectives for therapy, and perhaps I am going about this in the wrong way. What I *think* I need to do to address the idea of being guided by the clients is to listen more carefully to them during activities, to respond to their needs both expressed and indicated, and to allow them plenty of space to respond to activities, rather than give them choices about activities.

I reflected that my involvement in the verbal therapy in the morning made me feel more like a part of the team when it came to delivering music therapy; and my reflections also stated that the interactive de-briefs, usually had with kai, were *"a really good way for me to engage with new ideas and assess my work"*. The teamwork factor appears to have had a positive influence on my confidence.

## Themes

### Confidence

Words and phrases such as *out of my depth*, *worried*, *afraid*, and *insecure* appear quite often in my self-generated data. I suspect that this lack of confidence which shows in the data has an effect on my ability to be truly therapeutically present and thereby deliver my personal best practice. This has been borne out previously to the study in comments from tutors and colleagues such as *"become increasingly aware of your own strengths"*, and *"become less self-conscious and involved in your own processes"*. Parts of the session, however did show that I had confidence to try something I hadn't planned, for example at the start of the session by including a breathing and stretching warm up, and by extending the stone passing activity initially.

### Resource Myopia

On more than one occasion in this cycle, I found I had a feeling of inability to find new or exciting ways of delivering music therapy. When I branched out and extended the stone passing activity, I eventually felt like I *"didn't have enough ideas to sustain it"*.

### *Balance between Structure and Freedom*

Finding the balance between structure and flexibility is important, because in response to feedback from staff previous to the study, I wanted to allow clients to have ownership of their group and facilitate in a more free-flowing way. However, some of the ideas coming from this cycle indicate that perhaps I needed to take a stronger leading stance and provide more structure. That situation is complicated by the fact that in some sessions, I can deliver my session plan exactly as I planned it, and sometimes I must respond to the needs of the group regardless of what I planned. How and where do I strike a balance between the two?

### *Diverging from the Plan*

I demonstrated some flexibility and trusted my instincts by starting with the stretching and breathing. Here I did have the confidence to go 'with my gut'.

### *Relationship with the Team*

During the session, a colleague helped me to raise an important point about unhelpful thinking with the clients. After the session, during de-brief, another colleague helped me to plan the following week's activities, and to gain perspective on the session I had just conducted. Keeping these working relationships appears to make a positive difference to my practice.

### *Relationship with Clients*

The clients may have felt insecure when I abruptly stopped the activity. The clients' levels of trust in me may have been negatively affected by my not being prepared to use the recording equipment confidently. However, the final reflections circle activity showed that clients were comfortable and confident enough with the music to play their instruments individually.

### *Key Learning Points*

- Giving well defined choices to clients and keeping verbal interactions simple elicits clearer responses and cultivates a feeling of trust with clients, conversely, being non-directive and unsure about instructions leads to a lack of security for both the clients and myself.
- Confidence and self trust are important if I am to deliver my best practice - while it is important to trust my instincts and diverge from my plans, it is important to stay therapeutically present in the room.
- Not being properly prepared for a session (in this case, being confident in using recording software) may negatively affect my relationship with clients.
- Working with colleagues both during sessions and in supervision enhances the therapeutic value of my work and my ability to reflect and grow in it.



## Cycle Two

### Planning

In the second cycle I wanted to build on and consolidate the ideas brought up in the first cycle. On a practical level, I wanted to provide closure to the songwriting activities of the last few weeks and begin a group improvisation segment. I hoped that this would cater to the rolling group as about three clients in the group had finished the programme and it was likely that more would be joining the group.

My thoughts about how to improve my practice in the second cycle were centred around the following concepts:

- I felt that I wanted to explore the idea about the balance between the structure and flexibility of my facilitation of the group. I wanted to continue to give clear verbal instructions because this obviously elicited clear client responses in the first cycle; but I wanted to take the 'structure' a little further. In response to my reflections and findings from the first cycle, I planned to focus on giving clients choices and freedom during the actual activities rather than in the deciding of which activities to do. Accordingly, I created a well defined plan for the session.
- Also in response to the last cycle, I wanted to be mindful of sustaining musical interactions until they reached a natural end. I perceived the value of this to be two-fold: firstly, extra time in musical activities may help the group to relax and be more comfortable, and secondly, it may help me to push my own comfort boundaries and also have more time to achieve a feeling of being grounded as a facilitator.

### Action

When I arrived at the facility on the morning of the planned session, during the usual briefing about how the group was and planning for the day, the facilitators told me that some clients had brought music therapy up in a group therapy discussion during the week. Apparently two of the clients had talked about not liking stone passing and not seeing 'the point' of it in music therapy.

*"My first reaction was to feel quite negative – in fact the same very ill feeling that I sat with for a week last time I got clients' [negative] feedback, but I soon grabbed hold of that feeling and shook loose of it. [Facilitator] also said the group had said they really like MT. [Another facilitator] noted that the fact that they were able to express this had demonstrated a change in behaviour that was*

*congruent with the aims of the group. She agrees that clients don't have to like MT, but it is important that they engage with it.*

*My first thought was to not start with the stone passing today, and replace it with another activity. I quickly realised that this would not achieve anything. I did want to address the feedback, but I realised that this was not about me – it was about the clients. Only two clients had apparently been vocal about this, and they had both engaged well in the stone passing activity last week, one very enthusiastically. I realised that I needed to perceive this as an opportunity for growth. By talking to [facilitator] about this I also reminded myself that MT is not supposed to be light entertainment; that just like VT [verbal therapy] clients will feel uncomfortable and I have clear therapeutic goals which is why I use that activity.” [Reflective Journal, 01/07/09]* Being able, with the help of the team, to put the clients' comments into perspective as a manifestation of cognitive dissonance and lack of self-confidence rather than something I did 'wrong'; was very empowering for me. At the same time I acknowledged that moving the exercise into an improvisation was challenging for them and did require a level of trust which may not have been yet established with all the members of the group. I realised it was important to bring up this issue and discuss it with the group, and to share with them the therapeutic goals of their music therapy and the stone passing activity. When the group started, the two clients who had brought up this issue were not in attendance, but I was still aware that the rest of the group, including two new clients, had been part of the initial conversation about the relevance of stone passing.

*“I ... invited a brief discussion from clients about MT and why stone passing in particular is an activity I use. At my invitation, clients came up with ideas about why we might use this in the group, ('heighten energy' and 'group feeling') and I reinforced this by explaining it in terms of Te Whare Tapa Wha, as an activity with holistic benefits including body, mind, spirit and whanau.” [Clinical Notes, 01/07/09]* As it was, the stone passing activity ran very smoothly, and for comfort's sake (that of mine and the clients) I chose not to extend the activity into improvisation as I did last week. All the clients sang the song also – I was pleased to see this continuation of the risks we had taken last week with singing.

