Attachment theory and music therapy: What was the relevance of attachment theory to a student's music therapy programme for 'at-risk' mothers and their babies?

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Contents

Abstract

This qualitative secondary analysis research project sought to explore the relevance of attachment theory as it might apply to a music therapy programme set up and run within a residential service for 'at risk' mothers and their babies. The explicit purpose of the music therapy programme was to assist the mothers in bonding with their babies. The researcher was a student music therapist on placement at the facility, involved in weekly one-to-one sessions with a total of nineteen young women and their babies, over the time that each was resident at the facility. The music therapist also ran some weekly group sessions (mothers with babies) as part of the facility's mandatory education programme. The music therapy programme took place over twenty-two weeks, with a two week break after the first ten weeks. The research analysis commenced on completion of the programme.

Thematic analysis was used to look at two types of data; data from the placement (including clinical notes and personal reflective journal), and literature on attachment theory. There was an initial review of selected literature on attachment theory and music therapy. The researcher/student music therapist then carried out an inductive qualitative secondary analysis of the data that had been generated as a standard part of her practice over the period of the student placement. This was followed by a further examination of attachment theory literature to confirm key aspects of the theory. The findings from the inductive analysis were then looked at in the light of those identified key features of attachment theory.

The research findings showed many strong links between key concepts of attachment theory, and the patterns that emerged from the placement data, manifesting on a number of different levels. However some patterns might be more usefully explained and/or elucidated by other theories.

Findings suggested that attachment theory provided a useful framework and language for observing and understanding the interactive behaviours and external and personal structures that appeared to work for or against mother-infant bonding. In addition, the music therapy programme seemed a particularly suitable vehicle for promoting positive mother-infant bonding. However it was found that although the music therapy programme may have been helpful in a positive mother-infant bonding process, there was no evidence to suggest that this would necessarily extend to promoting a secure attachment relationship, given the personal, structural and legal factors associated with the high 'at-risk' context.

An attachment-based music therapy programme may well have a more useful role to play in a lower risk context where mothers and babies remained for longer in the facility, and where the programme could continue throughout the women's transition into the community and beyond.

Acknowledgments

Ethics statement

Ethics approval: Ethics approval for a secondary analysis had already been provided by the Massey University Human Ethics Committee, for music therapy students in 2013 (MUHEC 11/41). Informed consent for a secondary analysis research project was secured as part of the student placement negotiated between the New Zealand School of Music and the placement facility. Further consent was secured from the manager of the facility for this particular project.

Music therapist/researcher background: I have a background that aligns well with this research project. I am a mature student, with qualifications and extensive experience in areas of music, family and workplace mediation, teaching, and support and advocacy in the health and disability and family violence sectors. This gave me a sound understanding of the dilemmas inherent in a context requiring awareness of safety issues, and the frequently conflicting and competing values of safety and support.

Ethical issues: Given the extremely sensitive context of the student music therapy placement, including the involvement of vulnerable adults and children, particular care needed to be taken with research boundaries. There were significant risks associated with privacy (for instance, easy identification of the facility, given its distinctive purpose), with anonymity (where residents may be at risk if identified by members of the public) and with security of data (potential legal as well as ethical implications). In the light of these, every care has been taken to ensure the anonymity, safety and well-being of the mothers and babies throughout the period of research and in this report (as was taken during the clinical practice period). This includes the following;

The use of pseudonyms and removal of identifying features of mothers and their babies;

Minimisation of the possibility of the facility and/or its staff, or my placement supervisors, being identified;

Extra care taken with use and storage of data;

Further consultation with the NZSM supervisors, and with the facility managers about the appropriate levels of dissemination of the final research, once completed;

Ensuring on the placement that I avoided guiding, directing or setting up structures for the specific purpose of generating data on attachment at the expense of the safety of my clinical practice and my clients.

No deception was used at any time in my research.

Research risks were ameliorated through ongoing consultation with the NZSM research advisor, and adherence to the ethical guidelines of the NZSM guidelines document and the Massey University Code of Ethical Conduct for research and teaching.

> *Slumber, slumber, O my darling baby,*
>
> *Gently rocked by mother's loving arms.*
>
> *Safely rest and softly slumber,*
>
> *And her love shall shelter you from harm.*

Chapter 1: Introduction

This project explored the relevance of attachment theory as it might apply to a music therapy programme set up and run within a residential service for 'at risk' mothers and their babies.

In February 2013 I began a full time student music therapy placement with a branch of a large social service agency in New Zealand, whose services focused on the needs and well-being of families. One of the family-based services provided a twenty four hour residential facility for identified 'at risk' young mothers and their babies, and as part of my placement, I was invited to conduct a music therapy programme working one-to-one with the women and babies in the facility home. It was this programme which became the focus for my subsequent research.

The programme involved weekly one-to-one sessions with a total of nineteen young women and their babies, over the time that each was resident at the facility. After I had worked at the facility for some weeks, I was also invited to lead five group music sessions (mothers with babies) as part of the facility's mandatory education programme.

The music therapy programme took place over twenty-two weeks, with a two week break in the middle. The clinical notes and my own journal notes from all of these sessions were used in the secondary analysis, which commenced on completion of the programme.

