

**HOW DOES MY MUSIC THERAPY PRACTICE,
IN A TRANSITION SCHOOL FOCUSED ON SUPPORTING
ADOLESCENTS WITH MENTAL HEALTH NEEDS,
RELATE TO THE KEY COMPETENCIES OF THE
NEW ZEALAND CURRICULUM?**

BY

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ABSTRACT

This exegesis outlines research about the way the key competencies of the New Zealand curriculum related to music therapy practice at a transition school for adolescents with mental health needs. Secondary analysis of data, informed by grounded theory methods, was carried out in order to develop a theory about the relationship between music therapy and the key competencies. The competencies, which are focused on supporting students to develop broad skills that will help them in their education and throughout their lives, guided all work with students at the school, including music therapy practice. While educative in nature, the competencies also seemed to have some naturally therapeutic purposes, and this study focused on understanding how they related to music therapy in practice. Data that had been collected in the natural environment of the school to meet the requirements of the placement as a student music therapist were analysed. The findings showed that there was a significant relationship between music therapy practice and the competencies. This contributed an additional perspective and dimension to the way the competencies could be addressed with students. In particular, music therapy provided students with opportunities to try out different ways of being with each other and supported them to experience feelings of hope and empowerment.

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1. INTRODUCTION

1.1. The research

This qualitative study provides a critical account of how my music therapy practice, during a nine-month clinical placement at a school for adolescents with mental health needs, related to the key competencies of the New Zealand curriculum. Data recorded to meet the responsibilities of my placement were reviewed in order to develop a theory about the relationship between the competencies and my practice. While I initially encountered some tension between my own health focus as a student music therapist and the education focus of the school, I came to realise that the competencies could be utilised to bridge health and education perspectives. This study was an opportunity to understand more about how this worked in practice.

1.2. Personal position

Although I am still developing my personal approach to music therapy, my overall philosophy is humanistic and person-centred. I am influenced by psychodynamic processes, and see client behaviours and feelings as “rooted in previous experiences, particularly family experiences” (McFerran, 2010a, p. 33). I am, however, most comfortable with the eclectic approach that I developed during my placement, finding that blending “orientations, multiple methods, (and) numerous purposes” (McFerran, 2010a, p. 45), was the most effective approach to take with this client group, as supported by the research (Gold, Voracek, & Wigram, 2004).

My undergraduate degree is in law, where I specialised in human rights. This led to a passion for helping others to access their rights and advocating for transparent and user-friendly systems. I was similarly motivated in this study to analyse the place of an education framework in music therapy in order to best support the wellbeing of adolescents experiencing mental health issues. I wanted to bring

education and health together, just as I had wanted to understand the relationship between reason and feeling in law.

I also have my own personal experiences of mental health, having gone through depression at the age of 16. I recall the haze that surrounded life for me, when everything felt too hard and too much. And while going through depression was obviously a horrible experience, it was also one I would not change if I had the chance. My personal experience of mental health “unwellness” had a big impact on the decisions I made about my future and ultimately was a part of my motivation to pursue a career in music therapy. It also gave me some insight into how mental health can impact people’s lives.

My previous clinical placement rekindled my interest in mental health, working in a secure unit for adults with complex psychiatric needs, and I was interested to explore how music therapy could support adolescents experiencing “unwellness”.¹ I knew the work would remind me of my own adolescent experiences, both good and bad, and that it was important to remain aware of these and to keep my own processes separate during my placement.² I also felt that having some understanding of what it was like to be a depressed teenager was a good starting point from which to learn how I could best support the teenagers I worked with, whilst remaining aware that every person’s experiences are unique and their own.

1.3. The setting

The transition school (“the School”³) provided a small and supportive environment for up to 15 adolescents who, due to unwellness, had been unable to attend their usual school regularly. Students usually attended for between two and three school terms, with new students arriving throughout the year as space became available.

¹ I decided that “unwellness” best described the experiences of the teenagers I worked with and also encompassed their journey towards wellness.

² Ongoing supervision (standard practice in New Zealand) and personal therapy (as is commonplace in arts therapies training in Europe) have provided useful support in creating this separation.

³ The name of the school is protected for confidentiality reasons.

Staff provided educational and therapeutic support to help students make a successful transition back to their regular school, or on to further education or employment.⁴ Mental health diagnoses of students varied, but included depression, anxiety, social phobia, attention deficit hyperactivity disorder, borderline personality disorder, autism spectrum disorder, oppositional defiant disorder and/or post-traumatic stress disorder. I based my understanding of each of these diagnoses on the DSM-IV-TR definitions.⁵ School staff worked with each student, their family, regular school, mental health team and others to support their transition, and three-weekly review meetings were held with everyone to discuss progress.

The School maintained similarities to mainstream education, with a class timetable and lessons planned each day. Students were able to work towards NCEA⁶ credits during 'curriculum time' every morning. The occupational therapist ran the therapy-based part of the school programme during this time, running group sessions as well as meeting students individually. Curriculum time was also when most individual and smaller group music therapy sessions took place. An additional afternoon slot was set aside every Friday for all students to have group music therapy for up to an hour.

1.4. The environment

I arrived at the School armed with ideals and expectations about the approach I would take as a student music therapist and what I could offer. The recovery model, which guided work in my previous placement, promotes "the active role of people with mental illness in improving their lives" (Ministry of Health, 2002, p. 25). A central focus of this model is on empowering clients to guide their own recovery

⁴ School staff included a team leader, two teachers, two teacher aides and an occupational therapist.

⁵ (American Psychiatric Association, 2000). I chose not to include a glossary of diagnoses because I approached this study from an education perspective. Students' diagnoses were not generally discussed in detail at my place of work, although understanding their impact is obviously important for therapists.

⁶ National Certificate of Educational Achievement – the main national qualification for secondary school students in New Zealand.

process, by recognising that “each person with mental illness needs to define for themselves what ‘living well’ means to them” (O'Hagen, 2001, p. 1). This philosophy resonated with my own music therapy approach.

I learned quickly that staff at the School needed to hold both educational and therapeutic perspectives whilst working with students. I initially had doubts about how I could meet the expectations of the environment, while staying true to what I had learnt about music therapy in a mental health framework. My fear was that utilising educational perspectives would create more of a ‘structuring’ role in the work or present a barrier to building a supportive therapeutic relationship with students. It was helpful to realise that other arts therapists had similarly needed to “re-think their practice in order to fit within the overall philosophy of the school and the needs of their clients” (Karkou, 2010, p. 14).

1.5. Key competencies

The New Zealand curriculum’s key competencies played a central role at the School, guiding the school programme and framing students’ individual education plans (developed by teaching staff) and therapeutic plans (developed by the occupational therapist). The competencies are considered by the Ministry of Education to be “the key to learning in every learning area” (Ministry of Education, 2007, p. 12), and I was encouraged to utilise them in working with students.

Despite my initial resistance, I began to develop an understanding that the competencies had considerable therapeutic potential, particularly as I began reviewing the data, and could help guide my work with students. They also provided a language with which to discuss student developments with staff members and helped ensure students were being supported in their transition in cohesive and collaborative ways.

The New Zealand curriculum’s definitions of the key competencies are as follows:

- ❖ *Managing self*: “associated with self-motivation, a “can-do” attitude, and

with students seeing themselves as capable learners. It is integral to self-assessment.”

- ❖ *Participating and contributing*: “about being actively involved in communities”, meaning a variety of communities from family to school, drawn together for a variety of purposes, and may be local, national, or global. “... includes a capacity to contribute appropriately as a group member, to make connections with others, and to create opportunities for others in the group.”
- ❖ *Relating to others*: “about interacting effectively with a diverse range of people in a variety of contexts... includes the ability to listen actively, recognise different points of view, negotiate, and share ideas.”
- ❖ *Thinking*: “using creative, critical, and metacognitive processes to make sense of information, experiences, and ideas... for purposes such as developing understanding, making decisions, shaping actions, or constructing knowledge. Intellectual curiosity is at the heart of this competency.”
- ❖ *Using language, symbols, and texts*: “about working with and making meaning of the codes in which knowledge is expressed. Languages and symbols are systems for representing and communicating information, experiences, and ideas. People use languages and symbols to produce texts of all kinds.”

(Ministry of Education, 2007, p. 12).

1.6. Music therapy

Individual and group music therapy sessions took place every week, self-referred initially, and over time I liaised with staff to arrange priorities. Sessions included listening to and playing music, singing, songwriting, improvising, learning/teaching new songs and instruments, or drawing to music. I based each student’s music therapy plan on the key competencies, and utilised the language when giving music therapy feedback in review meetings. Aside from students all experiencing degrees of unwellness, their diagnoses, needs, and presentations often varied considerably.

I came to view one of music therapy's purposes in the School as to help enhance students' resilience, and was influenced by the view that "music has consistently been identified as one of the main strategies that teenagers use to cope" (Frydenberg, as cited in McFerran, 2010a, p. 44).

Given the relatively short-term nature of attendance at the School and the ever-changing timetables as students began to transition, flexibility was imperative in terms of when and how often I saw students. It seemed pertinent to recognise that, "brief therapy conveys 'therapeutic hope, doesn't pathologize (sic) and doesn't procrastinate in the sense of recognising that life needs to be experienced and not lived in the consulting room ...'" (Coren, as cited in Molyneux, 2005, p. 61).⁷

1.7. Community music therapy

My role at the School developed quite flexibly. I spent lunchtimes in the space shared by students and staff, played music with students during breaks, helped them out with their curriculum subjects, and joined in other activities. I also often lead morning music, when the School sang songs and played instruments together as part of the morning meeting. I was of the view that "participation in music therapy (is) one step towards active participation in a range of other systems that impact upon the young person" (McFerran, 2010a, p. 190), and not limiting my role to formal, pre-arranged sessions seemed important in supporting students to transition back to, and feel a part of, 'normal' life.

1.8. Exegesis layout

The literature review that follows paints a picture of how this study fits with, and was informed by, the available literature. The methodology section then outlines the research processes and philosophies that guided the data analysis process. Findings set out what was revealed during data analysis, and the Discussion section

⁷ Students attended between two and 13 music therapy sessions, either weekly or fortnightly.

reflects on the implications of the findings and suggests ways of exploring further issues.

The young people I worked with are referred to throughout this study as students, which rightly acknowledges the context of the work and the over-arching transition focus of the setting.

2. LITERATURE REVIEW

2.1. Search information

Search terms used for this literature review included “adolescent mental health”, “education”, “schools”, “music” and “music therapy”, as well as “key competencies” and their equivalent in other Commonwealth countries. Preference was given to literature produced in the past ten years, and included clinical reports, research articles, lectures, and theses. Databases included Massey University Library’s EBSCOhost Discovery Service, SAGE Research Methods Online, The Arts in Psychotherapy, Google Scholar, Web of Science, SCOPUS and PsycINFO. Additional articles were sourced from the Ministry of Education website, as well as music therapy journals and books related to therapeutic work in education settings.

2.2. Adolescents and mental health

The World Health Organisation (“WHO”) defines adolescents as individuals who are between the ages of 10 and 19 (WHO, 2005, p. 7). It is during adolescence that people start to work out “who they are and what makes them unique” (American Psychological Association, 2002, p. 15). Part of this process often includes working out one’s place within different layers of meaning, “from friends and family to the institutions that they are connected to, the culture and community that they exist in, as well as the expectations of adolescence that they are subjected to” (McFerran, 2010a, p. 54).