I then facilitated an improvisation warm-up in which one person leads with a musical or rhythmic idea on an instrument and the group echoes it on their instruments. Clear verbal instructions this time elicited not only clear responses, but also some good musical interactions:

*“Each client successfully took leadership and there was none of the usual hesitancy in taking leadership and, notably, no verbal interaction.” [Clinical Notes, 01/07/09]*

After another improvisation warm-up, we moved onto a group improvisation. One client who played the guitar had chosen the theme, which was Reggae, and this client also led the improvisation with a repeated harmonic progression. One client later described the improvisation as ‘chilled out’ and relaxing in nature. I facilitated using voice and melodic ukulele, and also spent some time mirroring and matching<sup>14</sup> clients in playing percussion. I noticed that when I modelled exploring some percussive rhythms, some clients tried exploring new rhythms also, rather than just keeping the 4/4 beat. In keeping with my goals, I was mindful of stepping back musically allowing clients the freedom to end the improvisation. *“...allowed the improv to continue for as long as the group wanted it to, so when it ended it was pretty much [the client playing the guitar]’s decision. Everyone sensed the approaching end, and [client] did a wee drum roll on the djembe.”* [Clinical Notes, 01/07/09]

After the improvisation,

*“I asked for verbal feedback. Two clients said they enjoyed it, and another said it felt like we were all in a trance, and the group generally agreed. I asked if we should do some more playing or sit with the relaxed feeling in the room. There was no response so I took a directive stance and said we would take a few minutes to relax.”* [Clinical Notes, 01/07/09]

Here I had forgotten my resolve to be more directive about choice of activities and did exactly what I had planned to avoid. If I had followed my session plan faithfully, we would have moved onto a very different improvisation activity immediately. However in that moment it felt like we should stay with the feeling created by the music of the improvisation. I was aware that the group had done some brief meditations in the past week and knew they would be comfortable with this activity.

*“Asking clients about activity choice after the improvisation was a deviation from my plan and would also affect my research goals. Although I think it was appropriate to deviate from my session plan, and the short meditation which followed was a good part of the session; giving them this choice did not elicit any responses and may have made clients feel as though I didn’t know what I was doing.”* [Reflective Journal, 01/07/09]. There is no evidence apart from their non-response to suggest that the clients felt uncomfortable with being given the choice, but in asking them I think I was demonstrating a lack of trust in my own instincts.

After the meditation, another improvisation on a different theme followed, in which my co-facilitator played a strong guitar riff which framed the improvisation well. The music this time was slower and more relaxed, although one client in particular played the auto-harp loudly without listening or musically interacting with the rest of the group. A turning point came when this client

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<sup>14</sup> See glossary for definition.

put the auto-harp down and started playing the djembe, and the music from that point was more cohesive and the group played with more ease. This improvisation ended by slowing down at the same time as getting louder, and I noticed that every group member was playing slower and louder as the music ended. I ended the session with a reflective round, asking clients to pass around the auto-harp and play briefly in a way which might reflect how they are feeling in the present moment, as well as verbally say what they had thought was important from the sessions (both verbal and music therapy) today. I noticed that each client's playing was more meaningful and explorative than usual – when I had done this activity before, some clients often just swipe a hand across the strings, or chose not to play at all. In this case, each client played with deliberation and thoughtfulness. I felt that this last part of the session had gone very smoothly.

### Reflections

It is interesting that most of my reflections about this session were about the feedback I had received, and I did not write very much about the rest of the session. I realise that I got very caught up in the feedback discussion and the first part of the session where I dealt with the feedback, and lost focus on the therapeutic value of the rest of the session. On the whole, I had been very pleased with my reaction to receiving feedback, and I had a lot of thoughts related to this in comparing it with my responses to receiving feedback in the past.

*“In November I was still struggling to find a way of working with the staff here – I felt incompetent and unconfident and chaotic. I was familiar with the programme they were delivering but not confident with all the concepts [Here referring to the therapeutic approach –in this programme there was more emphasis on clients identifying their thoughts and feelings and changing their current and future actions through mindfulness; whereas my earlier experiences of the programme run at a different facility by different facilitators was more gentle and required clients to be more introspective about the past in order to find ways of exploring their future.] I knew what I wanted to do in MT but I was not confident in doing it, and my colleagues may have picked up on this and felt the same way – thoughts like: MT is a good idea, but is it really good for this group setting? ... I [now] feel I have COMPLETE support and ‘buy in’ for my profession, and I feel like MT is now part of the programme in a way it never was back then.” [Reflective Journal, 01/07/09]*

### Themes

#### Confidence

While during this cycle I noticed a vast improvement in my confidence since November, especially as regards feedback, I also recognised that my need to ask the clients about what to do next sprung

from a hesitancy to trust my instincts, which were good - the idea to facilitate a brief meditation after the first improvisation was a valid one and proved to be a good activity. Improving my confidence would appear to be linked in to improving my practice.

### *Balance of Structure and Freedom*

Allowing clients the space and freedom for expression during the activities did elicit some meaningful musical moments, particularly the endings of the improvisations. I also noticed that my clinical notes were clearer and more detailed about the parts of the improvisation which I did not participate in so strongly – indicating that allowing the clients leadership of parts of the music allowed me more space to observe and listen closely.

### *Diverging from the Plan*

Including a meditation which was not part of my plan was a helpful and valid part of the session and a good segue into another improvisation.

### *Relationship with the Team*

Reflective notes indicate that my co-facilitators supported me in addressing the feedback with clients, and also helped me to frame the feedback I had received and gain perspective on it. I also felt very grateful for my colleague who played the guitar in the second improvisation, which again allowed me to observe and listen more carefully to the group.

### *Relationship with the Clients*

Helping clients to understand the value and aims of music therapy was always a challenge, and the rolling group often made it even more so. I think my relationship with the clients was strengthened in the session by my assertive approach to the feedback and re-iteration of the goals of MT.

### *New Focus for Improving Practice*

I realised that in this cycle, my original goals about creative, sustained and holistic practice had become less of a focus, and what I was grappling with was actually a deeper understanding of therapeutic process and the balance between structure and flexibility, between listening and acting, between leading or guiding and following, between allowing the music to unfold or guiding it to a place. The endless push and pull of this had become my way of understanding how I could improve my practice.

### *Key Learning Points*

- Receiving client feedback is an opportunity for growth and can be easily dealt with in consultation with colleagues and with an assertive attitude.

- Clear and confident verbal instructions and interactions elicit clear verbal responses, and also healthy and confident musical interactions.
- Allowing the clients more freedom during a musical interaction has the benefit of my being able to listen and observe more closely.

## Cycle Three

### Planning

I had now ascertained that it was important for me to be more direct in activity choice and that doing this would help me and my clients to feel more secure. I had also been able to practice using succinct language and verbal interactions during sessions and had found this elicited helpful responses. Now I wanted to focus on empowering my clients to have freedom and choices *within* the activities, and revise ways of facilitating to allow this to happen.

In planning this cycle, I read an article related to group improvisation, which had gathered information from interviews with several specialists in clinical group improvisation (McFerran & Wigram, 2007). Reading this article had a two-fold effect – firstly, it affirmed for me that many of the things I already did in facilitating improvisation were, in fact, the ‘right thing to do’. The article also gave me some new ideas about how to frame an improvisation session – it talked about ‘creating a culture of playing and listening’, and touched on my theme of how much structure to provide. The following four points seemed relevant:

- *The therapist must shape the music to encourage participation.* I could do this both verbally by giving clear ‘play rules’, and musically by using matching and mirroring techniques.
- *Both strong rhythms and free pulse can be useful in improvisations, but an absence of pulse can create more meaning.* I thought that for this session I could lead an improvisation without pulse, which may provide the freedom for expression which I wanted clients to have.
- *The level of structure and direction used by the specialists varied in accordance with their philosophical stance.* This key point made by the authors was interesting because being a student therapist at the start of my journey, with limited experience, I am still developing a ‘philosophical stance’ – while I have a basic knowledge of the underpinnings of music therapy, and an understanding of the ways in which I think MT is helpful to this client population, I am still learning a lot about MT in this environment. While I imagined that this could only develop through further clinical experience, I recognised that the action research

project is helping me to continue to develop my 'philosophical stance' on working with this client population.