The music therapy programme context

As discussed further below (ch.4), understanding of the programme context is important as it had a significant impact on the research findings.

The music therapy programme was conducted in the residential facility, which was set up as a supported flatting situation. Mothers typically came to the home prior to having their babies, or not long after; thus I occasionally worked with the women while they were still pregnant. Mothers could remain in the home for up to a year.

Almost all of the young mothers were referred to the home by a statutory government organisation and had already been formally identified by that organisation as being 'at risk' (although theoretically mothers could also self-refer). Typically the mothers entered the facility at a point of extreme crisis, where they were already at risk of having their babies removed. In this sense, the facility was their 'last chance' to 'prove' that they could provide a sufficiently safe and suitable environment for their baby. The early background of such mothers themselves typically involved multiple and complex risk factors, including family violence, drug and alcohol abuse, mental illness, and associated traumas. Learning disabilities were also a factor for a proportion of the women. Thus I was working with two successive generations considered at 'high risk'.

In line with New Zealand legal and social service family violence priorities, child protection was the paramount principle of the service. Thus the facility had a dual role; to support the attachment process of the mothers with their babies (which was done through provision of a variety of supported living, education and therapeutic programmes), and at the same time to monitor and assess mothers' sufficient capacity to keep their babies safe. Babies could be legally removed ('uplifted'[1]) from their mother's care at any stage during their stay, if their baby was considered to be sufficiently 'at risk'. Formal structures were in place for making this decision, with a first assessment being made at eight weeks. Mothers themselves might also make the decision that they did not feel able or suited to be the primary carer of their child.

As the student music therapist/researcher delivering the programme, I was only involved in the first of the dual functions of the service; that is, to support the attachment process. I had no role in formal assessment of the women, and did not have access to their files or to any information about their background, apart from what they chose to tell me themselves. Neither did I feed back any information about the sessions to management.

This distancing from any risk assessment role was important for two principal reasons. First, it allowed me to come to the facility and be with the women without assumptions and judgments, allowing the music to provide the ground for a positive and humane relationship, and the development of trust between us. Without such trust the programme could not have operated. Second, to some extent it reduced (though did not remove) the tensions in my role arising from inherent conflict between the support and formal monitoring functions of the service.

The Research question

The positive value of mother-infant attachment was not only a key assumption and principle of the service (second only to child protection) but also mother-infant bonding was the specified central purpose of the music therapy programme (whether 'attachment' and 'bonding' meant one and the same thing, remained to be seen).

This attachment value underpinned the therapeutic and educational programmes offered, and also appeared to underpin the facility's and statutory decisions about whether the babies were sufficiently safe to remain in the primary care of their mother (that is implying that sufficiently secure attachment is a key protective factor for babies). It was therefore important for me professionally to understand the nature of the connections between attachment theory, safety and a therapeutic programme, in this high-risk context.

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[1] See Appendix 1.

From an initial literature search I found a small body of music therapy research (based on clinical programmes) had been carried out with pre-term and otherwise vulnerable infants, and with 'socially deprived' or unwell mothers, but I could find little that addressed a situation where the music therapist was working with two successive generations both identified by society as 'at risk'. I felt at the time that this was a key gap in the research (a revision of this view is noted below in ch.5).

Thus my research question emerged from professional necessity and interest, but also coincided with an apparent gap in the literature;

What was the relevance of attachment theory in a student's music therapy programme for 'at-risk' young mothers and their babies?'

Secondary questions were:

- What patterns and themes could be identified in the relationships and interactions in the music therapy programme, attachment related or otherwise?

- How were these made evident in the musical interactions?

Personal connection with the research

As well as relevant work experience, I had strong personal interest in issues of infant-mother attachment, stemming from the infant hospitalization of two of my own (now adult) children, and (by serendipity) the birth of my first grandchild during the period of the placement. I had some concerns about how that might impact on my work and my research. However I was aware that strong personal connections with the research context are appropriate in a qualitative study (Braun & Clarke, 2006, p.80) and that such connections might provide useful insights and extra rich layers of research data (Wheeler, 2005, p.131). Appropriate safety structures and self inquiry during the placement (especially strong ongoing supervision and the use of a personal reflective journal) and the use of an ongoing reflexive process in the subsequent research period also enabled me to step further back from, and understand, my personal involvement in the data.

The music therapy programme

The programme developed as an 'optional' and voluntary extra to the women's daily mandated education and support programmes. Women could theoretically choose whether to attend the one-to-one sessions, though in reality there was considerable pressure to attend.

The programme was set up for weekly private music therapy sessions with each woman and her baby (sometimes I worked just with the mother, if the baby was asleep or ill). In practice, sessions were often less frequent, as external meetings and other crises as well as mothers' disposition and/or resistance often meant the session I had arrived for did not take place. Sometimes when I arrived for a session the baby had been 'uplifted' and the mother had left the home (for obvious safety reasons, no notice could be given within the facility when this was impending).