Unfortunately, a significant number of young people today are also struggling with social and emotional issues that are negatively impacting on their mental wellbeing. (Carr & Wigram, 2009). The WHO has estimated that around 20% of children and adolescents are experiencing mental health issues (WHO, 2005). An increasing number of teenagers are also at risk of under-achieving, dropping out, or being excluded from school due to mental health-related issues (Cobbett, 2009; McIntyre,

2007). In New Zealand, the statistics show that half of all people who develop any mental health disorder have done so by the age of 18 and are at a high risk of doing so again in the years to come (Ministry of Health, 2006, p. 64).

2.3. Adolescents and music therapy

Music plays a central role in the lives of adolescents (Hendricks, Robinson, Bradley, & Davis, 1999; Tarrant, North, & Hargreaves, 2002). It has been found to be particularly relevant during this stage of life because it helps adolescents negotiate and form their own identities (see Cobbett, 2009; McFerran, 2010a; North, 1999; Tarrant et al., 2002). Music is also an important tool for teenage self-expression (McFerran, 2010a). For teenagers who struggle with mental health issues on top of negotiating the “storm and stress” often associated with adolescence (McFerran, 2010a, p. 19), music therapy offers an alternative to the verbally-centred therapy that is often on offer and which may feel too confronting for some young people (Cobbett, 2009, p. 16). Along with other arts-based therapies, music therapy can enable “engagement and non-threatening exploration of emotional and social issues” (Karkou, Fullarton, & Scarth, 2010, p. 63).

A meta-analysis conducted in 2004 of relevant music therapy research concluded that music therapy was “an effective intervention for children and adolescents with psychopathology” (Gold et al., 2004, p. 1060). The literature has continued to provide strong evidence that music therapy can be an effective therapeutic intervention for adolescents experiencing unwellness (see Cobbett, 2009; Derrington, 2005, 2011; Flower, 1993; McFerran, 2010a; McIntyre, 2007; Strauss & Corbin, 1994). In the words of one music therapist, “the stereotype of a moody, monosyllabic and dreamy teenager is usually replaced by creative, communicative and dynamic play when music is the means of expression” (Derrington, 2011, p. 195).

2.4. Potential for music therapy in schools

It is somewhat surprising that, despite the high number of adolescents struggling with unwellness and the amount of time usually spent at school each week, music therapy with this client group seldom takes place in schools. McFerran found that only 21% of articles identified in a literature search referred to music therapy in education settings. (McFerran, 2010a). Of the 28 articles she identified, only one referred to music therapy with adolescents experiencing mental illness. A further four related to at-risk youth and seven to adolescents with behavioural problems.

A recently published book on music therapy in schools includes one chapter on music therapy work in a secondary school with adolescents experiencing complex emotional and behavioural difficulties (Derrington, 2011). Derrington re-emphasises the need to engage in the “culture of adolescence”, a concept underlined in a previous paper on the subject (Cobbett, 2009, p. 17), and that understanding the ways adolescents communicate is critical to the success of therapy (Derrington, 2011, p. 195). This gives further impetus for providing music therapy at school, where the “culture of adolescence” is everywhere. Other reasons include “the reduced sense of stigma felt by both young people and parents, the sense of safety created by a familiar environment and improved communication between professionals” (Pettit, cited in Cobbett, 2009, p. 16). It may also enable a quicker and more effective referral system for students who need support, and relieve some pressure on educators who may not know how best to support students’ wellbeing (Karkou et al., 2010).

2.5. Experiences of music therapists in schools

Searches for literature regarding music therapy in schools with adolescents experiencing mental health issues uncovered nothing that specifically explored interactions between health and education models. However, Derrington’s recently published chapter includes some discussion of the importance (regarding her

understanding) that “music therapy should not stand apart from one of the school’s systems of assessment but link in and also acknowledge students’ achievement” (Derrington, 2011, p. 209). She also links in with students’ individual education plans.

In an earlier article based on work in the same school, Derrington described her music therapist role as being “primarily to offer additional emotional support (to students) and assistance in identifying difficulties which they are experiencing” (Derrington, 2005, p. 69). She felt that “students respond positively to time out from the busy environment and peer pressure, to a space where they choose what to do, how to work and can set their own pace” (Derrington, 2005, p. 69). This humanistic and person-centred philosophy aligns with what qualitative music therapy research tells us, that teenagers “use music therapy in the ways that they use music: to have fun, to express something of who they are, and to explore who they might become” (McFerran, 2010a, p. 277).

A recently published study of two music therapists’ experiences working with secondary school students who were affected by the 2009 Australian bushfires describes how the shared experience of that tragedy seemed to unify students and brought a sense of purpose to music therapy (McFerran & Teggelove, 2011). Where a group of adolescents experiencing unwellness is not united by similar experiences, it may be that the focus of music therapy is more suited to building a sense of resilience, and in supporting teenagers to utilise music to enhance their understanding of themselves, as well as tolerate differences (McFerran, 2010a).

Although music therapy has an established place in special education in New Zealand, and research in school settings with students who have mental health difficulties does exist (for example Rickson, 2006; Rickson & Watkins, 2003), such research sits within a medical framework, and it is left to anecdotal evidence to show that music therapy can benefit students’ educational achievements, help improve their experienced levels of social, emotional and behavioural difficulties, and engage students more than verbal psychotherapy (Cobbett, 2009). However,

this remains a suggestion, and calls have been made for quantitative research into the effects of music therapy with this client group (Cobbett, 2009).

A recent study that considered the place of music therapy in a school for adolescents with mental health issues recommended that a way of “bolstering” the case for music therapy’s inclusion within an education setting would be for “future music therapy research (to) examine links between music therapy and educational goals” (Young, 2010, p. 91). The study points out the potential for music therapy research to consider the ways in which the key competencies provide cross-over between educational and therapeutic goals (Young, 2010).

2.6. Key competencies – origins and implications

The key competencies have a relatively new place in New Zealand’s education system. In 2007, the Ministry of Education introduced five key competencies to the curriculum, largely in response to the OECD’s ‘Defining and Selecting Key Competencies’ (DeSeCo) project outlining what people needed “for a successful life and well functioning society” (OECD, 2005; Rutherford, 2004). The competencies are designed to support students to “live, learn, work, and contribute as active members of their communities” (Ministry of Education, 2007, p. 12).⁸ They are not seen as “separate or stand-alone” (Ministry of Education, 2007, p. 12) and various competencies may be developed simultaneously.

It has been suggested by one international education expert that the New Zealand curriculum is currently “the best in the world”, due in large part to the recognition that essential learning is about “the development of self and self for society” (Atkin, 2011). The adoption of the key competencies recognises that teaching should no longer be focused solely on curriculum subjects, but on how educators can use their expertise, and the tools in the curriculum, “to enrich the lives” of the young people they are working with (Atkin, 2011). The competencies represent a shift away from

⁸ Refer page 5 for outline of the key competencies and their definitions.

New Zealand's previous 'essential skills' framework which had a narrower focus on "knowledge-based credentials" to a new focus on "developing certain broad areas of expertise or competencies" over time (Bolstad & Gilbert, 2008, p. 97). Widespread consultation was undertaken with stakeholders throughout New Zealand before the competencies were finalised, indicating that there is broad agreement as to their content (see for example, Rutherford, 2004). It seems that New Zealand's holistic and broad perspective of the key competencies has not been shared to the same extent by other countries, where the response to the DeSeCo project has often been to adopt competencies that resemble New Zealand's pre-competencies framework of essential skills (Hipkins, Cowie, Boyd, Keown, & McGee, 2011).

2.7. Key competencies in practice

While the competencies appear quite forward-thinking and enabling, and educators are overall supportive of what they stand for (Hipkins et al., 2011), researchers in the field suggest that "Western education policies reflect a narrowing of curriculum, assessment-driven teaching, reporting to standards and a re-emphasis on individual learning" (Fraser & Deane, 2010, p. 12). Thus, the intended curriculum may not correspond with the operational curriculum (Fraser, 2011). The conflict between the intent of education policies and what is "played out in the context of classroom life" has been recognised internationally (Eisner, 2005, p. 147). There may be some very real barriers to educators making the most of the key competencies in schools, including resource and time constraints. Regardless, it seems that currently the potential of the competencies is not being realised (Bolstad, 2011b).

The New Zealand curriculum indicates much potential for the competencies to be developed and shaped over time, through "interactions with people, places, ideas, and things" (Ministry of Education, 2007, p. 12). There is therefore ample scope for music therapy and other arts therapies to contribute to the way they could be utilised to support adolescents experiencing unwellness. It has also been acknowledged by education commentators that there is potential for the

competencies to be shaped “throughout all aspects of school life, both inside and outside classroom programmes” (Hipkins et al., 2011, p. 2).

2.8. Creativity in education

Concerns have been expressed that creativity, and the arts in general, is being sidelined in favour of more traditional curriculum areas such as numeracy and literacy (see also Bolstad, 2011a). It seems there is much latent potential for using creative, collaborative learning in order to enable young people to access the school curriculum (Fraser & Deane, 2010, p. 11). One study examined the way younger children engaged in class when focused on an issue that had personal and social significance to them. It found that utilising creative ways of learning addressed many ‘traditional’ subjects, including numeracy and literacy, as well as helping children to feel personally invested in their learning. The researchers suggest that “if we focus too narrowly on certain targets and assessments, we miss the deeper goals that emerge during an integrated project of this nature” (Fraser & Deane, 2010, p. 14). The collaborative opportunities offered by the arts might similarly assist with integrating adolescents into the secondary school curriculum, allowing for the key competencies to be used not as “add-ons taught through isolated lessons” but creatively “interwoven throughout” (Fraser & Deane, 2010, p. 13).

McFerran’s recent position paper on ‘Music for Wellbeing in Australian Schools’ expresses related concerns about the lack of access to musical opportunities in schools, arguing that music is an important contributor to the development of a creative school culture that “not only promotes the development of artistic and intellectual capacity, but also of healthy individuals and communities” (McFerran, 2010b, p. 18).

2.9. Summary

There is strong evidence that the therapeutic use of music enhances adolescent health, and it is clear that the adolescent population is experiencing increasingly high levels of unwellness. The broadness and living nature of New Zealand's key competencies suggests that they are focused on similar things to music therapy – supporting students to be happy, healthy and successful individuals. However, music therapy in schools is still relatively unexplored in this area. Given the current need for the place of the arts in the competencies to be further extended and explored, this research seeks to explore the place of music therapy in this context.

Research question

My professional curiosity, personal stance, and study of the literature led to this study's research question: *How does my music therapy practice, in a transition school focused on supporting adolescents with mental health needs, relate to the key competencies of the New Zealand curriculum?*

3. METHODOLOGY

3.1. Overview: Methodology and approach to research

This qualitative study involved reviewing clinical data kept during the student placement in order to ascertain the way in which my music therapy practice related to the competencies framework. A qualitative research method was therefore appropriate, in order to “enlarge (my) constructions of the world and to find and create individual meanings therein” (Bruscia, 2005b). There were no participants in the study, as all data sources were produced by me to meet the responsibilities of my placement, in the natural environment of the School. Reviewing data that has already been collected is known as secondary analysis, and data that is ‘re-used’ by the person who produced it in the first place is known as “auto data” (Heaton, 2004, p. 13). The secondary analysis was focused on “analytic expansion,” meaning the researcher makes “further use of their own data ‘to answer new or extended questions’.” (Thorne, cited in Heaton, 2004, p. 14).