- *Therapists working with verbal clients were more likely to assume a non-directive leadership, allowing the group to find its own meaning and follow its own volition.* This told me that my aim to allow the group more freedom during activities was valid.

I decided that the first activity should allow plenty of room for expressive freedom – I would divide the group into two and ask each group to create something to play for the other group, with a theme or aim behind it.

When reading through my notes from the last cycle I realised that I had deliberately given the main facilitating roles of both the last session's improvisations to others who had guitar playing experience – firstly a client, and secondly a co-facilitator had played guitar, which largely determined the nature and direction of the improvisations. While I realised that allowing others to lead on guitar had its value, I decided that in this cycle, I would *"take a leadership role on the guitar, even though I am not confident on the instrument, I am the person with the skills and training to facilitate M.M.M.'s [Meaningful Musical Moments] ... I would like to facilitate an environment where those could happen today."* (Planning Notes, 08/07/09) While allowing clients to lead improvisations had its place in this work, with the group membership changing constantly I decided that at this stage I needed to carefully shape the music while also providing the creative freedom I initially decided would be valuable in this cycle. My reading had alerted me to the amount of exciting and interesting ways I could frame improvised music to promote change, and I felt refreshed with new ideas for improvisations. I resolved to play the guitar in a final group improvisation today.

To summarize, my research goals for today were to:

- Be careful to allow clients plenty of space and opportunity for creative expression in the music, but also -
- to be mindful of my role as facilitator and be careful to shape the music in a way which will promote and extend creative expression.

### Action

The verbal therapy topic run in the first part of the session today was about relationships: clients were asked to examine the healthy and unhealthy relationships they had and how these changed when they stopped using drugs and/or alcohol. I played a more active role in delivering the VT than usual, which was not planned but which just developed under the circumstances.

One client had his young son with him today, and while the boy had been happy doing other things during the verbal therapy, I wondered if he would like to participate in MT. He seemed keen, and so I consulted the group, who said they would be happy for him to join. I wondered whether maybe having a child's playful presence might also encourage a feeling of playful expression around the group.

I began with an improvisation warm-up: each person was to pass a musical message to another person in the group until everyone had played music for someone else and also received music from someone else. This activity helped to develop the culture of listening that I was aiming for, and later my co-facilitators mentioned that it was good to see the musical messages passed between clients who do not necessarily 'get on' that well.

For the next activity, I divided the group into two and set out the play rules clearly: Each group had 10 minutes to prepare a short improvised piece which they were to perform for the other group, based on a theme or idea around relationships (chosen because of the topic of verbal therapy session).

The preparation was characterised by *'a lot on musiking going on ... rather than talking'* [Clinical Notes, 08/07/90], which surprised me because often a group will spend this time talking and avoiding having to engage musically. Perhaps this was because group cohesion was better this week with this particular combination of clients, and perhaps it was due to the solid improvisation warm-up and culture of listening which had been set up already.

Instead of asking who would like to play first, I simply asked one group at random to play. This avoided hesitancy or awkwardness about who is to 'go first'. This group *"...explained they had played with the idea of group friendliness. They played with cohesion and direction ... There was a strong sense of common direction in the group's playing and the music was easy going."* [Clinical Notes, 08/07/09].

*"When the group finished their music, I wondered whether or not to verbally process, so I waited a little without saying anything, and before long the next group started to prepare for their one."* [Clinical Notes, 08/07/09] My first instinct had been to start talking about the music we had just heard, but I hesitated just a little, wondering if this was a good idea, and during this time the second group started to prepare for their 'performance'. I realised I didn't need to say anything, and that here it was better to allow the group to continue in their flow. I reflected that *"Silence is the best thing – by my not saying anything, it felt natural for the next group to start playing ... and worked into my goals of reducing verbal interactions"*. [Reflective Notes, 08/07/09] I think the benefit of this



was that by continuing without my input the clients had some ownership of the activity, and that perhaps my being more grounded and mindful of my therapeutic presence was what led me to hesitate.

The second group then played their improvisation, based on a Spanish theme – a few weeks ago we had had an enjoyable improvisation based on a Spanish theme a client had played on guitar, and one of the clients in this group also played some guitar. This music was characterised by percussive environmental sounds and gradually moved into a relaxed Spanish-style piece.

*“...we didn’t verbally process this, it just didn’t feel necessary... The group were in a good mellow kind of space so it felt ok to start something freer without too much direction.”* [Clinical Notes, 08/07/09]

I decided on the spur of the moment to take the auto harp and guitars out of the circle, which left only glockenspiel, xylophone and violin for melodic instruments. The reason for this was that I wanted to facilitate a non-rhythmic improvisation, and decided that it would be interesting to hear the development of an improvisation without these ‘leading’ kinds of instruments. I played the djembe, which in size and potential for volume meant that I could shape and direct the music should I wish. By now everyone had relaxed into the session, and I felt a ‘culture’ of listening and participating had been established.

The music of the improvisation could be described as chaotic, but there was some active listening and responding going on between group members, and many clients were being explorative on their instruments. I was able to shape the music, and developed some matching and mirroring interactions with various group members when I felt I wanted to draw them into the music or acknowledge their musical creativity. I had always encouraged clients to swap instruments if they wanted to during an improvisation, and there was a lot of this going on, and some playful music was emerging too – one client picked out a UB40 tune on the xylophone for a while, others joined him in the rhythm a little. The same client later on picked out ‘Mary had a Little Lamb’ (in a Dorian mode!) on the glockenspiel. The others in the group seemed to enjoy this and acknowledged it musically. The improvisation lasted quite a long time and as a gradual decrescendo developed, my co-facilitator put down her instrument and started clapping softly. I slowly directed clients one by one to put down their instruments and start the clapping, until there were just two instruments still playing, the violin and the glockenspiel. I directed the reducing of the clapping to a finger click and an eventual stop. Although my aims were to allow clients a maximum amount of freedom during improvisations, I felt that taking a measure of control over the end of the improvisation helped to shape the music and keep the experience contained, and that to bring people back to doing mainly the same activity

was a good way of heightening their awareness of others in the group. Explaining this in clinical notes was difficult for me, because in this improvisation I felt very much in 'the zone', and while I was 'directing' the end of the improvisation, I was acting very much on instinct. The playing and responses of the clients indicated that they were also in a 'zone'. I did not feel necessary to make verbally explicit those things about the music which were implicit, and there is no evidence but my own notes to back this up. Unfortunately this was a moment which did not get talked about during the de-briefing with colleagues after the session.

*"We did not need to [verbally] process this either, but I decided on the spur of the moment to have a verbal reflections circle [As opposed to the musical reflections circle I had planned]. Reflections included positive feedback about MT from most. One client described a sense of chaos felt in the last improv and reflected that this is a bit like their life at present."* [Clinical Notes, 08/07/09] I think this client had made a connection with the fact that sometimes it is important to be able to experience and make sense of chaos or discomfort, and I felt this showed his growing awareness of the need to be able to sit with these feelings sometimes. Where often our improvisations remained pleasant and consonant, improvisations which are dissonant or chaotic are important because they help provide an experience of sitting with feelings which aren't necessarily pleasant – for people who have always dealt with unpleasant feelings by 'taking a hit' or 'picking up a bottle', this is an important part of recovery.