These individual sessions were structured according to each mother's and baby's preferences and needs. In my approach I leaned heavily on clinical ideas from family- centred music therapy programmes for children and mothers (Shoemark & Dearn, 2008; Nicholson et al, 2008; Bargiel, 2004; Pasiali, 2012) and infant-directed work[2] (de L'Etoile, 2006, 2012; Shoemark, 2008). Typical sessions involved both talking and music; sharing lullabies and play songs and rhythm games, sound and movement improvising, and for some, song writing and basic instrumental skills.

I also completed five group sessions in the mandated education and support programme. This had a more educational focus, and was an opportunity for fun group sharing of musical experiences with the babies, and sharing of music resources and ideas for mother-infant bonding.

Clinical notes from both individual and group sessions provided the major portion of data for the research.

Report structure

This report closely follows the steps taken in the research process. It begins with an initial broad literature review, outlines the methodology and methods used, then presents the findings from the three phases of the research; (i) from the clinical data analysis (ii) from revisiting the attachment literature, and (iii) from revisiting the clinical data findings in the light of the attachment literature findings. This is followed by discussion of those findings, and brief

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[2] See Appendix 1.

conclusions. The Appendices include a list of the pseudonyms of the mothers and their babies, a glossary of terms and some samples of data for the interest of the reader.

Chapter 2: Literature review

Attachment theory emerged in the 1940's and 50's from the psychoanalytical world, in which a number of clinical psychologists and psychoanalysts working in institutions had separately noticed the patterns of extreme distress experienced by children who were separated suddenly from their mothers, or who had a variety of change of primary carers in their first year of life. The theory was formally developed first by John Bowlby (as first presented in a UN paper on maternal mental health, 1951), drawing on concepts of ethology, cybernetics, information processing, developmental psychology and psychoanalysis (Bretherton, 1992). Bowlby continued to develop and explore the theory in his clinical practice observations and later writings (de l'Etoile 2006; Bergin, 2009), and colleague Mary Ainsworth's significant empirical research backed up his findings (Bergin, 2009; Bretherton, 1992; de l'Etoile 2006).

The literature shows that attachment theory has maintained a central place in developmental psychology theory and practice (Erdman & Caffery, 2000). Bowlby was consistently willing to adapt his theories over a lifetime (Tizard, 2009, p.1) in the light of his own ability to reflect and achieve new learnings; as a result his theories have become integrated widely into many clinical and social contexts(Erdman and Caffery, 2000; Zeanah et al, 2011, p.830).

In simple terms, attachment theory holds that every infant has a physiological and psychological need for a secure primary relationship with a caregiver, usually the mother. The security of such a relationship is believed to develop from the mother's ability to notice and 'read' the baby's cues and needs, and to respond appropriately and sensitively (Goldsmith, 2010; Forough, Mirisse & Muller, 2012), thus setting up a cycle of reciprocal positive interaction. Such secure attachment is held to be crucial not only to the neurological development of the child but also to the child's ability to regulate emotion (Bergin, 2009; Shoemark, 2008), to explore her physical and social environment from a secure base (Forough et al, 2012), and to form positive and secure relationships with others later in life (Goldsmith, 2010, p.5). Thus attachment focuses on the infant-mother (or infant-primary caregiver) dyad as the primary relationship that sets the pattern for interactions later in life (Meyer, Wood & Stanley, 2013).

Early attachment theory is considered to have been strongly influenced by neurobiological science (Crittenden & Dallos, 2009). Bowlby's original theories about the developing infant brain hypothesized connections between parts of the brain that dealt with fear, care-giving and attachment, and held that undeveloped parts of the infant brain in the very early months post-partum were developed and 'wired' through reciprocal interactions with the mother as the baby learnt survival strategies to keep the mother proximate (Goldsmith, 2010). Although recent neurological research has since revised understandings of the functions of different

parts of the brain (in particular new information shows that fear, attachment and caregiving are centred in separate parts of the brain), it appears to continue to support Bowlby's theories about the interaction between the three (Goldsmith, 2010).

Attachment theory, with its interest in dyad relationships in the family has always had a strong link with systems theory (Marvin, R., in Erdman & Caffery, 2000; Crittenden & Dallos, 2009; Meyer, Wood & Stanley, 2013) and with family therapy (Pasiali, 2012; Crittenden & Dallos, 2009). Attachment theory's continuing links to family therapy, systems theory and neurobiology have led to some interesting contemporary theory that seeks to integrate these theories (for example Crittenden and Dallos' proposal to integrate attachment and systems theory into family therapy, recognising the special contributions of each (Crittenden & Dallos, 2009) and Meyer, Wood & Stanley's discussion on the integration of brain development, systems theory and attachment theory (Meyer et al, 2013)).

As with all theories, there have been further developments, some of which are competing (see further discussion in section 4.2 below). However of special interest for a therapeutic programme in a 'high risk' context, are the attachment based therapeutic interventions[3] in a context of trauma (Bergin & Bergin, 2009; Forough et al, 2012), and more specifically inter-generational transmission of trauma (e.g. Mohler, Resch, Cierpka & Cierpka, 2001). Such research relates in particular to effects of disruption to attachment, and interventions that might repair such disruption.