3.2. Theoretical research and grounded theory

A theoretical research methodology was utilised in this study, also described by Bruscia as ‘explication’, which “requires a clearly delimited focus on a particular aspect of music therapy and what is already known or done in relation to it” (Bruscia, 2005a, p. 541). The researcher asks simple reflective questions of their practice, comparing and contrasting their own experiences with “existing ideas or perspectives of other theorists, looking at research, and intuitively synthesizing all these sources of insight into an original theory or vision” (Bruscia, 2005a, p. 545). This study aimed to “make explicit what is implicit; or ... describe what is, or what is done, based on ... (my) perceptions and perspectives” (Bruscia, 2005a, p. 541).

Data analysis was informed by grounded theory methods, which are focused on “discover(ing) theory from data” (Glaser & Strauss, 1967, p. 1). Grounded theory is

known as “a general methodology for developing theory that is grounded in data systematically gathered and analysed” (Strauss & Corbin, 1994, p. 273). A major difference between this study and other grounded theory studies is that data were produced and analysed concurrently, for different purposes. Data production occurred in order to meet my clinical placement responsibilities, and data were secondarily analysed in order to develop a theory about my practice.

This study was aligned with Strauss and Corbin’s more flexible approach to grounded theory, rather than the original developers of the method, Glaser and Strauss, who were focused on studying social processes. This is because “music therapy researchers are interested in studying musical and psychological processes as well” (Amir, 2005, p. 370). I was informed by Birks and Mills’ recently published practical guide to grounded theory (Birks & Mills, 2011), and was influenced by Amir’s seminal contribution in which she utilised grounded theory methods – her study on meaningful moments in the music therapy process (Amir, 1992).

Deductive and inductive processes were utilised during data analysis, the former referring to the initial conceptual framework provided by the key competencies. This was in line with Miles and Huberman’s grounded theory approach (Amir, 2005, p. 366). The process then became inductive as data was categorised or coded, within each of the competencies. Categories were developed that were “initially low level and subsequently developed to a higher level as the analysis progressed” (Birks & Mills, 2011, p. 91).

3.3. Social constructivism

All data that was reviewed was written by me, in language to which I relate. I developed definitions and interpretations of the key competencies, which were in line with the School’s views and influenced by the literature and discussions with my clinical liaison. In considering and reflecting on the clinical data, I was at times reminded of the social constructionist perspective that we must “challenge the presumption that language can adequately map individual experience” (Gergen &

Gergen, 2007, p. 11). At times, it seemed that language was not enough to describe my experience as a student music therapist, let alone begin to understand and write about my perspective of others' experiences in therapy. It is important to emphasise that this study represents my account of the "nature of things" (Gergen & Gergen, 2007, p. 9), and does not attempt to provide an objective truth.

3.4. Data sources

Data sources for this study included documentation that was prepared to assist my learning as a student music therapist and consisted of: a reflective journal detailing my critical reflection of music therapy sessions with students, music therapy clinical notes, notes and discussions from meetings with team members (including family members and other relevant people); a vignette of music therapy interaction; and music therapy assessments and treatment plans I wrote to help guide my work with students.

The three school terms provided a natural structure within which to analyse data. I sampled data by identifying a school day at the beginning, middle, and end of each school term when individual and group music therapy sessions took place. No further sampling was possible due to time constraints. I considered that three rounds of data analysis, each encompassing three timeframes, would provide sufficient data to capture the essence of the relationship between my music therapy practice and the key competencies.

3.5. Data analysis

After sampling the data, round one of the analysis commenced with the process of open coding, or categorising, under the relevant key competencies. This required me to constantly remind myself of the essence of each competency, as well as the research question, to ensure critical analysis took place, rather than re-describing the data. I wondered during this phase about Glaser's concern that the use of

deductive coding paradigms could “force data into a theoretical framing ... as opposed to allowing theory to emerge inductively from the data” (Birks & Mills, 2011, p. 96). However, much of the analysis seemed to happen quite naturally. I coded data under the competency that seemed to best capture the essence of what was happening, whilst noting links with other categories and keeping track of data that did not fit easily into the competencies.

Two further rounds of data analysis were conducted in much the same fashion. I gained some sense about how music therapy practice interacted with the competencies after round one, and carried forward several questions into round two, such as wanting to know why there was a surprising absence of data relating to one competency. Round three involved the same processes. With each round I worked at understanding and testing out ideas and issues raised in the previous round. I wrote analytic memos to myself whenever I had “thoughts, feeling, insights, and ideas” in relation to the study (Birks & Mills, 2011, p. 40). In round two, and to a greater extent in round three, I noticed that themes and categories were being repeated from round one, and no further codes were formulated in round three, leading me to believe that the “categories (may be) fully developed or ‘saturated’” (Birks & Mills, 2011, p. 70).

After round one, open coding in round two occurred simultaneously with more intermediate level, or axial coding, which is a process whereby “data are put back together in new ways after open coding, by making connections between [and within] categories while elevating the level of conceptual analysis” (Strauss and Corbin, as cited in Birks & Mills, 2011, p. 97). This led to “refin(ing) the (initial) categories by finding core and sub categories” within the data (Amir, 1992, p. 48). I began advanced coding after round three was completed, which included actively sorting through my analytic memos in order to “aid the final formation of (my) grounded theory” (Birks & Mills, 2011, p. 115). I was informed by the “storytelling” process often used by grounded theorists in order to produce a “final theory and provide a means by which the theory can be conveyed to the reader” (Birks & Mills, 2011, p. 118). This led me to develop the bridge diagram (see figure 1 on p.23).

Data analysis required “constant comparative analysis” (Birks & Mills, 2011, p. 11), whereby every code and subcategory was continuously compared with another, to ensure that the theory that developed was grounded in the data. This revealed how closely linked the key competencies were.

Unlike more traditional grounded theory studies, this study did not have one core category “that encapsulates the process apparent in the categories and sub-categories constructed” (Birks & Mills, 2011, p. 100). Instead, it was informed by the view that “the importance of selecting a core category appears to have lessened, with a broader approach being taken that describes how categories and their sub-categories integrate together to form an abstract grounded theory of a substantive area of inquiry” (Charmaz; Clarke, as cited in Birks & Mills, 2011, p. 100).

3.6. Ethical considerations

This study was reviewed by the New Zealand School of Music Postgraduate Committee. I followed Music Therapy New Zealand’s Code of Ethics for the Practice of Music Therapy in New Zealand (Music Therapy New Zealand, 2006), and the Massey University Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (Massey University, 2010) during my clinical placement and whilst undertaking this research. As the research involved nothing outside of usual music therapy clinical practice it was deemed to be ‘low risk’.

The School gave its informed consent for the clinical data to be subjected to secondary analysis for research purposes. Assent and informed consent were obtained respectively from the student and parents of the student described in this study’s vignette. My clinical liaison at the School acted as an intermediary by approaching them on my behalf, after the student had transitioned back to school, in order to minimise any perceived pressure to approve the study, and to give an opportunity to ask questions of a neutral party. See Appendices 1 – 6 for documentation regarding ethical procedures.

While there were no research participants in this study, New Zealand's small population size and the limited number of specialist schools in this area, means there is some likelihood that the setting itself will be identifiable to future readers.

4. FINDINGS

4.1. Overview

The findings below show the numerous ways in which my music therapy practice related to the key competencies (henceforth referred to as “KCs”). Many categories that developed under each KC link closely to others. This highlights their interconnected nature, and their development suggests music therapy links the KCs naturally. Music therapy definitions of the KCs that evolved and developed during the study are provided at the beginning of each KC heading in italics. They do not replace the Ministry of Education definitions and are not intended to be exhaustive, but provide a sense of how I viewed the KCs. They are the result of discussions with staff regarding how the KCs could best be considered and utilised in music therapy sessions.

Table 1 below sets out the categories and sub-categories that emerged during data analysis, and is followed by details of how these were developed and analysed. A vignette of clinical work with one student provides a more extensive and holistic account of the way the KCs appeared in music therapy.

Managing self	Participating & contributing
<ul style="list-style-type: none">Communicating limits<ul style="list-style-type: none">Self-protectionSelf-criticismCommunicating needsStudent(s) ‘managing self’Challenging as part of group processes	<ul style="list-style-type: none">Student(s) finding meaning for themselvesStudent(s) finding self-motivationCreating meaning for staffModelling by staffEvolving quality of engagement
Relating to others	
<ul style="list-style-type: none">Collaborating<ul style="list-style-type: none">BondingBrainstorming	

<ul style="list-style-type: none"> ○ Moving Forward • Playfully negotiating • Student offerings • Developing a music therapy culture 	
Thinking	Using language, symbols & texts
<ul style="list-style-type: none"> • Talking/reflecting • Chatting • Student- initiated thinking ○ (Student) leading the session 	<ul style="list-style-type: none"> • Using elements/theory of music • Symbolising with music • Utilising creative processes

Table 1: Categories and sub-categories

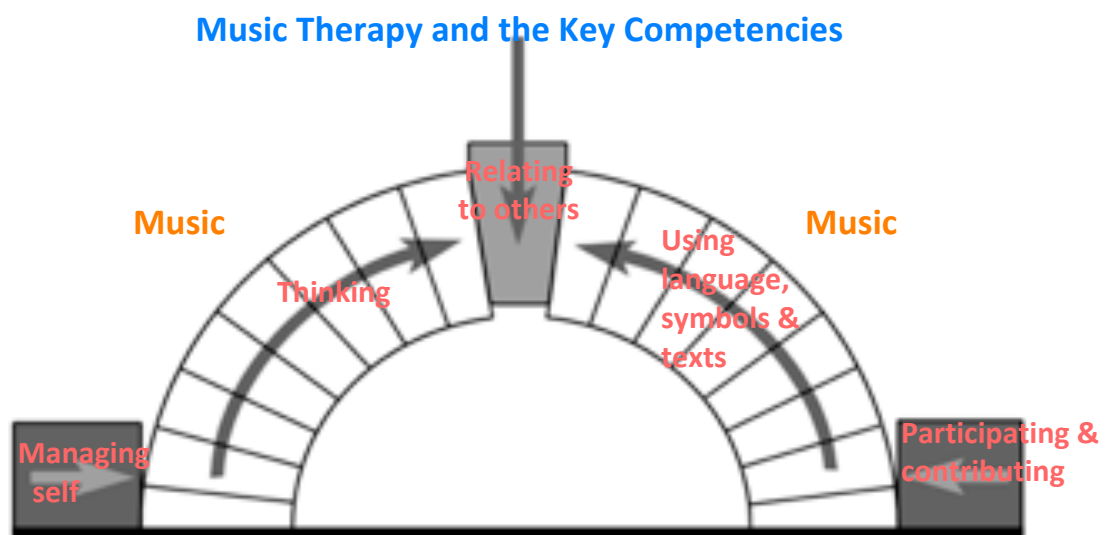


Figure 1: Bridging the KCs

Figure 1 illustrates my understanding of the way the KCs are reflected in the findings, like keystones of a bridge, with music providing one way of negotiating it. Music therapy seemed to help students to access the KCs, and provided a way of bridging health and education perspectives. Overall, data analysis suggested that 'relating to others' was integral to these processes, which is why it features as the middle keystone.

4.2. Theory

The findings outlined below show there was a significant relationship between my music therapy practice and the KCs. Music therapy contributed an additional perspective and dimension to the way the KCs could be addressed with students. In particular, the collaborative nature of songwriting and improvisation gave students opportunities to try out different ways of being with each other and experience feelings of hope and empowerment. Such opportunities appeared to enable students to manage themselves more effectively, thus opening up their capacity to participate and contribute, relate to others and explore their abilities to think in creative ways. Utilising language, symbols and texts similarly offered opportunities for developing students' creative and critical thinking, which helped them to reflect on their personal lives and their own ideas and also to relate to others in alternative and effective ways.