### Reflections

I felt that implementing the research goals I had for this cycle led to a valuable session for clients and that this session demonstrated some progress towards my goals for improving my practice.

*"Today was fantastic, pretty much what I think of as ideal MT – the kind of experience I imagined facilitating before I started here ... like there was a SAFE musical space, a really contained space created by the clients ... great creativity and a real group feeling. Perhaps it was helped by the absence of [client] who has had a tendency to manipulate and dominate and has been a concern to the group and facilitators in other respects, and [two clients] ... whose unfocussed-ness and chat during group has disturbed the group a few times. Today I felt like I trusted my instincts a lot and it worked, mainly because I felt connected to the group feeling and the ambience, and I was responding to that."* [Reflective Journal, 08/07/09]

Inspired by the success of the session, and perhaps aware of nearing the end of my work at this placement, I wrote some of my thoughts in a more poetic format:

*"Full Circle. The group sits in a circle. The roundness of a glass, a syringe, a smoke; the need to return to things as they were before dependency. The return for me to being enthusiastic about the work, to doing it as I had envisaged. Rounding off the placement, the cycles of the action research.*

*We sit in a circle and think about it all;  
How our body and our brains and the rest connect;  
And day by day I see the stones passed around.  
I am trying to connect; I am trying to complete the circle.  
But it does not come from me, when it does come  
It is the music that does it,  
when I step out of the circle  
The music starts up.  
A full circle; but without me in it.  
18 months of learning, keeping the circle strong,  
Coming back to it all again and again.  
The cycles of moon, earth and soul repeating,  
How many circles of reflection, of feelings, of energy, of stones passed around?"*

[Reflective Journal, 08/07/00. The reference *Keep the Circle Strong* is one of the mantras used in the therapeutic community in the women's prison where I did some MT work during the placement.]

## Themes

### Confidence

Although it appeared to be a successful improvisation without it, I still avoided playing the guitar as I had planned, showing that I still have insecurities about this. However, in other respects, having found that I was doing many things 'right' according to McFerran & Wigram 2007, I went into this session with a more confident attitude and I think this positively affected the session and my impact on the group, in that I felt able to trust my instincts and respond to the needs of the group, rather than put myself in the way by worrying if I was doing things right, as I have in the past. Heightened confidence led to my being more grounded in the space after the first group had played, so I hesitated just long enough to realise that my first instinct (to verbally process) had been mistaken.

### Balance of Structure and Freedom

During this cycle I think I developed a more free flowing kind of direction and balance. I built on the findings of the earlier cycles by providing strong, clear verbal directions and assertively introducing activities; but my more confident therapeutic presence meant that I had more flexibility to decide in

the moment when it is important to lead, and when to allow the group to lead. It seems that while I have identified clear areas for me to become more structured in, flexibility within this is still very important.

### *Relationship with Clients*

My reflection that *I felt connected to the group feeling and the ambience* was bourn out in the clients' musiking, creative exploration, and verbal feedback. Perhaps part of this was simply that the group were in a good place on this day. Perhaps my being more involved in VT than usual led to a more established relationship by the time the MT came around.

### *Reduced Verbal Interaction*

One of my original aims, which had faded into the background by now, was to bring musical interactions to the forefront of my sessions. This session did allow for exactly that, the music was enough so that there was no need for verbal discussions. While I had noticed the absence of three clients, which may have contributed to the reduced verbal interactions, I felt that the stronger and yet more flexible therapeutic presence I brought to the session contributed also. Is it possible that my perception of the success of this session combined with the reduced verbal interaction is contributing towards a development of my personal schema and philosophical viewpoint around the value and nature of music therapy? The evidence is developing to indicate that by being a strong and yet flexible therapist, I can facilitate change with this client group through a music-centred approach.

### *Key Learning Points*

- Reading music therapy literature can help to boost confidence and inject practice with creative ideas and concepts.
- When careful cultivation of a 'culture of listening' is set up, a non-rhythmic and more dissonant music experience is safe and has therapeutic value for clients, just as much as a tonal and familiar music experience has.
- Being mindful of my therapeutic presence and its effect on the clients led to my being able to trust my instincts more; and a more natural ebb and flow of the structure of facilitation which enables the clients to take risks and explore their creativity ensued.

## Cycle Four

### Planning

In preparation for the action of cycle four, I re-read a 1983 article about MT with substance abusive and dependent people (Murphy, 1983), and I also had clinical supervision with my music therapy supervisor with whom I had met regularly throughout the placement. I also read through my clinical notes and reflective journal from cycle three. One common theme which emerged from all three of these processes was related to goals:

- Reading the article prompted me to question the goals I had had in mind for the group, and how I perceived these goals. *"I have general goals which are geared towards assisting clients to modify their addictive behaviour, and I keep them in mind in all interactions. More specific goals generally present themselves in the therapy room, which can be identified and addressed within the session, but in order to improve my practice, perhaps I need to revisit the general goals in planning and identify specific ones for each activity?"* [Reading Notes, 13/07/09]
- In supervision I was able to identify some distortion around my keeping my clinical practice and AR separate – my goals had become very focussed around 'me', and my clinical goals for the clients seemed to have taken a backwards step in the last week. I recognised a need to clarify the clinical goals for the clients once more: *"I may have blurred the boundaries between my goals for my practice and my goals for the group. I need to clarify what my clinical goals for the group are, and be mindful to focus only on these during therapy – goals for my practice can be considered outside of the therapy session"* [Supervision Notes, 14/07/09]
- In revising the previous cycles I noticed I had *"...mixed views about research and practice – my clinical notes had become more about me than about the clients"* [Planning Notes, 15/07/09] I felt it was important to address this by re-visiting the clinical goals for the group and my personal goals for practice improvement separately.

My specific clinical goals for the group in the coming week were:

- to reduce isolation and increase group cohesion
- to cultivate a safe space for clients to be creative in
- to encourage relaxation skills through receptive and active music therapy activities.

My broader goals around improving practice were those which had grown out of the last cycle: namely, to maintain the strong yet flexible therapeutic presence, and to create a 'culture of

listening'. I decided to use a new approach to improvisation, starting by asking the group to listen to a piece of music which had relaxing elements in it, and then inviting the group to improvise their own music afterwards. The idea of combining receptive techniques with improvisation would, I hoped, encourage the 'safe' space I aimed to create, as I had found listening was often less intimidating to clients, and I was aware that there would be two or three new clients in the group this week.

In hindsight, I now realise that there was an opportunity in this cycle to examine and refresh my methods of writing clinical notes. My clinical notes had started to show more about my actions and thoughts than being an account of what happened and what I observed, I had begun to blur the boundaries between clinical observations and reflection. This is discussed further in the discussion chapter.

This was to be my last session at this placement. I had talked with my music therapy supervisor about closure, and we had identified that this was going to be an important thing for me to consider personally. We decided that I could provide closure to the clients by facilitating an improvisation centred on endings and moving on, which would be a way of acknowledging my leaving the facility without making it a huge focus. Because the group has rolling membership, closure of therapeutic relationships is something clients frequently experience with various therapy and counsellors. In many ways I treated this cycle as if I were to be continuing the work into the future.