One such piece of research is Suchman et al's (2010) study on a randomized pilot programme of attachment based individual parenting therapy for mother and toddlers, where the mothers are also enrolled in a substance abuse programme; that is, substance abuse is identified as a primary risk factor for the children's attachment. Preliminary findings support the effectiveness of an attachment-based intervention, in contrast to traditional parent training, in this context.

An even more complex 'high risk' context with many-layered risk factors is examined in Byrne, Goshin and Joestl's 2010 large intervention study of intergenerational transmission of attachment for children raised in a prison nursery; a significant finding of this study is that with effective interventions, mothers with insecure attachment can raise infants with secure attachment.

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[3] See Appendix 1

Attachment theory and music therapy with mothers and infants

Attachment theory emerged from robust observation of interactions between mother and infant. A music therapy programme appears an ideal framework for observation of the interactions in the mother-infant dyad, so it is no surprise that there is a growing body of music therapy work in areas where attachment is of primary concern. Much of this research emerges from the analysis and evaluation of clinical music therapy programmes. Many such programmes have been set up to address an implied or explicit element of 'risk', with the 'risk' element explicitly linked to the mother-child bond.

Some of these programmes have a wide scope, with attachment risk factors best described as environmental or social. For example Nicholson et al (2008) use a rigorous multi method approach to evaluate the effectiveness of the 10 week Sing and Grow group music therapy programme (delivered originally by 17 clinicians) for socially 'marginalised parents' and their under-5 children. The programme focused on communication between parent and child to improve the attachment relationship and the child's wider social engagement; its outcomes were largely positive, including that the programme was 'highly acceptable to the types of parents who fail to attend traditional parenting interventions'.[4] Abad and Williams (2007, 2008) continue to provide ongoing evaluation of this same wide-reaching and repeated programme, feeding into continuous improvement of the programme.

Another Australian example is MacKinlay & Baker's study (2005) of a 'Sing, Soothe Sleep' lullaby program, which was aimed at increasing first time mothers' pleasure and confidence in their relationship with their babies.

A significant body of research focuses on music therapy programmes where the attachment 'at risk' factor is primarily associated with the child. Some programmes (such as McLaughlin's observational case study of mothers and their children with 'special needs' (2009)) involve young children. However the majority of the research involves programmes for mothers and infants, often with premature and/or hospitalized infants. This research includes Shoemark's study of infant-directed singing for medically fragile infants (Shoemark, 2008), Cevasco's study involving pre-term mothers and their infants (Cevasco, 2008), and Barcellos' research with premature babies using music as a 'holding' environment to allow attachment to happen (Barcellos, 2006). All of these studies report positive outcomes in their use of music therapy, particularly through building parental confidence in interacting with their infant, especially through singing.

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[4] It did, however, identify that the model fell short in terms of cultural inclusiveness.

A very helpful overview of the theory and evidence underlying the development of mother/infant attachment and music's potential place in that process is offered by Bargiel (2002). Bargiel also proposes an early intervention music therapy model that utilises parental singing, for the baby whose attachment is at risk. This detailed significant model covers purpose, content and assessment, and is rigorous in its theoretical justification for every step.

There are other studies where the clinical music therapy programme sets out to address an 'at-risk' attachment factor that is more explicitly associated with the mother. For example in de L'Etoile's series of studies around the use of infant-directed singing for at-risk mother-infant pairs, the 'at-risk' factor is identified as the mother's depression (de L'Etoile, 2006, 2012; de l'Etoile & Leider,2011). These studies suggest strong links between a depressed maternal interaction style, and poor self regulation in the child; de l'Etoile also finds that infant directed singing (through parental coaching) plays a critical role in self-regulation and gives mothers a meaningful way to contribute to caregiving (de l'Etoile, 2012, p.364).

In Pasiali's research (2012), maternal depression is similarly the identified risk factor, though this is a much smaller study; a detailed but thorough cross-case analysis of music therapy work with just a few families where the mother is experiencing maternal depression. The therapeutic work focuses on helping parent and child learn to better respond to and interpret each other's verbal and non-verbal signals; what Pasiali describes as 'mutually responsive orientation'(MRO).

Although not primary research studies, there are two resources that are particularly useful in gaining a broad overview of programmes and research into the use of music therapy to promote bonding and/or attachment. First, Creighton's (2011) significant literature review highlights a wide range of research programmes that investigate attachment-related concepts such as attunement, infant-directed speech and emotional regulation in a music therapy context. Some of this research is specifically devoted to the infant-mother dyad. And second, Edward's (2011) edited compilation of the writings of those carrying out research and clinical practice in this area, offers a positive advocacy for the successes and continuation of the work.

Despite the above range of studies, an initial literature search was not able to find any studies that looked specifically at music therapy working with two generational levels where both are identified as 'high risk' – that is, working with 'at risk' mothers' own attachment issues, as well as those of their babies, where the babies are formally identified as 'at risk' *primarily* because of the status of their mothers. In addition in the evaluations of clinical programmes, there was little discussion in the literature of the impact of the music therapist's presence (as a 'third') on the mother-infant dyad, and on the therapeutic dynamics, with respect to attachment in a 'high risk' context.