4.3. Managing self

- ❖ *The way students respond to, and express, their feelings; self-awareness of their needs and limits. How students see themselves.*

The KCs are framed in positive, goal-centred language, and 'managing self' is focused on supporting students to see themselves as capable learners. I therefore initially looked for positive signs of students 'managing'. However, it became evident early on that a lot of 'managing self' data showed instances of students struggling to 'manage' – hence the definition (above).

After the first round of analysis, I noted that “the initial and overall central focus” of the work appeared strongly linked to 'managing self'. My reflective journal suggested that, being new to the setting and the client group, I was focused on noticing how students presented and reacted in music therapy, particularly as I completed assessments for each student and developed therapeutic plans. In round

two, several new categories were formed, but none developed in round three, indicating that 'managing self' data had reached saturation.

4.3.1. Communicating limits

The data revealed a number of instances where students appeared to experience discomfort, particularly during initial individual sessions. I wondered whether group music therapy provided a buffer from the self-consciousness of individual sessions. I interpreted this discomfort as students communicating their limits or boundaries to me. Sometimes a student said "it's too hard", and other times their body language suggested they were struggling to manage what they were feeling while in the room with me. Initially, students often sat in the beanbag with their arms around their knees, looking at the ground. In later sessions this discomfort seemed to dissipate. This pattern continued as new students arrived following successful transitions, but not to the same extent in the second and third terms, leading me to wonder whether first term sessions also involved me working on 'managing' myself and how best to support students' needs.

a. Self-protection

I initially coded 'communicating limits' as 'self-protection', to reflect the motivation behind much of the work – students wanting to avoid feeling vulnerable or being judged – but 'communicating limits' began to reflect a broader set of data. 'Self-protection' was observed when students rebuffed positive feedback or diverted discussions from themselves, on to more generic topics. In group sessions students sometimes took time away in the 'chill-out room' before returning to the session, explaining to me afterwards that things had felt "too much".

b. Self-criticism

Students' self-criticism was particularly evident in round one, from comments like "I'm useless" or "I can't do it". This also included students using apologetic language during sessions, or expressing a desire to be perfect. There was a decrease in the frequency of this data in the second and third rounds, and I wondered whether this

was because of strategies I developed to focus sessions away from an atmosphere of pressure or expectation, as outlined in my reflective journal. However, data relating to a preoccupation with perfection did continue to appear in subsequent rounds. This 'uselessness' seems closely linked to students' struggles with unwellness.

4.3.2. Communicating needs

In term two students began to approach me asking for music therapy, which seemed to increase as 'communicating limits' data lessened in individual sessions, suggesting there had been a shift in the way students viewed music therapy. As I increasingly incorporated improvisation into group work this was also evident, with students giving feedback that "it didn't make any sense", or asking "what's the point of this?" This seemed a way of communicating a need for more guidance, justification and/or structure in music therapy. When I suggested reasons or my thoughts about the value of the activity and reflected on this with students, this seemed to assist in addressing these needs. This data also links to 'playful negotiations' and 'talking/reflecting' below.

4.3.3. Student(s) 'managing self'

During the first term, a shift from students seeming anxious and self-conscious, towards a sense of being more present or invested in sessions was evident. For example, one student lost track of the time during one session and instead of turning to the clock to check when she could leave, which she had been doing quite anxiously, she asked me how much time we had left. She had previously been clear that her role in most things was to be timekeeper, and handing this job over to me felt significant, that there was a sense of this student 'managing herself' more effectively and trusting others to help her. Often this shift occurred in the latter half of sessions, with students increasingly displaying signs of self-confidence or comfort being in the room and interacting with me, or expressing a determination to persevere with something they found difficult. In group work, finding a role in the

group, such as xylophone player or rhythm-keeper, seemed to help bring a sense of calm or purpose for students. The concept of 'finding one's place' particularly links to 'participating and contributing' below, although there are links to other categories too.

4.3.4. Challenging as part of group processes

This code emerged in the second term, when several students began to appear distant or disconnected from the group, electing not to take part or declining to join in group discussion. Other behaviours included voicing boredom and laughing at others. Second term work involved more improvisation in group sessions and the data reflected a sense of uncertainty from students around this. I initially coded this data as 'resisting group processes', which seemed to express my frustration that things did not go as smoothly as I had hoped. However, after reflecting further, the code was changed to reflect an acknowledgement that challenging was not necessarily negative, and was perhaps even an important part of group work. Students who had been more compliant in term one appeared to develop self-confidence as they began challenging processes or voicing their dissatisfaction. It is also noted that over the course of the school year the student population 'type' gradually changed as students made the transition back to school, with the arrival of new students with different mental health needs. In the first half of the year the student group had been quite settled, with little conflict to manage. In the second half this changed with increasing conflict and complex group dynamics.

4.4. Participating and contributing

- ❖ *That which engages students and motivates them to take an active role in music therapy; that which is meaningful to them. Relates to a sense of belonging and authenticity.*

Music therapy provided a wide range of opportunities for student participation, and often incorporated students' interests and suggestions. This KC seems particularly

focused on what engaged students in music therapy – what was meaningful and what motivated them.

‘Participating and contributing’ data often strongly linked to ‘managing self’, particularly regarding the readiness of students to ‘participate and contribute’. When a staff member asked me to hold an unplanned music therapy session with a student who was not managing well in class, for example, it was hoped that this would help the student to reengage in the classroom. From the beginning of my placement, and throughout the three terms, it was evident that having students participate in, and contribute to, music therapy sessions enabled them to re-engage in other school programmes. The quality of student engagement developed throughout the year, with students demonstrating an increasing amount of comfort, courage and curiosity in sessions.

4.4.1. Student(s) finding meaning for themselves

This category includes when students appeared to feel a sense of relevance or personal connection to music therapy, including when I perceived a student was having fun, was particularly focused on an activity, felt empowered or energised, or expressed joy about something in the session (either group or individual music therapy).⁹ Examples included a student’s expression of enjoyment when I harmonised with her as we sang, and a student bringing in a book about a favourite rapper for me to learn more about him. Sometimes these moments were accompanied by a spontaneous expression of meaning, such as “that was cool!” At other times it was my feeling that something had shifted and the student was particularly valuing the experience. Students sometimes decided to share their meaningful moments with others, such as sharing a song written in music therapy with peers. Concepts of ‘hope’ and ‘empowerment’ kept appearing – suggesting to

⁹ There were many instances in the notes and in my reflective journal when I made a reflection that I judged something was meaningful for the student: this was intuitive and could not always be tested out, as the student might not have been specific verbally, but was nevertheless a regular and significant part of my recorded observations/interpretations.

me that these things were important to foster in sessions. ‘Relating to others’ and ‘using language, symbols and texts’ also has a strong presence in this data.

4.4.2. Student(s) finding self-motivation

Moments when students decided to join in, or take an active role in sessions, were difficult to categorise without always knowing students’ reasons, but seemed to involve self-motivation. Active participation, such as student-initiated activities or suggestions, became more explicit and increased over the second and third rounds of analysis, in both group and individual sessions.

It was important to me, and my approach as a student music therapist, that students had space to decide how to join in rather than being required to do so. My reflective journal recorded my own “therapist unease” when staff members in support roles in group sessions prompted students to join in. Upon reflection, I could have been more explicit with them, that as the group facilitator, I had no expectations about what ‘participating and contributing’ should be. However, by term three my confidence in my approach seemed to have increased, as, when I validated a student’s decision not to join in an activity, the support staff member knew that was acceptable in music therapy. The student then made the decision to join in again after a few minutes. Self-motivation was often ‘discovered’ by the student when they connected with something particular in music, such as being proud of learning ukulele chords, or writing a song on Garageband.¹⁰ Students with musical strengths also had the chance to shine in music therapy, which seemed significant given these opportunities were not often available in the classroom. While this data connects to ‘finding meaning for students’ above, it is captured separately to convey the prominence of student self-motivation in the data.

When I reviewed the data again, I was also struck by the number of times I had noted that a student’s “sense of fun and humour really came out in music”. Similar to this was the enthusiasm students often expressed when they saw me writing

¹⁰ Music software for Apple computers.

their names on the board as scheduled for music therapy that day. Music therapy seemed at times to provide something for students to look forward to, which seems significant, given the unwellness they were all experiencing, and seems to highlight the importance of music to adolescent wellbeing.

4.4.3. Creating meaning for staff

The data also captured a sense of creating meaning for staff, myself included. For example, staff reported that students were able to participate particularly well in the class that followed the first music therapy session at the School, which led to a decision that music therapy should precede the class again if possible. I also had feedback early on that music therapy was having a positive impact outside sessions, as students began to play the school guitars in break times. Similarly, staff found students were more able to participate and contribute after individual music therapy (when not managing well in the classroom, as outlined under ‘managing self’). Staff who provided a support role in group music therapy have said that it was helpful for students to experience and tolerate “weirdness”, such as when instruments were tuned differently, because things were also likely to feel “weird” as they began to transition back to their regular school.

In addition to the meaning created through staff feedback, my reflective journal also captured my enthusiasm about success in sessions. Examples of ‘what worked’ included: being genuinely curious and interested to learn about students’ music – which helped form connections and engage students in sessions; giving students paper to write down thoughts before discussing them – which made it easier to share ideas; drawing to music – which unified, contained and calmed the group at the beginning of sessions; musically ‘holding’ a student with a steady guitar strum – which seemed to help ground them and bring them into the moment; and the use of the therapy room rather than the classroom – which seemed to help students relax and feel safe in therapy.

When students pushed themselves in their levels of participation, such as beginning

to use their voices in music, this also created meaning, as I knew how challenging it was for them to explore these things. More structured activities were used in group sessions as the student population changed, to provide a comfortable and safe space for all students. Data from my reflective journal suggests structure helped me feel more at ease at times when I felt challenged in working out how best to facilitate later groups.

4.4.4. Modelling by staff

Sometimes I demonstrated examples or possibilities for participation, either implicitly, by picking up an instrument and playing it, or explicitly, by providing suggestions. In one session a support staff member also unintentionally modelled how students might question or challenge the reasons for improvising. Data highlighted the amount of singing I was doing by myself, in order to encourage others to do the same. My reflective journal revealed how self-conscious I could feel about using my voice strongly. Sometimes it seemed effective to sing in a gentle way, and more accessible for students to join in. At times the culture of 'uncoolness' related to singing was also felt by me, and I recognised that this was likely to be felt by the rest of the group too – I felt the need to model to students that singing could at least be 'acceptable'.

4.4.5. Evolving quality of engagement

The data highlighted that the quality of student engagement evolved or grew considerably over the three rounds of analysis. When a new student joined the music therapy group in term two, an experienced student explained to them what music therapy was, saying "you just feel more relaxed afterwards." In the third term students took turns bringing a song to share at the beginning of the session, and the amount of discussion generated by this, such as what to look up on YouTube or how to spell a band name, also seemed to provide important socialising opportunities. Thus while further codes did not develop in rounds two or three, the quality of student participation and contributions seemed to change and deepen with

experience for lots of students. Again, there are links to other KCs: 'managing self' in general, and 'developing a music therapy culture' under 'relating to others'.