### Action

I had less time for my session today due to VT running a little over time, and needing to finish early to farewell two graduating clients. There were three new clients in the group today, which usually means a shifting of the sands in terms of group cohesion, but the verbal therapy session had gone smoothly. I started with a stone passing exercise, which, being new to some people, I reflected was *"a little messy and created an unsettled feeling"*. [Reflective Notes, 15/07/09] I felt this way because some clients did not appear to engage with the activity and chatted about other things while the activity was happening.

For relaxation listening, I used a new-age track of about 7 minutes which included natural environmental sounds. I chose this track because I thought the clients would connect with this music, and I knew that choosing more popular music with which they may be familiar can be contraindicative in recovery. I took the clients through a basic breathing induction before playing the track.

*"Everybody seemed to be in a relaxed state physically and engaged with the activity".* [Clinical Notes, 15/07/09]

Because there were three new clients in the group, and because two clients and I were finishing in the group today, I decided to do the improvisation on the topic of *Beginnings and Endings*. I introduced the concept and the clients accepted it readily. I set the play rules for one person to start playing at a time, so that there was a gradual build up of sound in the improvisation. Initially, a family member of one client who was attending the group today said they would not participate. During instrument choice, another client offered her a shaker, obviously wanting for her to feel more included – she accepted the shaker and did participate in the improvisation. This demonstrated that clients felt some ownership of the group.

*"The music began very freely with no pulse – at one point I introduced a gentle rhythm on the djembe, thinking that this would be a good metaphor for having to roll with changes such as beginning and ending being in a group, but also because I felt I needed to guide the music more because it was so disjointed – some clients took this up and some didn't, which led to an increased feeling of disconnection. ...The music took a long time to wind down and finished very quietly – I did not play a strong part in this as I had in improvisations last week. Because of the theme I wanted to observe and see how the clients managed ending the improvisation. I asked the group for some verbal reflection but there was not much forthcoming. I felt like people wanted to say, "that was dumb" but were too scared. I suggested that the music might be a metaphor or reflection of how we feel as a group – perhaps the disjointedness and lack of cohesion was something we felt as there are new people in the group etc. – many in the group nodded and 'mmm...'ed in agreement."* [Clinical Notes 15/07/09] I introduced rhythm when I remembered some of my goals for the session, and because I thought it may help to create a safer space for the clients, and even though it wasn't developed by the clients, I think it was important to at least offer some direction.

After finishing this interaction, I had just enough time left to facilitate a reflections circle. I remembered the session goals of increasing group cohesion, and decided some verbal sharing - as opposed to more abstract musical sharing - would be helpful for this. I asked clients to share their thoughts on music therapy as a whole, and also to tell the group a little about the music they listened to while 'using', and the music they might listen to now. This was something I often did when new clients were in the group, which helped to establish a therapeutic relationship with the clients, and worked in well with the VT goals of mindfulness. *"Some clients said they had experienced some relaxation in MT, many said they enjoyed it – although they could have been saying this to make me feel good as it was my last session with the group. Some said they had purposely changed*

*their listening habits since they stopped using, others said they still listened to music they had played when using.” [Clinical Notes, 15/07/09]*

After a somewhat difficult improvisation, it was helpful to end with the more familiar verbal discussion.

I had found it difficult to feel a connection with the group during the session today. Focussing on the session goals I had devised helped me to hold the session together.

### Reflections

I initially struggled to be dispassionate in reflections from this session. *“I just don’t feel like reflecting right now ... I wonder if this is reflection overload?”*

*“I feel like my colleagues set up a nice group feeling in the VT and I destroyed it in MT, and talked about this in de-brief. My colleagues helped me to see that this was not really the case.” [Supervision Notes, 15/07/09]*

About identifying that the disjointed music may be a metaphor for the disjointed group: *“I was worried this may have taken something away from the group and the music we had just made - I think this was where my worry about destroying the VT feeling came from – but my colleagues explained that this was actually good and healthy - for me to be transparent and clear about what I’m thinking is role modelling good communication and is in fact essential. This made me feel a lot better about that.” [Reflective Journal, 15/07/09]*

I believe my difficulties in reflecting about the session were related to the intense amount of thinking and reflecting I had done in the past few weeks: *“...this project consumes my thoughts a lot; what I write down is a distillation of what runs through my head” [Reflective Journal, 15/07/09]* I also believe I was experiencing ambiguous feelings about ending the placement – on the one hand I was very ready and excited to be moving on, and on the other, I felt like I hadn’t learnt enough: *“I think I can not fall into the trap of thinking that this is it – I have progressed as far as I will. I HAVE progressed A LOT and am DOING REALLY WELL, but – and this is an idea which came out of supervision yesterday after talking about my next placement – I am only at the beginning of my MT journey, and nothing accounts for time and experience, so really for where I am at I am doing quite well.” [Reflective Journal, 15/07/09]*

It is important to acknowledge that my negative feelings after the improvisation and after the session were linked to my feelings about closure and leaving the facility, and also that these feelings would have perhaps gone unchecked were it not for the support of my colleagues.



## Themes

### *Balance between Structure and Freedom*

When a client offered an instrument to another group member who had initially refused to be part of the music, it demonstrated that the clients felt some ownership of their group and a degree of freedom within the environment. During the improvisation I tried to carefully lead the music into a new space, but I didn't force a change of feeling, finding that allowing ebb and flow of structure and flexibility appears to work well within improvisations.

### *Relationship with the Team*

A client whom I had worked with previously in a different programme mentioned that I was more involved in delivering the VT than previously, and they noticed my confidence and inclusion in the team. Reflecting with my colleagues enabled me to contextualise my negative feelings about the session, and encouraged me to see the value in it.

### *Relationship with the Clients*

The difficulty for me to feel connected to clients today may have been due to my feelings around finishing the placement, but also that there were three new clients in the group. That a client felt confident to invite the family member into the musicking showed that they felt some autonomy within the environment.

### *Clarifying Goals*

Re-defining my goals appeared to work well in that I was able to refocus on them when I felt that things were not going so well. Clarifying my goals helped me to understand my role during the improvisation, where I offered some rhythm to help connect the 'disjointed' music, but did not impose it when it was not accepted by the whole group – I was able to remember that I wanted to be flexible in this regard.

### **Key Learning Points**

- While in previous cycles I had learnt and come to appreciate the value of music-centred activities, sometimes it is appropriate to have verbal discussions with clients, and can help them to feel more comfortable.
- Myriad factors can influence the way a session is run – by having clear goals in mind and revisiting and reviewing these goals frequently a facilitator can deal with situations more readily.
- Being dispassionate in reflecting about MT sessions can sometimes be a challenge for me, but discussing this with colleagues brings perspective.