These apparent gaps in the research offered an opportunity to look at the usefulness of attachment theory in a context such as this music therapy placement, where an attachment approach was a 'given', and where help appeared to be needed to repair and construct capacity for bonding and/or attachment on *both* infant and mother levels (although as can be seen in the discussion below, I later revised my view of the importance of this distinction).

Chapter 3: Methodology and methods

3.1 Methodology

The research was a qualitative secondary analysis; a methodology for conducting a free-standing study 'using pre-existing data originally collected for other purposes'(Heaton, 2004). It sought to identify patterns in the clinical data, and in the selected theory, through the iterative and recursive process of thematic analysis (Alasutari, Bickman & Brannen, 2008, p.218; Braun & Clarke, 2006, p.86).

Qualitative research has as its goal the 'discovery of meaning' and the researcher 'is the primary instrument of the research' (Abrams in Wheeler, 2005, p.247). In this context, I sought to discover the 'meaning' of attachment theory as historically espoused by therapy practitioners and theorists, and to further find out what attachment theory might 'mean' in the context of my music therapy practice in this placement. I recognized that as an embedded researcher I would be the source and filter of most of my data, and the discovery of meaning in my research would be constructed through a process of personal involvement and engagement (Wheeler & Kenny, in Wheeler, 2005, p.65) framed by my own cultural background and values. The significance of this could not be underestimated given that this particular context, being so focused on birth, mothering and vulnerable mothers and babies, would inevitably trigger my own responses and biases, and that both the identification and analysis of my findings, would be made through the strong lens of my own values and life experiences. I had already used a reflective journal which had given the opportunity to explore the nature of the data, and my own personal reaction to it. However within the actual subsequent research analysis process, I also needed to ensure *reflexivity*, a process of consistent self-inquiry and disclosure (Wheeler, 2005, p.247), in peer discussion and consultation with my research supervisor and others. To this end I kept a second journal to record personal thoughts and reactions as they arose during the research process (Bruscia, 2005), helping ensure that I took 'ownership and responsibility' for my 'perspectives, assumptions, motives, values and interests'(Wheeler, 2005, p.246).

Finally, triangulation of data through the use of multiple data sources - observational notes, theory, personal narratives, and songs - allowed examination of the 'degree to which each source confirms, elaborates and disconfirms' (Alasutari et al, 2008, p.222) the developing meanings that emerged from the analysis and the reflexive process. Again, given the embedded nature of my role as both researcher and student music therapist, and that I myself was the major source of data, triangulation of the data sources was crucial in providing important checks on my findings.

3.2 Methods

Although I had carried out an initial literature search prior to starting the placement, I did not begin the research analysis until full completion of the music therapy programme. Ethical considerations were important in both data gathering and analysis stages of the research; these are outlined above on p.6.

3.2.1 The data

Data was gathered from the following sources;

- Selected attachment theory (original sources from key early theorists, later seminal reviews, as well as selected journal literature from 2005, showing contemporary developments and discourses);

- Ongoing clinical notes recorded as part of my day-to-day music therapy practice, as available to the facility;

- Personal notes taken from my supervision sessions;

- My ongoing reflective journal, recording my personal observations, responses, reflections and interpretations and personal creative work throughout the programme;

- Songs used in my work in the music therapy programme;

- Written policies and procedures provided by the facility.

3.2.2   The analysis

The following steps were taken in the research analysis; (i) A thematic inductive analysis of the data from the placement (ii) A closer analysis of attachment theory literature, identifying key principles and developments (iii) A further deductive and inductive analysis of the findings from (i) in the light of the key concepts of attachment theory identified in (ii).

The basic analysis steps were linear, though in reality the process became more of an iterative, spiral process, with cross-checking and moving backwards and forwards between the clinical and theoretical data (Braun & Clarke, 2006). However a basic linear approach helped ensure that the initial inductive analysis was completed with minimal attachment-theory bias, so that patterns not obviously related to attachment theory should also have the opportunity to emerge and be given weight. Clearly however, some initial knowledge and ongoing reflection on theories of mother-infant bonding was needed to be able to be ethical and effective in my placement, and there was an inevitable bias towards issues of 'bonding' in the clinical data itself.

3.2.2 (i)

The thematic analysis of the clinical data was inductive; that is, although I had already carried out an initial literature search centered on attachment theory, I attempted to approach the data without existing attachment-related assumptions, and simply sought to identify any significant-seeming patterns and issues that emerged from the data. An inductive process looks at the data 'with an open mind' (Rickson, 2011, p.1), allowing 'meaning' to emerge from the data itself. In seeking such patterns, I used the entire set of data (Braun & Clarke, 2006, p.83).

I first read quickly through the data, annotating thoughts, ideas and connections to develop a set of analytic memos. I then went back to the data, working slowly and in detail, seeking patterns both within and across the data pertaining to each woman and baby. I used an iterative process, more clearly developing and re-defining the emerging themes as I went along, then grouping these according to larger themes, categories and finally large codes (Amir in Wheeler, 2005, p.366).