4.5. Relating to others

❖ *The quality of interactions – both student-student and student-staff; comfort in collaborating and negotiating with others; and attempts to connect with others.*

This KC seemed to 'fit' my approach straight away and I felt music therapy would provide many opportunities for students to relate to each other and to me. However, after round one of the analysis, I was confused that, while I felt intuitively that it was happening, I could not see much evidence of 'relating to others' in the data. A memo to myself afterwards stated "why haven't I captured RO (relating to others)? It's all about RO!"

I decided in round two to look more closely for signs of this data, and went on to discover an abundance of 'relating to others'-type interactions. However, they remained elusive when I tried to code them, and I was reminded at times of the quote from the Australian cult film, 'The Castle', when the lawyer's only argument is, "it's the vibe of the thing". It seemed this work was just more implicit in nature and was therefore less easy to code. The often complex and dynamic nature of music therapy with students may also have impacted on my abilities to capture the essence of how they related to me and with each other in sessions. Data with strong elements of 'relating to others' was also often captured elsewhere, highlighting that several KCs were often 'at work' at the same time. Most categories emerged during round two, and continued to evolve in round three, although no further categories were formed.

4.5.1. Collaborating

'Collaborating' was the only category to arise in round one, and remained prominent (in both group and individual sessions) throughout all three rounds of

data analysis. At first it included obvious collaborative aspects like negotiating session activities, planning future sessions, and playing music together. In round two, sub-categories began to emerge in a somewhat sequential order: bonding, brainstorming, and moving forward. It became clear that 'collaborating' was an important part of music therapy at the School. This seemed particularly important given the isolation often felt by young people experiencing unwellness. My reflective journal recorded my impressions that students were becoming increasingly comfortable in group music, which relates to 'challenging as part of group processes' data above. In term three, the collaborative nature of sessions seemed particularly ingrained in the music therapy culture of the School. This also links to 'developing a music therapy culture' and 'leading the session'.

a. Bonding

This sub-category first emerged out of group sessions analysed in the second term, involving a listening and reflecting activity. As the music played and during reflections afterwards, there was a shift in the energy of the room, particularly when the students reached an agreement that the song had felt "really sad", "like a funeral". It seemed that sharing this 'sad' experience unified the group, more so than songs that were perceived as 'happy' or 'angry'. The group seemed to have a similar unifying experience when I played the cello for them in the third term, which was also perceived as "really sad". Other 'bonding' data included student agreements about how "weird" improvising was or when the group chose a song they all enjoyed to learn and perform together. Music therapy seemed to provide students with many opportunities for bonding.

b. Brainstorming

I began to notice increasing amounts of 'brainstorming' in second term work, distinguishable from 'thinking' (below) due to the centrality of 'relating' in the interactions. This ranged from groups working out how to piece together lyrics for a song collage, to compiling a 'happy songs' playlist. During the third term there was also an increase in 'brainstorming' in individual sessions with students, regarding what they found helpful in music therapy and what goals they wanted to work on.

The importance of having a comfortable and safe therapeutic relationship with the students in being able to 'brainstorm' is why this data was categorised here. See 'thinking' (below) for related data.

c. Moving forward

Collaborative developments in music therapy also began transferring elsewhere, such as social connections between peers, students playing the school guitars together in break times after using them in music therapy, and students suggesting songs for 'morning music' (part of morning meeting). A significant moment was when a student shared exciting news about following up on a career lead after attending a career expo with me and other students. This category seemed to reflect the results of collaboration, and highlighted the importance of helping students to make connections to meaningful things outside of music therapy, in moving forward into their 'normal' lives outside of the School.

4.5.2. Playfully negotiating

This category appeared as soon as I turned my attention toward 'finding' evidence of 'relating to others' in the second round of analysis. It is likely that it would have been present in the first term, had I chosen to review data again with this new lens. There were many examples of 'playfully negotiating', or interacting with students in a light-hearted way, as I encouraged them to experiment with things that felt challenging to them – either musically or verbally. One example of this is when I noticed a student looking uncomfortable during a group improvisation, holding a djembe drum but not playing it. I caught her eye, threw her the bells I had been playing, gave her a quick smile and grabbed another instrument to play myself. She smiled at me, rolled her eyes and started to play, almost in a grudging way but seemed to relax into it, playing the bells in a humorous way with others. Sometimes it seemed these interactions allowed students to save face with their peers because they had not specifically chosen an instrument, while also being given permission to join in. At times I verbally negotiated or dared students to try something new, and similarly responded to their challenges to me, such as asking me to bring in a song

to share if they were expected to – which resonates with ‘collaborating’ above. While these interactions often included humour, it seemed important to give students genuine and warm encouragement at times. Perhaps this data was more pronounced in term two because therapeutic relationships with students had had time to develop in comfortable and safe ways.

I also noticed a shared sense of humour develop between group members in the second term onwards. In one session a student suggested we pretend to be farm animals, as we went around the circle. This seemed to unite the group in a shared sense of playfulness, and when one student said, “anyone would think we were crazy” if they walked into the room, it also seemed to give students the opportunity to express humorous insight into their unwellness that in a way united the group.

4.5.3. Student offerings

This category relates to students’ motivation to form connections with others, and is distinguished from ‘self-motivation’ above by its interactive quality. This included offering to teach me a guitar riff, showing me how to use Garageband, and educating me and other students about their favourite musicians. Also included was when a new student decided to share a favourite song as a way of introducing himself. I was struck by the egalitarian nature of music therapy when reviewing this data, where students could try out different roles, moving away from being the ‘unwell teenager’ for a while. My reflective journal recorded my enjoyment in learning more about students’ musical tastes, and that having an opportunity to be the expert seemed a great opportunity for them. One session particularly interested me, when a teacher was acting as support person in the group. He had a genuine interest in learning about the students’ musical tastes, and they had a chance to educate him about that, and experience new ways of being with their teacher. In turn, the teacher reflected on the new knowledge he had gained of the students.

4.5.4. Developing a music therapy culture

This category also links to several other KCs, particularly ‘an evolving quality of engagement’ above. In reviewing the data, it appeared that a music therapy culture developed over the three school terms around music therapy processes and how experiences were shared, particularly in group work. I noticed a growing knowledge, understanding, and acceptance in relation to how the students saw each other in music therapy, over time. This was apparent from the unifying processes evident in the work, such as activities that became rituals in each session. Students’ growing comfort and enjoyment of sessions became evident in how they began to look forward to different activities, such as when I forgot to include an activity a student said “Hey! You forgot about...!” Structured improvisation warm-ups seemed to bring an energising quality to the group, and set students up to share more ‘daring’ and unpredictable experiences together. In term three I also noticed students letting each other know if they found a person disruptive in the group.

4.6. Thinking

❖ *Students’ comfort in reflecting on meaning in thoughtful and curious ways; initiating discussions about meaning; and suggesting ideas for sessions.*

I was initially the most resistant to ‘thinking’s’ place in music therapy, perhaps because it elicited visions of teachers and text books in my mind. However, data analysis helped me to gain an understanding of what ‘thinking’ represented, and it became apparent it was frequently happening in music therapy sessions. ‘Thinking’ was the most verbally represented of the KCs, and often involved reflecting on meaning in the spaces after music. There was a gradual increase in the amount of student-initiated thinking and leading in sessions in rounds two and three, and while new categories did not develop in round three of the analysis, the depth of thinking seemed to evolve considerably by the end of term three, in line with the way in which music therapy work also linked to the other KCs.

4.6.1. Talking/reflecting

This category was the clearest one to emerge from data analysis. Talking and reflecting seemed guided primarily by me in term one, and related to the effect or meaning of the music made or played in sessions. It also included reflecting on what it felt like to try out challenging things. Sometimes this led to an expression of accomplishment by the student and at other times they asked if we could do something else (see links to 'playful negotiations' and 'communicating limits'). Reflection tended to follow music. Rounds two and three of the analysis revealed the place of 'thinking' had evolved in sessions to include reflecting with students about what felt the most helpful for them in music therapy that day – whether writing songs about how they were feeling or singing a favourite song with me would be likely to help them more. In the third term, students also reflected on their preference for rules and structure when playing songs or improvising in groups (see 'communicating needs'). My reflective journal recorded that I found getting to music as soon as possible and leaving more space for verbal reflections towards the latter half of the session more effective and natural in sessions – that music evolved speaking. It seemed that as I became more comfortable with the place of talking and reflecting in sessions, speaking happened in a more natural and free way.

4.6.2. Chatting

There were many instances of casual 'chatting' at the beginning of sessions. The first significant 'chat' I had with students often occurred whilst we were focused on something else, such as mixing music on Garageband or tuning a guitar. The focus on something musical seemed to help students to feel comfortable about having a conversation with me. These chats were often not closely related to the session itself, and sometimes led to students sharing other worries or concerns. In reviewing the data, these discussions often seemed more authentic or organic than when I initiated reflections, particularly in term one, and were more likely to originate from the students, often evolving into deeper forms of reflection.

4.6.3. Student-initiated thinking

From the end of term one onwards students began to express a personal interest or preference for specific music therapy processes, such as when I harmonised with them in singing, or a particular way I accompanied them on the guitar. Increasingly, in terms two and three, students began to relate music therapy processes to a sense of feeling better, illustrated in spontaneous feedback such as, “man, I feel heaps better now!”

a. (Student) leading the session

In later stages of music therapy with a student, particularly as the culture of music therapy developed (above), they increasingly initiated suggestions about what they wanted to do in music therapy that day, like “I’m in the mood for... today”, and “can we do ... now?” This became a sub-category of ‘student-initiated thinking’. My reflective journal showed I questioned whether I had the balance right sometimes, in being as student-led as I was, and my clinical supervisor often reminded me that I needed to remain goal-oriented in sessions. However, this approach seemed useful much of the time, and strongly linked to the collaborative nature of music therapy that developed at the School.

4.7. Using language, symbols and texts

- ❖ Utilising creative processes in music therapy; student(s) using music as a symbolic language to make their own meaning; and developing skills in utilising the elements/theory of music in sessions.

I was preoccupied by the meaning of this KC during my placement and whilst analysing data. It had not been a focus of other therapeutic interventions at the School, and I had therefore not included it in students’ music therapy plans. I learned from teaching staff that this KC had not felt particularly relevant to their work with students either. This led me to wonder whether music therapy could help

inform this concept, particularly as data analysis identified potential links to it in my practice. In rounds two and three of the analysis, it began to seem like music was being utilised by students as a language, and had considerable potential for students to create and interpret meaning. The creative, musical elements of much of the work seemed best captured under this KC, and the 'colour' of the work was also particularly evident here. 'Using language, symbols and texts' seemed to capture the more implicit aspects of the work, as well as represent some of the value of music therapy to students.

4.7.1. Using elements/theory of music

This category developed quite naturally and early in round one. The focus of early music therapy sessions with students was often on helping them learn something, such as songs they enjoyed, guitar chords and tabs, or transposing music into other keys so the pitch was easier for singing. These tools seemed to provide students with a sense of purpose, which was particularly important in initial music therapy sessions. Other students were interested in how pop singers made catchy tunes, and so time was spent looking at common chord sequences used in these songs. Again, this aided in initial engagement in music therapy, and is connected to 'thinking' processes.