## Table of Themes

Cycle One	Cycle Two	Cycle Three	Cycle Four
Confidence	Confidence	Confidence	-
Resource Myopia	-	-	-
Balance Between Structure and Freedom	Balance Between Structure and Freedom	Balance Between Structure and Freedom	Balance Between Structure and Freedom
Diverging from the plan	Diverging from the plan	-	-
Relationship with the team	Relationship with the team	-	Relationship with the team
Relationship with clients	Relationship with clients	Relationship with clients	Relationship with the clients
-	New Focus for Improving Practice	-	-
-	-	Reduced Verbal Interaction	-
-	-	-	Value of Clarifying Goals

## Table of Key Learning Points

<b>Cycle One</b>	<ul style="list-style-type: none"> <li>• Giving well defined choices to clients and keeping verbal interactions simple elicits clearer responses and cultivates a feeling of trust with clients, conversely, being non-directive and unsure about instructions leads to a lack of security for both the clients and myself.</li> <li>• Confidence and self trust are important if I am to deliver my best practice - while it is important to trust my instincts and diverge from my plans, it is important to stay therapeutically present in the room.</li> <li>• Not being properly prepared for a session (in this case, being confident in using recording software) can negatively affect trust between myself and the clients.</li> <li>• Working with colleagues both during sessions and in supervision enhances the therapeutic value of my work and my ability to reflect and grow in it.</li> </ul>
<b>Cycle Two</b>	<ul style="list-style-type: none"> <li>• Receiving client feedback is an opportunity for growth and can be easily dealt with in consultation with colleagues and with an assertive attitude.</li> </ul>

	<ul style="list-style-type: none"> <li>• Clear and confident verbal instructions and interactions elicit clear verbal responses, and also healthy and confident musical interactions.</li> <li>• Allowing the clients more freedom during a musical interaction has the benefit of my being able to listen and observe more closely.</li> </ul>
<b>Cycle Three</b>	<ul style="list-style-type: none"> <li>• Reading music therapy literature can help to boost confidence and inject practice with creative ideas and concepts.</li> <li>• When careful cultivation of a 'culture of listening' is set up, a non-rhythmic and more dissonant music experience is safe and has therapeutic value for clients, just as much as a tonal and familiar music experience has.</li> <li>• Being mindful of my therapeutic presence and its effect on the clients led to my being able to trust my instincts more; and a more natural ebb and flow of the structure of facilitation which enables the clients to take risks and explore their creativity.</li> </ul>
<b>Cycle Four</b>	<ul style="list-style-type: none"> <li>• While in previous cycles I had learnt and come to appreciate the value of music-centred activities, sometimes it is appropriate to have verbal discussions with clients, and can help them to feel more comfortable.</li> <li>• Myriad factors can influence the way a session is run – by having clear goals in mind and revisiting and reviewing these goals frequently a facilitator can deal with any situation.</li> <li>• Being objective in reflecting about MT sessions can sometimes be a challenge for me, but discussing this with colleagues brings perspective.</li> </ul>

Peer reviewing was helpful in the analyses of the findings, in that it brought clarity and perspective to some aspects of the cycles and helped to form some of the themes. The reviewer's comments led to the development of the *Relationship with Clients* theme and the emphasis on developing trust. The reviewer's comment also contributed to my understanding of how and where I was being flexible in carrying out sessions.

## Discussion

### Practical Learning – Key Learning Points

The practical findings I made during the cycles all appear to be about striking the right balance between two extremes for some key aspects of facilitating clinical music therapy sessions:

Clear instructions	No instructions
Trusting self	Constantly questioning self
Working as part of a team	Working as an individual
Following a plan exactly	Not having a plan at all
Not taking part in the music at all	Dominating the music completely
Whole session spent musiking	Whole session spent in verbal interactions

What I discovered is that in each of above six respects I needed to either a) move towards the other end of the continuum; or b) develop more flexibility in moving around the continuum at different points and stages in a session, and depending on multiple factors including group cohesion, client needs, session goals and facilitation style.

### A Full Circle - But Without Me In It

An important discovery came up in Cycle Three. In my prose/poem *Full Circle* the quote “when I step out side of the circle / the music starts up” is quite telling about my learning about becoming a more therapeutically present facilitator. I have a tendency to be constantly aware of my interactions with others, and during sessions I had a habit of constantly monitoring my own my processes. In past sessions I had spent a lot of time worrying “am I doing the right thing”, which led to my being distracted, or feeling responsible for the entire session, or being overly controlling; or being overly critical of self. By ‘taking myself out of the circle’ I can become truly therapeutically available. The difference is that instead of thinking “what do *I* need to do now?” I am thinking “what do *the clients* need right now?” The group is still a full circle; but without me in it.

Nothing is a better example of this than the stones. I had a woven box with stones, crystals and shells which I would pass around for clients to use in our introductory activity. Initially I had put all my crystals in the box. Around cycle two of this research, for a reason I don’t remember, I was sifting thru the box and decided to take out the crystals that meant something to me – one a previous counsellor had gifted to me, one my sister had given me, one I had brought at a particularly tough time in my life. In hindsight, I realized that this was a kind of symbolic gesture echoing the move towards a better way of practicing which didn’t have the “I” in it.

## Theoretical Learning - Themes

### Confidence

This was identified as a recurring theme in cycle one, and was obviously linked to improving my practice because of comments from co-facilitators. The theme developed in Cycle Two with examples of 'good' confidence enhancing my therapeutic presence and 'groundedness'. Cycle Two also showed examples of poor confidence leading to a lack of self trust. Being mindful of this as a potential block to delivering my personal best practice was helpful and confidence improved in Cycle Three. This piece of learning is ratified by the comments of Freed (1987) about the need for a music therapist to trust both her skills and her profession. There is also evidence to suggest that confidence grows with experience in the field: one of Silverman's main findings in his 2009 study of music therapists working in substance abuse rehabilitation was that *"a significant relationship was found between years as an MT-BC [Music Therapist, Board Certified] and perception of positive impact of music therapy"* (Silverman, 2009, p.123).

### Resource Myopia

A theme which only appeared in Cycle One, my feelings of having inadequate creative tools at my disposal may have been linked to confidence issues. I believe that being a student therapist with comparatively little experience it is not surprising that I had difficulty in finding the right creative tool at the right time.

### Balance between Structure and Freedom

This concept was one which had fascinated me from the time I began studying music therapy, and it became one of the main themes running through all four cycles. The theme developed from my identifying a need to provide clearer verbal directions in Cycle One. In Cycle Two, I found that there was value in allowing clients more freedom during musical interactions, and in Cycles Three and Four I struck a balance between providing structure in terms of instructions and musical boundaries, and flexibility within musical interactions and session direction. After creating clear boundaries to keep clients safe, I was able to allow room for creative expression and ownership of their group. In hindsight, it makes sense that this should be a flexible thing, especially considering the rolling group membership – in any session, there was generally at least one client who had just joined the group, and the group would be constantly moulding itself around these changes. Being constantly mindful of how I facilitated in terms of therapeutic structure and flexibility also helped me to become more present in the therapeutic process and not caught up in my own processes.

### Diverging from the Plan

Although related to the above theme, this concept warrants highlighting because I found that sometimes the best session plan can change in a moment, and I needed to be constantly aware of working with how a group presented. Rolling group membership was a big factor in my ability to stick with a plan or diverge from it. This theme only appeared in Cycles One and Two because I believe by Cycle Three, I had been able to reconcile these two themes into an acknowledgement that session structure will follow a natural flow and that I needed to roll with that.