 3.2.2 (ii)

In this step, I returned to take a more focused look at attachment theory itself. I used open coding to identify and 'define' as succinctly as possible core aspects of attachment theory as well as any key subsequent and current developments and debates since then. This analysis was explicit – that is, not seeking to interpret in any way (Braun & Clarke, 2006). This process provided me with a further set of themes (Wheeler, 2005, p.366) for the next step of the analysis.

3.2.2 (iii)

In this final step, I reviewed findings from the first stage of the analysis, in the light of the attachment theory, looking for connections, as well as for what might be different and/or contradictory. In this way, I hoped to gain a sense of the relevance or otherwise of attachment theory principles to the work that had been done in the music therapy programme.

Chapter 4: Findings

Findings from the research are presented below in the general sequence in which I carried out the steps of the analysis.

To assist in preserving anonymity, all women and babies referred to in this text have been given pseudonyms, and reference numbers provide a session number rather than a date. Examples from the clinical notes are referenced with a mother's name, the baby's name if present during the session, and the session number of the clinical note (e.g. Anna & Ria: 6). Examples from the journal are referenced with the date of journal entry (e.g. J: 5 June).

4.1 Findings from the inductive analysis of the clinical data and journal notes

These findings are from my clinical records of working with 19 women and their babies (in five cases the fathers were also sometimes present too), and my journal and supervision notes from the placement.

The identification of these patterns emerged from the narratives of each therapeutic relationship at the placement, within my role as music therapist. In some cases, where women spent only a short time in the facility, that relationship might be very brief, sometimes just one session. Others where the relationship was longer provided more data and perhaps better ground for noticing emerging and ongoing patterns. However I felt the strength of this research lay in capturing what was happening with all of the women, and I have valued all equally in the findings.

In organising these findings, I initially tried to distinguish between non-musical and musical aspects and patterns. However I quickly noticed how inextricably interwoven these two areas were; findings are therefore presented below in an integrated way, reflecting the inevitable weaving and integration of musical and non-musical elements within the sessions.

Identified patterns relate primarily to four important areas; first, issues of identity and 'personhood' that the young women brought to their relationship with their babies; secondly, the observed dynamic interactions primarily between mothers and their babies, but also with and between the mothers, the facility, the music therapist, and the music programme; third, the role of the music therapist as 'third' in the therapeutic relationship, and finally the wider context within which these issues of identity and interaction sat, and which impacted on all other areas.

4.1.1 Identity

Significant patterns emerged relating to identity, for both the mothers and their babies. 'Identity' is referred to here in its widest sense, including the women's sense of self and self-efficacy, the 'self' that they presented in the music therapy sessions and with their peers, their understanding of their baby's 'self', the life stories and experiences that had built towards forming and shaping their identities, and their visioning of themselves and their babies in the future.

Experiencing self efficacy and autonomy

Self efficacy can be described as the belief that the self can be effective. A majority of the mothers I worked with displayed a low and/or fluctuating level of self efficacy in the sessions, which often seemed independent of the 'bigger picture' of what was happening in their lives.

These mothers seemed to struggle to make simple choices in small things and appeared unused to making choices, or reflecting on what choices might be available to them (an exception was their certainty about their musical preferences). The music therapy programme seemed to be useful in helping them practise making autonomous choices on many levels, and becoming comfortable with that.

Low self efficacy affected confidence levels, evident in the mothers' general low confidence in handling their babies, and in making music in both the one-to-one and group sessions. Low confidence levels were reflected in the mothers' general reluctance to use their own voices, even in response to their baby's vocalizing. Some mothers needed strong support to vocalize at all. Two were never able (or willing) to do so in front of me.

Jody came in with Tracey, who was alert and lively. The MT started to sing the Hello song. Tracey responded with a big smile and started making small sounds. MT - 'Tracey's talking!' Jody - 'She likes all music'. 'Shall we sing it again then together? Jody's eyes downcast. She held Tracey close to her. Didn't talk, make any noise (Jody & Tracey: 1)

I won't sing. I can't sing (Amber& Katherine: 1).

Time was needed to build rapport and trust in the therapeutic relationship, in order to develop the women's self-efficacy, autonomy and confidence. Of the women who were able to stay longer in the programme, some who started in silence began to talk and hum to their babies (Esther), others became willing to try singing (Marney), especially if supported with my voice and strong rhythmic guitar strum (Letitia). Within and throughout the programme sessions, the use of pitch and steady beat became more consistent. Alongside the women, I grew more

confident in my own use of these elements and of my own voice, and this seemed to add to the mothers' confidence in spontaneous vocalizing with, and in response to, their babies.

In contrast to the majority, a small number of the mothers appeared to have a very strong sense of self, and self-efficacy. They were usually willing to vocalize and improvise, and took pleasure in creative song writing:

MT played back L's rap from last week. L. had big smile. 'I love it!' 'Is there anything you want changed?' 'No, not a thing, it's perfect!' Sang together 5 times. L. sang loudly on the choruses. Very happy when she left. (Letitia: 7).

This group were sensitive to being controlled (*I don't like being told what to do*: Jacinda: 1), appeared to have a high sense of entitlement and were overtly vocal about their situation in the facility (*They've all lied:* Marney: 10). They sometimes appeared quite rigid. They appeared to have considerable power (both negative and positive) in the peer group and the facility, and when they were present in the group music sessions, appeared to be trying at times to destabilize the positive feel of the group. Others expressed fear or dislike of these mothers, as well as admiration.