4.7.2. Symbolising with music

After round one of the analysis, I wrote a memo about how "students seemed to be connected to the symbolic nature of music, that perhaps it provided them with a language in which to represent deep meanings that may be difficult or even undesirable to verbalise". I began to see the symbolic power of music as an important communication tool for students, as well as a medium for them to understand or conceptualise their own thoughts and feelings without any pressure to verbalise them. This linked to concepts of empowerment and self-expression – that music facilitated students to 'play' how they felt, however they chose. Instruments and roles chosen by students in group music often seemed symbolic –

the student who felt able to play the bells but not the djembe drum, or when a student described their role in a group improvisation as providing the heartbeat. Words used in songwriting often seemed to act as metaphors for students' feelings. Music produced in group improvisations also seemed symbolic of where each student was at, in that moment. In individual sessions, sharing musical memories of a loved one who had passed away seemed to be a way of symbolising and working through grief. I sometimes chose songs during sessions that represented feelings such as hope, when it seemed students needed support.

The symbolic power of improvisation was particularly evident in rounds two and three. It seemed to be a helpful 'object' for students to reflect on about their feelings, initially with comments like "it felt weird" or "it's too awkward." Staff thought these could be helpful opportunities for students to experience and see what it was like to tolerate such feelings, as well as to experience when it felt less awkward and what seemed to make the difference. This would often lead to 'talking/reflecting'. This category strongly connects to 'participating and contributing' data above.

4.7.3. Utilising creative processes

Music therapy provided many opportunities for students to utilise creative processes – from composing a riff on the guitar, to assuming a leading role as rhythm-keeper in a group improvisation. Sometimes these processes were not around creating music, such as when students took turns bringing along a song for group music. Everyone listened to that song and drew whatever came into their minds as the music played, and shared the pictures at the end. Some students drew things that were meaningful to them, and others enjoyed using the time to "scribble and zone out". But they all seemed to enjoy the process of creating something that was unique and inspired by the music, and there were ongoing requests to continue this warm-up activity, which allowed for creative, non-verbal responses. The creative nature of music therapy seemed central in supporting

students to feel good about themselves and their creative abilities, and invested in the therapeutic process. This is particularly evident in the vignette that follows.

4.8. Clinical vignette

This vignette considers my work at the School in more depth. It focuses on music therapy sessions with one student, in order to shed further light on how my practice related to the KCs over the 12 individual sessions we had together. The student's name and identifying details have been changed for reasons of confidentiality.

Katy was 15 years old when she began attending the School. She had been diagnosed with major depressive disorder and social phobia, which had contributed to her being unable to regularly attend her usual school. Katy arrived at the School a quietly spoken, acquiescent young woman. After talking with staff about the kinds of goals that might best support Katy, I developed a music therapy plan which included: becoming comfortable in expressing her emotions and needs, developing her self-confidence, including an ability to say no or voice a contrary opinion, and supporting Katy to develop her sense of fun.¹¹ While I used the KC language in formulating her plan, it is fair to say I lost track of that language during music therapy sessions and instead focused on the goals that spoke to me as a student music therapist, such as “expressing”, “confidence” and “fun”. In addition to individual sessions, she took part in a number of group music therapy sessions that I ran during this time.

In our first session we sat and chatted about her previous musical experiences. Katy was familiar with a variety of instruments, particularly the guitar, but explained she had not played for a long time, since she had started feeling low. She chose “Let it Be” out of my songbook, which became a theme song throughout our sessions. Katy seemed to relax into playing the guitar very quickly, and appeared comfortable and

¹¹ While initially goal-setting appeared too overwhelming for Katy to participate in, over time she became actively involved in her music therapy goals during sessions.

confident playing the chords. She also picked up on the concept of transposing to different keys very quickly when I showed her how.

We found there were some bands we were both familiar with and enjoyed, and I downloaded the guitar chord charts for songs by these bands so we could sight-read them, which we often did at the beginning of sessions. Katy began to play a strong steady strum on the guitar in response to my increasingly gentler strumming. While she usually accepted my suggestions without offering a contrary opinion, her playing became increasingly strong and confident, as if the music was speaking for her. In one session I asked her to join me in singing, and she said “no!” I felt disappointed initially, but a discussion I had with her teacher made me realise that feeling able to say no was a positive development for her.

Katy was drawn to the idea of songwriting straight away, but warned me that she used to do creative writing and was “really bad at it”. However, her concerns about her abilities seemed to dissipate as she became more and more engaged in the songwriting process. Katy developed her own chord progression very quickly, incorporating chords she liked, with a very rhythmic and steady guitar strum, which she thought was like a heartbeat. She spent time teaching me how she wanted her song to sound. I was continuously struck by how strong Katy’s musical self seemed to be, and how this contrasted to the person I often saw outside of music. Katy’s rediscovery of music seemed to increasingly have an overflow effect on her interactions with me, as she began to provide opinions and suggestions in music therapy, and with her peers, as she began to pick up the guitar and play it with friends during breaks. She was also becoming increasingly confident and engaged in group music therapy.

Katy began to arrive at each session armed with music manuscript to show me how she had developed her song since our previous session. The meaning of the song developed considerably as she began to add words that related to how she was feeling in the moment. She was able to express her concern that she would ruin the song if she tried singing, but worked through this as we hummed together, and as I

began to challenge her to sing “Let it Be” with me. She was able to match my voice when I sang in a soft and gentle way and this seemed to pave the way for her to sing her own song.

Katy came across a poem in the school holidays that she had written when she had felt at her lowest point and brought it to her next session, wanting to include the words in her song. The song seemed to become darker, more complex. She began to talk about how everyone else thought she was doing really well and making progress, that she could “sort of see” that this was true, but did not really connect with that feeling yet. The songwriting process seemed to be a significant part of her journey in piecing together how far she had come.

At times we talked about school, what it felt like to transition back there and the trepidation she had about attending some classes. Katy began to express how music therapy felt for her, saying several times that she felt lighter after music therapy. Katy’s father reinforced the value of this for Katy following a review meeting to discuss Katy’s transition progress, when he said Katy had described music therapy as like “flicking a switch” for her, that she just felt better afterwards.

Towards the end of our sessions we recorded Katy’s song and put the finalised recording on her iPod. She expressed her delight at finishing it and felt it captured how she had been feeling over the past few years. She thought she would share it with others. As we wrote down together what Katy had learned about herself in music therapy, I was particularly struck by her belief that, “I accomplished something meaningful”.

Reflecting on the sessions I had with Katy, it seems clear that the KCs were all at work during sessions. I particularly noticed that:

- ***Managing self:*** She was able to express herself in music, channel her feelings into her song, and communicate her limits when she declined to sing with me initially. Music therapy also seemed to give her relief from her

immediate anxiety. Katy's complete ownership of the songwriting process also reflected a strong sense of 'managing self'.

- **Thinking:** Katy spent a lot of time reflecting during sessions on how she wanted her song to sound and thinking about what she could do to make it accurately capture how she felt.
- **Relating to others:** Katy and I built a therapeutic relationship around collaborating together, both in learning new songs and working out what sounded best for her song. She arrived at sessions excited to show me the progress of her song. Katy's rediscovery of her guitar skills also led her to begin playing with her peers during break times. Her decision to share her song with others seemed to be significant for her, in revealing a part of herself she had not talked about, and sharing her pleasure with others about having written and recorded a song that she was proud of. Relating to peers was clearly a significant challenge at times for Katy, and the use of her music seemed to provide a bridge to relating to others, such as a topic for conversation.
- **Participating & contributing:** Katy found a lot of self-motivation in music therapy, to develop something that felt meaningful and authentic. Her connection to music seemed to impact on her presence in group music therapy too, particularly as she began to contribute her point of view in sessions. In creating her song she had also contributed something tangible, a piece of art, to the world.
- **Using language, symbols & texts:** Katy made her own meaning out of music, utilising her knowledge of music theory and her guitar skills to create her own chord progression and develop her song. She also made meaning out of words that she had previously associated with feeling low by incorporating them into something that she was proud of. Katy demonstrated a sense of agency and competence in using a symbol system other than words, which seemed to empower her to explore her feelings further. The creative processes she used in music therapy seem to best fit within this KC.

In addition to the KCs, it struck me that during music therapy Katy seemed to develop a sense of hope that she would be okay. The songwriting process was a way of recording, in a way that empowered Katy, how far she had come since she had begun to feel depressed. This did not necessarily seem captured by reference alone to the KCs, although perhaps one of the roles of music therapy could be to add different dimensions to the KCs and highlight the potential for how they could be interpreted. For example, empowerment clearly links to 'managing self'. Given some of the difficulties Katy (and other students I worked with) had been experiencing in returning to school and her goal to return there, I think that her rediscovery of her creative and musical abilities might also have helped her link to other creative pursuits at her usual school. Music therapy may also therefore provide an important transitioning tool for some students. While music therapy was only a part of the picture in terms of the support Katy received during her transition back to school, it seemed that it both contributed in terms of KC goals, as well as giving her tools to explore her identity and her feelings.

5. DISCUSSION

5.1. A comfortable relationship

The study's findings revealed a growing comfort in the relationship between my music therapy practice and the KCs. My recurring doubts about their everyday applicability whilst at the School were assuaged as I went through the data and became satisfied that my work often addressed the KCs quite naturally. This showed that the KCs could accommodate both health and education viewpoints, and also suggests there is considerable potential for music therapy to utilise this framework. The New Zealand curriculum acknowledges that, "in practice, the key competencies are most often used in combination" (Ministry of Education, 2007, p. 38). This was highlighted in the data. While at times categorising seemed slightly artificial due to the overlapping and intertwining of the KCs in music therapy, this also provided evidence that music therapy offered rich possibilities for developing the KCs in holistic ways.

Rather than lessening the therapeutic value of music therapy, the KCs aligned with my practice in more ways than expected, and did not seem to impinge upon the value of the work. This aligns with Derrington's experience that accommodating education tools in music therapy "added to the student's social and emotional aspects of learning which is key to success in school" (Derrington, 2011, p. 210).

5.2. Key findings

The findings of particular interest included the way that collaboration ('relating to others') evolved in music therapy over the three terms of data, and how students took the opportunity, particularly in group music, to try out ways of being and experiment with different roles in relating to one another. This links to McFerran's (nee Skewes) view that in group situations music "provides an opportunity for clients to explore themselves in relationship with others and to experience people's

responses to new behaviours and ways of being” (Skewes, 2001, p. 187). These findings also highlighted the importance of acknowledging and integrating the “culture of adolescence” in music therapy (Cobbett, 2009, p. 17). Part of supporting the students to develop their relationships and connections not just to others but to themselves involved maintaining a curious and interested person-centred presence during sessions, and an openness and genuine motivation to learn and be taught by them, as experts on their own musical tastes. This also highlighted what I found to be “constantly a fine balancing act between making suggestions and actively enabling them to come up with their own ideas” (Derrington, 2011, p. 204).

The collaborative opportunities offered by music therapy, particularly in group work, seemed particularly important at the School, where students could try out different ways of being with each other, socialise and connect with others about music they were passionate about, share and offer their opinions, give and receive peer support, and have fun. Perhaps this work is one way of filling a gap in what has been identified as an individual focused approach to Western education (Fraser & Deane, 2010).

I was also interested in how my own ‘lens’ seemed to shift during the course of the research – it seemed that what I viewed as central to the work evolved during the course of data analysis. This was hinted at in the data too, with a shift from focusing on the importance of building relationships with students, particularly during terms one and two, towards recognising the importance of the music itself. ‘Relating to others’ and ‘using language, symbols and texts’ were the KCs that represented those two things – the therapeutic relationship and the ‘musicking’ in music therapy – and seemed overall the most implicit in the data. Cobbett posits that “the experience of therapy is mutually created in relationship and through the shared language used (including)... the musical language in music therapy” (Cobbett, 2009, p. 17). Were there opportunities to conduct further data sampling and analysis, I would explore the balance of ‘relationship’ and ‘music’ data in sessions. My sense is that in time, the bridge diagram (figure 1 above) would shift towards ‘relating to others’ sharing the middle keystone with ‘using language, symbols and texts’.