### Relationship with the Team

I was able to pinpoint right from the first cycle that working closely with the counsellors who delivered the programme was important, not only in de-briefing and putting my thoughts about sessions into perspective, but during sessions also. I felt that I had a lot of support from my colleagues, and I appreciated that they trusted me enough to allow me to help deliver parts of the verbal therapy sessions. In doing this project and asking them to help me with it, I felt that this strengthened my relationship with them and helped me to become a better therapist. Although the high levels of contact and de-briefing with them was perhaps due to my being a student, ideally, if I were to return to this kind of work as a qualified practitioner, I would wish to cultivate the same levels of trust and respect and contact with other staff. At least two music therapists, Gallant and Kapteina, writing about working in the substance abuse and dependence field recommend closely working with interdisciplinary colleagues (Gallant, Holosko, & Siegel, 1997; (Kapteina, 1989).

### Relationship with Clients

Establishing trust is a universally recognised important feature of working with substance dependent and abusive adults, and before I started this study I had already learnt a great deal about this. The study however helped me to bring this knowledge into focus: if I sat back and gave no direction at all, the clients would have felt unsure of what to do, if I had dictated every part of a session, they would not respond at all. By carefully monitoring the amount of structure I provided I believe I was able to improve the levels of trust and comfort between myself and the clients – this was evident in various things they did during sessions. Quite often, my thoughts about the challenges of having rolling group membership appeared in the data, and I believe this and the fact that I was only present one third of the time of the other counsellors were working with the group, meant that establishing a therapeutic relationship often needed to be an instantaneous thing, and was complicated further by the need for the group also to absorb or release new members from their midst. I do believe that music therapy, and indeed group verbal therapy, would be much more useful in a group with fixed membership, especially as many of the goals for this client group are around

helping clients to learn to trust others and understand the needs of others more fully. Unfortunately, with facilities pushed for funding, staffing and resources, this can not be the case – often the IOP programme was the only option for people desperately and urgently needing intense treatment for their disorders, and if they had been asked to wait six weeks or even two weeks until the next group induction, this would put a lot of clients and their families at risk.

### **New Focus for Improving Practice**

In cycle two, I identified a new focus for the study which I did not see coming – many of my findings about improving practice were centred on the structure and flexibility of my facilitation. I continued to focus on this aspect of practice, but through doing this I was able to explore some of my original ideas around creative, sustained and holistic practice. This will be covered later in the discussion.

### **Reduced Verbal Interaction**

Cycle Three saw a marked change in how I facilitated and a lot less verbal interaction, which was one of the things I wanted to achieve. I achieved this through a deeper understanding of the amount of structure I built into sessions. I began to find meaning in the music, and felt that the music was enough to facilitate change for the clients. This was the first session where I chose not to verbally process improvisation experiences, and the session appeared to be valuable for the clients.

### **Value of Clarifying Goals**

Clarifying my goals in Cycle Four helped me to maintain focus during the session and continue to be totally present in the session, even though I felt the session was not going too well. This is a subject which could be explored in future studies.

In writing the reports for each cycle I asked a recently graduated music therapist colleague to view the planning, action and reflections of each cycle, and to give feedback about the relevance and importance of the themes. This helped with the formulation of certain themes and with the drawing out of certain ideas which I had initially underrepresented.

### **Incidental Learning**

Action research appeared to be the best approach to answer my initial research questions, but it came with some difficulties. The amount of self-reflection required led me towards the end of the cycles to confuse my goals for my practice with those for the group. Fortunately, a timely supervision with my clinical music therapy supervisor prevented this from becoming an issue in my practice, but the confusion did appear in my clinical notes, which had by now become less objective and more self-focussed than on the group. Action Research also had challenges because being a student, I did not yet have the armoury of tools and methods that a more experienced practitioner



would have, and this meant that sometimes I struggled to find effective solutions to clinical problems. I do believe, however, that the benefits of doing the research project far outweighed the drawbacks. In many ways I can now say that I was perhaps looking for a deeper understanding of process in my work than for better ways of doing things, and I think that the process of planning, acting, and reflecting helped me to find this understanding. Freed states that *“the music therapist who has motivation to gain self knowledge is more likely to have healthy self esteem and provide a genuine role model for chemically dependent clients.”* (Freed, 1987, p.18) I would like to think that the self-knowledge I have gained in the course of this study will continue to contribute to my being a better music therapist.

The skills required in constantly evaluating and reflecting on ones’ own work are skills which I will use throughout my therapy career, and are now more honed than they otherwise might be. I have also learnt a lot about the value of collaborating with interdisciplinary colleagues, and the value of having peer reviewing as a mode of assessing one’s work. One of the most important things I have learnt simply through doing action research is that it is important to try to view one’s work in a neutral and impartial light; to step back from the environment before making judgements about ‘good’ and ‘bad’. This is learning which will ultimately benefit clients of music therapy.

During Cycle Three I was able to identify that I was developing a philosophical viewpoint which tended towards a music centred music therapy approach, and I started to believe that music ‘for it’s own sake’ could be more powerful than music which is verbally processed. Although it is still too early in my development as a practitioner for me to say that I absolutely assign to this notion, I think that doing action research helped me to begin to develop a personal construct around meaning and therapeutic potential in clinical interactions in this setting.

### Potential Learning

More recently, when re-reading assessment feedback from before I embarked upon this project, I noticed that I had received feedback from at least three different people about my needing to administrate my work more effectively, in terms of keeping more objective clinical notes and creating more detailed session plans. It is interesting that when I initially set out to identify areas in which I could improve practice I overlooked these remarks, instead choosing to focus on processes and within-session elements of practice. Fortunately, the process of action research helped me to realise the value of administrating my work by bringing my attention to the value of clear and objective clinical notes and detailed planning. In Cycle Four, although I identified a lack of objectivity in my clinical notes, I chose instead to focus on re-defining my goals. I can now see that it would have been more valuable to have focussed on taking better clinical notes after the session, and this

could have been the next step towards improving my practice. If the project had continued, I believe a Fifth Cycle would have focused on a need for taking more objective clinical notes and doing more detailed planning.

Some of the ideas emerging from this work would be appropriate as topics of study in their own right. In Cycle Three, I talked about being 'in the zone' during an improvisation, but I was not able to show this because it had happened in the music. This kind of idea could be explored in a music-centred research project. A music-centred action research project which examines musical session material to indicate areas for practice improvement could be a very valid way of developing practitioner learning.

Although action research is often specific to a particular context and person, I believe that each project contributes by making tacit knowledge of what makes 'good music therapy' more explicit and therefore allowing the profession as a whole to develop theory around the nature of clinical music therapy.

## Summary

By carrying out specific planning, action and reflection cycles during this project, I was able to identify certain themes around the nature of my practice and see what ideas and influences were recurring. The action research project uncovered some important practical learning for me about facilitating music therapy as a student in this context; I discovered that striking a balance between structure and freedom in a range of elements of my work - including planning sessions, verbal interactions and musical interactions - was key to improving my practice. I have learnt about becoming a more therapeutic presence in clinical music therapy, and I have learnt more about my personal philosophical constructs around music therapy and how I facilitate it.

## Glossary of Terms.

**12-Step treatment** – A treatment paradigm for alcohol and drug addiction, more commonly known as *Alcoholics Anonymous*; the 12 steps are a faith-based approach and has been one of the most used treatment approaches for addiction since the 1940s.

**Action Research** – A practitioner based research methodology which uses reflective processes as problem solving tools and ultimately leads to improving a way of doing something.

**Amphetamines** – A stimulant for the central nervous system; can have dangerous side effects and usage can lead to drug dependence.

**Bio-psycho-social** – A term which acknowledges the relationship between biological, psychological and social influences.