Journal findings show that with this second group, my own sense of self felt threatened at times. What was intended to be a helpful 'client-centred' session sometimes ended up with my feeling controlled and ineffectual.

[In the group during opening song] *Challenge from Sharee – blocking me visually with her cell phone. 'I'd have to be mental to want to be doing singing with some woman' …I'm trying to laugh about it but there's something there that hits at the core…*(Journal: 25 June).

I felt with these women that my low-key approach sometimes invited a kind of behavior of contempt, and recognizing and working with that kind of defense, and with its flip side of shame, was a challenge without feeling denigrated or ashamed about my work. As the placement developed I learnt to work in a more tightly structured and vital way with this group, allowing myself to be more directive and overtly energetic in the music. This often resulted in high levels of mutual enjoyment, as with Letitia above.

For women in both groups, shame seemed to be an underlying presence in the sessions, ever ready to trigger and/or compound a loss of confidence. A positive intervention by a perceived competent (or powerful?) 'other' (myself, or the woman's partner) typically resulted in a visible draining of confidence in the mother. The majority group of women tended to respond with both physical and emotional withdrawal, thus reinforcing an uncomfortably powerful music therapist-infant dyad:

K. said she didn't want music. Changing Lily on couch. Lily crying loudly. MT held Lily's hand and sang Hello song strongly. Then softly. Lily 'stilled', quieted, almost immediately, eyes half closed. MT drew K's attention to effect of music. K. nodded, but looked embarrassed as if she had been shown up. MT stayed with them until nappy change finished. MT Re-offered music. K declined.

Modeling had hitherto seemed an important role of the music therapist in this kind of context, but turned out to be, on the whole, disempowering, and not a useful strategy. If I modeled a technique and the baby responded positively, it might cause pleasure on one level, but inevitably also seemed not only to decrease the mother's sense of her own competence but also to increase her shame. In particular, having someone else model how lullaby singing could put their baby to sleep, seemed to strike at the essence of what being a mother meant to them. I stopped doing so early in the placement.

Bringing into being

'Ghosts in the nursery'[5]

The quote above poignantly captures for me what I experienced as a state of 'absence' in a small number of the mothers. In my session notes I often struggled to describe this. Sometimes it seemed that the mother entered the room as an apparition, which then occasionally could be 'brought into being' through music, only to disappear between one session and the next. I felt these mothers were somehow disconnected at a deep level, or perhaps even in a state of dissociation:

[Esther is] *Reserved and shy, and like an unactivated sweet person – seems disconnected from babe and looks down at her in her arms as if she's not sure how she got there.* (J: 20 May)

Esther sat quietly in a corner (the same corner) of the lounge suite. Like a wee ghost. (J: 3 June).

Such women were all pleasant, and usually appeared to enjoy the sessions, but seldom were they able to remember anything we had done in previous sessions. I wondered whether this was about emotional rather than cognitive issues, and might be related to numbness and/or dissociation as a result of trauma.

This same small group of women also appeared to be physically and emotionally distanced from their baby, and needed strong encouragement to touch or hold their babies, during our shared music:

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[5] A term used for 'a caregiver's unresolved traumatic events that come out of their own attachment system, which in turn affect their caregiving system'. (Erdman&Caffery, 2000, p.315).

Lena seemed quite separate from her baby….I encouraged her to touch Rowan while we sang. She held his hand awkwardly. Rowan fell asleep. I passed Rowan to her. She held him loosely, away from her body…she looked astonished that he slept (Lena & Rowan, 1).

When their babies did respond to being touched or held, or initiated an interaction, the mothers might initially seem intrigued and pleased, but would often soon hasten to 'pass the baby over' or leave the session. I wondered if the interaction was too intense for them, or whether the prospect of attaching to someone then losing them, unbearable.

I experienced a strong interesting parallel process in working with these women. I found that if I was not immediately able to write up their clinical notes, I typically lost complete recall of anything we had done in the session, sometimes permanently, despite the fact that many of these sessions seemed meaningful and productive (Journal:22 June). I had to work hard to 'reconnect' my own memory pathways. I did not find I had this problem with any of the other women.

It is noted that all of the women in this sub-group had their babies removed from care while they were in the facility.

Connecting with the past

This theme relates to how the women perceived and talked about themselves in the past, and in particular their past relationship with music.

For all of the women, music seemed to be an important part of their current identity in the present, and a way of connecting with their peers, and of soothing themselves. Most had strong expressed preferences for particular musical styles and songs. However, only a small group of women could tell me about any memories of music from their childhoods. This group sometimes vocalized and sang spontaneously to their babies, and all identified themselves as a possible source of music for their baby. Almost always they were able to connect specific songs with a memory of a parent (*This is one of my very favourites. My mother used to sing this.* Maia: 3. *That song. My Dad used to sing that to me:* Janice & Emma: 2*).*The songs were recalled with nostalgia, even in the cases where they also disclosed the same parent as a source of abuse. All but one also had older children with whom they had built a strong early relationship through song. This small group strongly identified themselves with positive memories of music in their past, including particular children's songs that were an important positive part of a childhood relationship, and/or with their older children.