5.3. Grief, hope, and empowerment

The findings suggested that one of my key roles as a student music therapist was to help foster feelings of hope and empowerment for students, not least because of their journey towards “wellness”. I observed frequently in reflective journal data that a kind of grieving seemed to be a key component of what students were going through in music therapy sessions. It seemed that students were “grieving shattered hopes and dreams of the future due to physical or mental illness” (McFerran, 2010a, p. 218). Music therapy thus provided an important way of “directing young people towards hope for the future” (McFerran, 2010a, p. 235). The data, particularly the clinical vignette, suggested a strong link between students utilising creative processes and experiencing feelings of hope. Giving students the opportunity to try out creative processes in music therapy also seemed to empower them. In Katy’s songwriting experiences in music therapy, for example, she developed a strong sense of “ownership of the processes involved and the outcomes resulting from (her) experiences” (Daveson, 2001, p. 30). This data links to the recovery model’s focus on empowerment, and it was interesting to me how relevant this was in my work at the School, and that the KCs captured much of this data.

However, some of the data remained somewhat disconnected from the KC framework, and I wondered whether my study was hinting at the development of a sixth KC, where the centrality of creativity in nurturing feelings of hope and empowerment in young people is acknowledged. Katy’s deep satisfaction that she “accomplished something meaningful”, for example, showed how powerful the songwriting experience was for her. Music therapy seemed to represent an effective tool for adolescents experiencing unwellness to create hope for themselves.

A recent strategic review of the health inequalities experienced by people in the UK, found that “without life skills and readiness for work, as well as educational

achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives” (Marmot Review, 2010, p. 19). This again highlights the importance of empowering young people for their future. Music therapy gave Katy, for example, the opportunity to develop a strong sense of achievement, which was both educational (evident from the KCs that were at work throughout the process) and creative in nature.

5.4. Creativity and multiple uses of key competencies

I recently re-watched a popular speech given by Ken Robinson, where he highlights the importance of creativity alongside the more traditional subjects of literacy and numeracy (Robinson, 2006). This made me reflect further on the importance of providing creative opportunities for young people. It has been suggested that the arts “provide a rich and meaningful context for the development of the five key competencies” (O'Connor & Dunmill, 2005, p. 8). However, it seems that they are being “squeezed into the margins of a jam-packed curriculum” (Fraser, Price, & Henderson, 2008, p. 5). It could be suggested that the arts have a special place in the education system because they both help students access the more traditional subjects (Bolstad, 2011a), as well as provide a sense of joy, hope, and meaning, which seems crucial to healthy teenage development – they “teach us things that cannot be experienced through other disciplines” (Fraser et al., 2008, p. 5).

Regarding music therapy as an arts-focused practice, I presented my preliminary findings at a music therapy conference in early November 2011, and was interested by several audience members’ responses to my thoughts about whether the KCs captured the true value of music therapy. One audience member, a retired arts educator in the Ministry of Education, suggested that not only did the KC framework help inform music therapy practice, but that music therapy seemed to provide more depth to the meaning and development of the KCs (Field, 2011). A benefit of working within a different framework may also be that music therapists can become more aware and knowledgeable about issues in education – including the KCs.

The potential for the arts to support young people to develop their creativity and comfort in learning may be endless. One teacher-researcher developed the practice of dancing feedback and feedforward to her students, which developed into a culture of nonverbal, 'danced' communication between students and with their teacher as part of the class (Fraser et al., 2007, p. 22). It seems that a significant part of the beauty provided by the arts may not easily, or desirably, be described by words alone. In the words of one revered music therapist-researcher, music "is itself a way of knowing; it too encourages multiple constructions of truth and reality" (Bruscia, 2005b).

5.5. Team collaboration and a sense of ownership

With regards to the applicability of this study to my clinical placement, the responses I had from staff to an email detailing my preliminary findings included: that it was helpful feedback about how the students were developing in the KCs; and referring to the framework was helpful in highlighting the effectiveness of music therapy with the students. Upon reflection, it may have also been helpful to refer to the KCs when reflecting on sessions with students – to point out that they were developing skills that were really important for school, thus highlighting their progress and chances of success at returning to their school. It is something I did not explore as much as I could have.

My reflective journal revealed a growing understanding, and sense of ownership, about the KCs over my nine month placement. After a clinical supervision session from early in the year I recorded in my reflective journal, "(my supervisor) wanted to know what I had done with ... (the students) that related to their therapeutic plan, and said that even when students might seem more unwell than they had been, that I still needed to keep in mind the need to move forward with their goals, have justifications for what I do, ... even if we are not at the top end of the work we have been doing, that I needed to still link back to the KCs." This study led me to realise that I was doing this naturally. An entry later in the year noted, "there is so much going on in the room, and I am beginning to see the KCs as helpful in giving

me focus. When something that looks like ‘managing self’ pops up during a session I think, ‘ah yes, that’s the direction to be taking, centre it around that idea’, and I feel more clear... given the unpredictability of the work and the person-centred nature of music therapy that’s actually quite helpful sometimes!”

5.6. Music for wellbeing in schools

While the KCs represent an important tool to interact with, understand, and manage when working in education settings in New Zealand, McFerran’s position paper, ‘Music for Wellbeing in Australian Schools’, considers specifically what music can contribute to the wellbeing of young people (McFerran, 2010b). She outlines three critical dimensions of wellbeing in Australian schools: happiness, connectedness, and creativity. A table outlining the way these concepts relate to the KCs is included in Appendix 7. This model could provide music therapists with more specific guidance and support when working with young people in education settings, and could also inform the work of educators, in providing insight into the myriad ways that music can promote the wellbeing of young people in schools.

5.7. Future Research

There is considerable potential for future music therapy research on the way the KCs could be utilised and incorporated with this client group. The participatory nature of action research may lend itself well to further enquiries, allowing for a fuller picture of the perceived value of the work by those affected – including the voices and perhaps music of adolescents themselves and other staff members. This would go some way to addressing an identified research gap regarding studies that “specifically address the value of music therapy for adolescent clients” (McFerran, 2010a, p. 275). Action research may also go some way to addressing the issue that “any language used to describe the experience of music does not necessarily capture the essence of the actual experience” (Amir, 1992, p. 28), as it would

include the language of the adolescents themselves, who seem often to have creative, straightforward and insightful ways of seeing the world.

6. LIMITATIONS

Given that this study had no research participants, it is limited to my interpretations of the data. At times I wondered “without singularity of truth and reality, and little possibility for objectivity, how does one ever know anything with any certainty?” (Bruscia, 2005b). However, I realised that interpreting and questioning my own practice was an important skill to develop, and that my experience of this may be helpful for others to reflect on.

During much of my placement, I analysed data and continued to practice music therapy concurrently. I endeavoured to remain mindful that data analysis was focused on building a theory, so as to minimise its influence on my practice. However, as I began to analyse the data and see the relevance of the key competencies to my practice, I began to see more links and seemed to adjust my practice accordingly. In counselling and psychotherapy research, it has been acknowledged that “the dual relationship created by practitioners undertaking research on their own counselling or psychotherapeutic service is very likely to affect, either positively or negatively, both the therapy and the research” (Bond, 2004, p. 14). One effect of the dual relationship on this study was evident when I noticed that a revelation about the centrality of ‘relating to others’ in the data seemed to have affected my note-writing at that time – that I had begun recording all positive illustrations of ‘relating to others’ in my notes. Negative responses may therefore not have been as accurately captured as positive ones.

Lastly, it was some time before I began discussing the meanings of the KCs with other staff members at the School, and I initially tried to make sense of them by myself. When I began to ask staff about the KCs, this led to a substantial increase in how I understood them and how they could be utilised, as well as staff understanding what music therapy could contribute. Engaging with staff about this sooner could have led to greater clarity early on.

7. CONCLUSION

Although I still recognise a sense of dissonance in some areas between a framework focused solely on wellbeing and one focused on learning, I am considerably more comfortable with the place of the KCs in my practice. I also understand more fully the potential of the KCs for informing and being informed by arts-based practices.

The findings show that even without always purposively incorporating them into music therapy, KC goals were being met in every session. This highlighted the broad and holistic nature of the KCs. The framework also allowed me to make different meaning out of the work, in order for others to see how music therapy can relate to an educational viewpoint.

It is hoped that this study will help music therapists, student music therapists, and stakeholders in education settings to conceptualise how music therapy might contribute to supporting adolescents experiencing unwellness to build the skills they need to transition and function in mainstream schools.

One song that connected with many of the students I worked with throughout my placement was by a 'screamo' band, BOTDF, called "Believe in me". It was a song suggested by one student and became a theme song for many morning music meetings as well as group music therapy sessions. It is one that will always relate to the time I spent with students, and reminds me of the important place of hope in working with teenagers experiencing unwellness.

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APPENDIX 1



[REDACTED]

Principal
[REDACTED]

By email: [REDACTED]

Dear [REDACTED]

I am a second year Master of Music Therapy student undertaking a clinical placement at [REDACTED]. As part of my training I am required to research an aspect of my practice by undertaking a secondary review of data recorded as part of usual music therapy clinical practice. The purpose of the research is to improve my learning and to inform other music therapy students and practitioners of particular issues involved in the work.

With informed consent from all affected parties, I would like to look at how music therapy best fits in an education setting with a strong mental health focus, and particularly how it relates to the key competencies of the New Zealand curriculum. I would like to closely observe and critically reflect on how this has worked in my music therapy practice during my placement at [REDACTED] and produce my interpretation of its value. I am required to include a case vignette from practice which might involve an individual case, a group, or the practice setting as a whole, to illustrate a particular point in my exegesis. This preliminary communication is to ask permission for the research to take place in this facility. Further information will follow.

My contact details are: [REDACTED]. My supervisor at the New Zealand School of Music is Sarah Hoskyns, [REDACTED].

Yours sincerely

Laura Halligan

cc: [REDACTED] email

APPENDIX 2



Music Therapy Programme (MMusTher)

Research Title: How does my music therapy practice, in a school focused on supporting adolescents with mental health needs to return to mainstream education, relate to the key competencies of the New Zealand curriculum?

12 August 2011

Request to Review Data

As you know, I am a second year Master of Music Therapy student undertaking a clinical placement at [REDACTED]. As part of my training I am required to research an aspect of my practice by looking back at the records I have kept while working with students. Due to [REDACTED] overall focus on supporting students to become ready to transition back to their regular school, I have been interested in how the New Zealand curriculum's key competencies fit with my music therapy practice, and have chosen to focus my research on the relationship between the two. The purpose of my research is to improve my learning and to inform other music therapy students, practitioners and carers of how the key competencies could be utilised by music therapists working within settings that have some focus on education.

My research process will involve looking back (secondary review) over clinical notes that I have written following music therapy sessions, re-examining notes that I have written in my reflective journal, and reviewing any recorded footage taken as part of music therapy sessions. A reflective journal is part of a music therapists' usual practice and aids in documenting personal reflections, learning processes and critical thinking.