**Cannabis** - A psycho-active drug derived from the dried and ground leaves and stems of the female plant *cannabis sativa*.

**Cognitive Behaviour Therapy** – CBT - A behaviour therapy influenced by both behavioural and cognitive psychological paradigms that examines cognitive processes such as thoughts, feelings and assumptions about self and others.

**Cognitive Distortions** - Or cognitive biases are tendencies to perceive events in a negative or inaccurate way.

**Core Beliefs** – Can be either positive or negative basic learned assumptions about the nature of life – for example “I am a victim of my circumstances” or “I have a right to be angry at the world”.

**Dialectical Behaviour Therapy** – DBT - An extension of CBT, DBT combines client-centred empathy and acceptance with practical behavioural approaches such as problem solving and skills training.

**Etiology** - A medical term meaning the study of the causes and origins of a disorder or illness.

**Family Therapy** – A form of verbal therapy which involves a whole family or extended family in the treatment process.

**Gestalt Theory** – A psychological paradigm which is constantly evolving, the basic tenets of which are that the whole is greater than the sum of its parts.

**Group Therapy** – As an alternative to individual therapeutic treatment, group therapy emphasizes the social nature of group process as an important factor for change.

**Guided Imagery in Music** – GIM - A method of music therapy which uses receptive music listening.

**Harm Minimisation** – A global approach to alcohol and drug issues which involves policies and actions designed to limit the social, financial, legal and health impacts of alcohol and drug use. Education plays a large part in harm minimisation approaches.

**Intensive Outpatients Programme** – IOP - The name of the programme within which this study

took place.

**Locus of Control** – A theoretical construct describing the levels of perceived control an individual has over their thoughts, feelings and behaviour. Internal LOC indicates the person perceives themselves as in control, and external if the person perceives themselves as having no control.

**Lyric Analysis** – A method used in clinical music therapy which allows clients to identify cognitive biases or commonalities with their own experiences, or can simply be used to enhance reflective and mindfulness skills.

**Matching and Mirroring** - Music therapy improvisation techniques set out by Wigram (2004). Matching involves the therapist improvising music that is compatible with the client's style of playing, while mirroring is doing exactly what the client is doing musically, expressively and through body language.

**Mindfulness** – Mindfulness is being aware of the present moment in thought and deed, as well as taking a non-judgemental stance about internal or external factors.

**Motivational Enhancement Therapy** – MET - Also known as Motivational Interviewing, this method is a directive client centred counselling style which helps clients to explore and resolve ambivalence about change.

**Musiking** - A term used by this author to denote the act of playing or participating in a musical activity.

**Opioids** – A synthetic narcotic that resembles natural opiates, having a sedative effect.

**Post Acute Withdrawal Syndrome** – PAWS - Symptoms which occur after acute withdrawal from alcohol or another substance. Symptoms can include but are not limited to: inability to think clearly, memory problems, emotional regulation problems, or physical co-ordination problems.

**Positivism** – A philosophy of science which holds that only experimental investigation and observation can contribute to substantial and accurate knowledge. *Non-positivism*, conversely rejects the idea that only observed phenomena can be considered to be accurate knowledge.

**Physioacoustic Method** – Also known as vibroacoustic or vibrotactile therapy; physioacoustic music therapy uses a chair or mattress specifically designed to transmit low frequency sounds to the body, often combined with appropriate pre-recorded music.

**Psychodynamic Therapy** – A form of psychotherapy which focuses on unconscious processes and their influences on past and present behaviour.

**Rational Emotive Behavioural Therapy** – REBT - A form of CBT, REBT focuses on resolving emotional and behavioural problems and disturbances.

**Recovery** – The journey to wellness for a substance dependent or abusive person which accompanies abstinence and active positive change.

**Relapse Prevention** – Tools and skills which help a person in recovery to deal with events or environments which may lead to them relapsing.

**Socio-ecological** – A term which recognises the relationship between a person and his or her environment.

**Substance Abuse** – The use of a drug to an extent that the person is not capable of fulfilling daily tasks or requirements, and fails in attempts to abstain. There is no physiological dependence.

**Substance Dependence** – The use of a drug to an extent that tolerance is elevated and withdrawal symptoms manifest when the drug is not taken. Often accompanied by physiological dependence.

**Te Whare Tapa Wha** – An holistic Māori health model: the four inter-dependent dimensions of Māori health are *taha tinana* – physical health, *taha hinengaro* – mental health, *taha wairua* – spiritual health, and *taha whanau* – family health. (Durie, 1998)

**Therapeutic Community** – A participative, group-based approach to addictions treatment, usually residential.

**Using** – In the context of alcohol and drug rehabilitation, this word is used to describe actions which led to intoxication.

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an holistic way (based on the Maori health schema of *Te Whare Tapa Wha*); and secondly, by working with clients in creative and expressive non-verbal processes. By considering these concepts I have identified the main investigative question as: How do I bring active musical experiences to the forefront of my interactions with clients in an holistic, sustained and creative way?

### **Project Procedures**

The data gathering period for this research will occur over a four week period, by using my clinical notes from sessions, and my personal notes from supervision and interdisciplinary reflective sessions to consider new ways of working for the following week. Once the four week-long cycles have ended, I will be analysing the data from my clinical notes and reflective journal to draw out and categorize main themes relevant to my main question.

This research is designed to protect the privacy and rights of the vulnerable client group I work with; and also to avoid any departure from normal clinical practice. Therefore I am the primary and only participant. This notification is provided - and consequently your permission requested - to enable me to use my personal reflections of our supervision and reflective sessions in the project. Our sessions will not be recorded, and no departure from standard practice will occur during this time.

At no stage will the name of the organisation involved, or your own name be used. There is a possibility that you may be identifiable due to the limited occurrence of music therapy being practiced in the drug and alcohol sector in New Zealand at the current time, however every possible step will be taken to protect your identity.

### **Your Rights**

You are under no obligation to accept this invitation. If you decide to give your permission, you have the right to:

- withdraw from the project at any time without giving reason until the end of the data collection period.
- ask any questions about the study at any time during process of the research
- be given access to a summary of the project findings when it is concluded.

If you have any questions about the project, please do not hesitate to contact my research supervisor (named above) or myself.

#### **Ethical Approval**

This study has been reviewed and approved by the Central Regional Ethics Committee Administrator Sonia Scott. If you have any concerns about this research that you wish to raise with someone other than the researcher, please contact Sarah Hoskyns (Research Supervisor) or Sonia Scott.

<u>Central Regional Ethics Committee</u> <u>Administrator</u> Sonia Scott [REDACTED] [REDACTED]	<u>Research Supervisor</u> Sarah Hoskyns, Associate Professor, Master of Music Therapy Programme, NZSM. [REDACTED] [REDACTED]
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Thank you for your time and co-operation.

Sharon Yearsley

## Appendix #2

### Consent Form for Clinical Supervisor and Placement Advisors



#### Clinical Supervisor and Placement Advisors

#### Consent Form for review of supervision and clinical review notes.

*This consent form will be held for a period of ten (10) years*

☐ I have read the Information Sheet and have had the details of the study explained to me.

☐ My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

☐ I agree to the notes of my conversations with Sharon Yearsley to be reviewed by Sharon Yearsley.

Therefore, I agree to give permission for the supervision and clinical review notes to be reviewed and included in the data of this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

.....

**Printed Name:**

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