I am writing to ask for permission to review the data I have collected as part of usual clinical music therapy practice in order to look broadly at how the key competencies fit with my work. After discussions with my supervisor I believe that it is not necessary to ask individual students for their permission, as the focus is not on any one student, but on my practice with a broad range of students. I will be seeking specific consent from two students separately regarding writing a vignette to capture an aspect of my work with them, to illustrate a particular point about my learning, and will draft information sheets, assent and consent forms for this purpose. Those forms will explain that I will not use their real name in any publication or presentation arising from my research and that their response to my request will in no way affect my ongoing work or relationship with them, nor will there be any expectations regarding extra sessions or ongoing work. There will be no pressure on any individual to

give consent for this, as there are other students who can be asked. I will be requesting [REDACTED] to make the first approach to the students concerned so that they are free to say no.

The secondary analysis of the data will take place on my password protected computer, at my place of study (home office). Consent forms will be kept for 10 years from the age of 16 years and will be stored at the New Zealand School of Music, Music Therapy Department, in a locked cupboard or filing cabinet, and files will be marked "confidential". The research supervisors have access to the data and are responsible for its safe-keeping. This project has been reviewed and approved by the New Zealand School of Music Postgraduate Committee. The Chairs of Massey University Human Ethics and Health and Disability Ethics Committees have given generic approval for music therapy students to conduct studies of this type. The music therapy projects have been judged to be low risk and, consequently, are not separately reviewed by any Human Ethics Committees. The supervisor named below is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please contact Professor John O'Neill, Director, Research Ethics, [REDACTED]

Sarah Hoskyns, Research Supervisor and Music Therapy Programme Leader at the New Zealand School of Music: [REDACTED]
[REDACTED]

Laura Halligan, Master of Music Therapy Student: [REDACTED]
[REDACTED]

Yours sincerely

Laura Halligan

APPENDIX 3



Music Therapy Programme (MMusTher)

Research Title: What is the relationship between my music therapy practice and the key competencies of the New Zealand curriculum

18 September 2011

Dear [REDACTED]

Information Sheet for [REDACTED]

As you might recall, I am a second year Master of Music Therapy student undertaking a year-long clinical placement at [REDACTED]. As I briefly outlined to you at [REDACTED] final review meeting, as part of my training I am required to research an aspect of my practice by looking back at the records I have kept while working with [REDACTED] students this year. Due to [REDACTED]'s overall focus on helping students to transition back to school, I have been interested in how the key competencies of the New Zealand curriculum fit with my music therapy practice, and my research therefore focuses on the relationship between the two. The purpose of this research is to improve my learning and to inform other music therapy students, practitioners and other interested parties of how the key competencies could be utilised by music therapists working within education environments.

My research process involves looking back (secondary review) over clinical notes that I have written following music therapy sessions, re-examining notes that I have written in my reflective journal, and reviewing any recorded footage taken as part of music therapy sessions. A reflective journal is part of a music therapist's usual practice and aids in documenting personal reflections, learning processes and critical thinking.

I am writing to formally express my interest in reviewing and analysing my practice as a student music therapist working with [REDACTED]. As part of my research write-up I am required to include a case example from my practice, i.e. an excerpt about my work with a student, to illustrate a particular point about my learning. I would like to write my case example about the work [REDACTED] and I have done together. If you decide to allow me to use information about music therapy sessions with [REDACTED] in my research, [REDACTED] real name will not be used in any publication or presentation arising from this research. The secondary analysis will take place at [REDACTED] or, if kept on a password protected computer, at my place of study (home office). Consent forms will be kept for 10 years from the date

██████████ is 16 years old and will be stored at the New Zealand School of Music, Music Therapy Department, in a locked cupboard or filing cabinet, and files will be marked “confidential”. The research supervisors have access to stored data and are responsible for its safe-keeping.

For the final part of my degree I have to present my work, in a private session, to two examiners and my research supervisor. During that private presentation, I would like to play some music that was recorded whilst working with students at ██████████, and would like to play some music that ██████████ and I recorded together in music therapy sessions. This recording would not be shared with anyone outside that room.

I will provide copies of my completed research to ██████████ and will forward you the case example relating to music therapy sessions with ██████████ if you would like a copy. I will present the practical case material to my examiners in private session at the end of my University degree and I may also present the work to staff members at ██████████. If my work is of suitable quality, findings may be published in suitable music therapy or other professional journals, in collaboration with my research supervisor, Sarah Hoskyns.

If you agree to ██████████ involvement in my research, please sign the copies of the enclosed consent form and return one to ██████████. If you decide against data relating to ██████████ being used in my research, that is also fine, and I have others I can approach.

My project has been reviewed and approved by the New Zealand School of Music Postgraduate Committee. Generic ethics approval has been given by both the Massey University Human Ethics and Health and Disability Ethics Committees for music therapy students to conduct studies of this type, as they have been judged to be low risk.

The supervisor named below is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please contact either Professor John O'Neill, Director, Research Ethics, ██████████ or ██████████, Occupational Therapist at ██████████ or email ██████████.

Sarah Hoskyns, Research Supervisor and Music Therapy Programme Leader at the New Zealand School of Music: ██████████ or email: ██████████

Laura Halligan, Master of Music Therapy Student: ██████████

Yours sincerely

Laura Halligan

APPENDIX 4



18 September 2011

Dear [REDACTED],

Information Sheet for [REDACTED]

I have written to you and to your parents separately to ask what you think about me using an example of our music therapy work in a project I have to write up for my course at the New Zealand School of Music. You don't need to do anything for me to do this, I will just be looking back at my notes from the last few months, which describe my perspective of what has happened in our music therapy sessions. I will not use your real name in any of my writing, and will not refer to the name or location of [REDACTED] either.

As the final part of my study I have to present my work, in a private session, to two examiners plus my supervisor. During that private presentation, I would like to play some music that was recorded while working with students at [REDACTED]. I would like to play the song we wrote and recorded in music therapy, if that is okay with you.

It is completely okay if you don't want me to involve our sessions, as I can ask somebody else if you would prefer I didn't. My final project will be available for others to read in the University Library and I will present the work to my teachers, examiners and to staff at [REDACTED].

If you are not sure about anything, you can give [REDACTED] a call [REDACTED] and you have a couple of weeks to decide. If you decide you feel okay about it, please can you sign the copies of the enclosed assent form and return one to [REDACTED].

Thanks [REDACTED], and I wish you all the best for whatever your future brings.

Best wishes,

Laura

APPENDIX 5



Research Title: What is the relationship between my music therapy practice and the key competencies of the New Zealand curriculum

Consent Form

I, have read and understood the information provided about this research project in the information sheet dated 18 August 2011.

I give consent for data related to [REDACTED], and which has been collected for clinical purposes at [REDACTED], to be used in the research project: ***What is the relationship between my music therapy practice and the key competencies of the New Zealand curriculum*** to be carried out by Laura Halligan (Student Music therapist) as part of the requirements for her Master of Music Therapy at the New Zealand School of Music.

I understand that [REDACTED] name will not be used in any publication or presentation arising from this research.

I understand that the secondary review and analysis will take place at [REDACTED] or, if kept on a password protected computer, at the student music therapist's place of study (home office).

I understand that consent forms will be kept for ten years from [REDACTED] 16th birthday and will be stored at the New Zealand School of Music, Music Therapy Department, in a locked cupboard or filing cabinet, and files will be marked 'confidential'. The research supervisors will have access to the data and will be responsible for its safe-keeping.

I understand that the student music therapist may present the work to staff at [REDACTED], and to the New Zealand School of Music (MMus Ther) staff and music therapy students. If the work is of suitable quality, findings may be published in suitable music therapy or other professional journals, in collaboration with the research supervisor, Sarah Hoskyns.

I understand that I can withdraw my consent by informing [REDACTED] in writing at any time up to the completion of research analysis, 15 October 2011, without being disadvantaged in any way.

This has been discussed with me by [REDACTED] Occupational Therapist, [REDACTED].

I wish to receive a copy of the vignette relating to music therapy sessions with
[REDACTED] (please tick one): Yes ☐ No ☐

Signed:

Print name and
relationship to
student:

Date:

APPENDIX 6



Research Title: What is the relationship between my music therapy practice and the key competencies of the New Zealand curriculum

Assent Form

I, have read and understood the information sheet telling me what this research is about.

I have spoken to [REDACTED], Occupational Therapist, [REDACTED], about the research and been able to ask questions and have them answered.

I understand that while data is being reviewed (until 15 October 2011) I can decide to stop being part of this study and that it is perfectly okay for me to do this.

I agree that data related to music therapy sessions I have had with Laura Halligan, Student Music Therapist, can be used in her research project, and that my name will not be used in association with her research project (please tick one): Yes ☐ No ☐

I agree that Laura Halligan can use the music we recorded in our music therapy sessions to play in a private presentation of her project to her examiners (please tick one):
Yes ☐ No ☐

I would like to receive a copy of the vignette relating to music therapy sessions with Laura (please tick one): Yes ☐ No ☐

Signed:

Print name:

Date:

APPENDIX 7

Katrina McFerran's 'music for wellbeing' model as compared with the key competencies framework (McFerran, 2010b):

Music for Wellbeing	Key Competencies
<p>Happiness: addressed through music by providing opportunities for the expression and release of positive and negative emotional states (internal perspective). The outcome of musical expression has repeatedly been described by students participating in music therapy programs in Australian Schools as 'feeling better'. This can be observed through increased mood regulation resulting in decreased aggression, improved anger management, reduced anxiety and increased confidence (external perspective).</p>	<p>Managing self strongly connects with the concept of 'happiness', often giving students relief from immediate feelings of depression or anxiety. It also relates to helping students to develop self-awareness of what music is helpful and what might be less so when feeling low. Music therapy also provided many opportunities for students' self-expression and often seemed to lead to a sense of 'managing self', or 'happiness'.</p> <p>Using language, symbols and texts: music therapy provided students with opportunities to represent and communicate ideas in non-verbal ways, which often seemed to result in students 'feeling better'.</p>
<p>Connectedness: achieved through participation in shared musical activities that lead to a perception of being included and valued (internal perspective). Music programs that focus on integration, engagement and collaboration work at manifold levels to respond to the needs of the individuals involved and achieve measurable outcomes. Students in music therapy groups describe connectedness as 'feeling understood' and discovering that 'over time, you realize that you're not alone.' Observable outcomes include the development of social skills in the areas of communication, interaction and mature teamwork (external perspective).</p>	<p>Relating to others: the collaborative element of this KC strongly links to 'connectedness', and the development of social skills during sessions which often transferred out of the room, was evident in the findings.</p> <p>Participating and contributing: students seemed more likely to actively participate when they had a sense of connectedness to the session. Self-motivation and meaning relate strongly to the concept of 'connectedness'.</p>
<p>Creativity: critical for students to flourish and is experienced through the developmental process of identity formation (internal perspective). The construction of identity is based on</p>	<p>Using language, symbols and texts: this KC is particularly relevant to the concept of 'creativity', in the non-verbal, symbolic, musical potential for expressing ideas.</p>

<p>experiments within family and peer-groups and is framed by the range of opportunities available to explore potential and foster resilience. Students in music therapy groups describe ‘going beyond your comfort zones’ and discovering capacities they ‘didn’t know existed’. Being engaged in flow activities, such as learning an instrument or participating in facilitated musical experiences can promote the development of life skills as well as musical skills (external perspective).</p>	<p>Participating and contributing: students seemed to find meaning and self-motivation when they utilised creative processes, which often included developing their musical skills.</p> <p>Relating to others: collaborating in creative processes happened often in sessions, and seemed to empower students, as they realised they possessed creative abilities.</p> <p>Thinking includes using creative processes to make sense of experiences and ideas, which often formed a substantial part of music therapy sessions with students.</p>
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Table 2: ‘Music for wellbeing’ and the KCs