A second, and much larger group, claimed to have no memory at all of any early musical life, and no memory of any songs ever being sung to them. Even common early children's songs

(such as 'Twinkle Twinkle') appeared unfamiliar to them. Working with them felt sometimes like working with a 'blank' slate:

MT – 'Is there a song you like?' E. couldn't think of any. 'Maybe someone sung to you?' "I didn't hear songs when I was little. Nobody sang songs to me.' (Erena & Zak: 2).

Looking at the responses of each of these groups to the music therapy programme, it seemed that for those who had strong musical pasts, and the ability to remember and reflect, the music was an important way in which the women had been able to accumulate a sense of positive identity, despite the tragedies experienced in their lives.

Picturing the future

For most of the women, it seemed that picturing themselves in the future in any way at all was very difficult, and picturing themselves (as a parent) with their babies was even more so. More specifically, picturing themselves making music beyond the programme was difficult (except for the particular group identified above who had already had strong musical memories). Only six of the women saw themselves as doing music with their babies beyond the programme, and these were the women who asked for some musical skills and resources.

When I get home I'll definitely want to get a guitar. I need to know all the chords. My aunty will be so surprised that I've learnt the guitar when I'm in here! (Jess & Christie: 3).

Notably, the facility policy observed that helping the women to visualize themselves in the future was a key goal. It seemed that music therapy might have an important role in helping the women both connect with their own past selves through music, but also that music could help build an accumulated 'self' and that they could carry theirs and their baby's music out into the community.

Finding significance in the songs

As seen above, some songs used in the programme were significant for some women because of their prior associations. Women were frequently excited to find we could together reproduce a favourite song, and in general, they appeared to express and/or develop a strong sense of identity through their significant songs.

However most of the songs we used were new to the women, and I was surprised how much a few songs accumulated significance throughout the programme, as they became more familiar. I had expected that I would focus on adapting portions of the women's preferred listening music (mainly hip hop, R & B and country) to create lullabies and play songs for their babies. However all the women specifically requested for me to bring baby songs, especially lullabies. I

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felt that they were proud that they could learn a mother's song, and could identify themselves as a mother. Being able to sing their baby to sleep seemed symbolic for them of what a 'good' mother could do.

Some songs became significant for all, and seemed to contribute to a sense of group identity, as well as favoured individually (see Appendix 4).

Resourcing

Apart from a small group, the women were resource poor when it came to knowledge of baby and children's songs. And apart from one woman, none had instruments or instrumental skills. Two had experience in kapa haka groups, but could not remember songs from there.

I was surprised at their hunger for special songs for infants. They often asked for the words of the songs, and many seemed disproportionately overcome when I made them scrapbooks of the words of their preferred songs when I finished the placement:

Dropped off scrapbook for L. L. near office. Expressed delight. Big smile. Leafed through. Showed to staff. Pointed out her own song and started singing it. (Letita & Amber: 8).

It seemed to me that in offering some music resources and some skills mastery, music therapy was able to provide the mothers with another way in which they could build not just their confidence and self efficacy, but also to have something to carry out into the community when they left the facility.

Identifying with ethnic culture

Culture had a stronger part to play than I initially expected, in the women's expression of identity through song preference.

Women's ethnic connections seemed important, but in an unpredictable way. As a normal part of my music therapy practice, I brought Maori, Samoan, and a few lullabies of other ethnicities to the sessions. Some of the women identified as Maori, but for only one was that identification a positive one. However a number of non-Maori women said their babies had Maori fathers, and they were keen to learn waiata for their babies. Three other women were excited when we learnt lullabies from their own ethnic heritage. I persevered with bringing little waiata and other non-English lullabies into the group sessions, and at the end when choosing songs for their scrapbooks, all women without exception chose to include those songs. Music therapy therefore seemed helpful in helping women value their own and other ethnic identities.

Being in the peer group

The influence of peers was evident throughout the programmes, in both its positive and negative aspects. The young age of the mothers (under twenty-five, and many still in their teens) no doubt contributed to this, as well as the shared-house context.

Findings showed that the women cared greatly about how they were perceived as a mother, by the other women in the house. They did not like being shown up in front of their peers and needed to be seen to be coping, so were often resistant to advice and help (*I don't need to be here. I'm a good mother.* Amber & Katherine: 1).

Some were very comfortable in a group context, and participated much more strongly in the group music therapy sessions than the one-to-one sessions. However, the group context also was an inhibitor for others, especially those who already struggled with confidence and identity issues. The peer group could support, but it could also shame and intimidate. The changing make-up of the group, as people left and joined the facility, meant that hierarchies of power were always being re-established – and lack of group stability often seemed a barrier to positive relationships between the women.

For some women (especially those who were strongly assertive) controlling others appeared to be an ongoing strategy for developing their own sense of self and identity. Strategies included overt moves to intimidate other women, such as using derogatory nicknames for other babies, competitive dressing up of their babies (*power dressing*, J: 22 June) as well as attempts to control the music therapy timetable and the music therapist. For the women who were less assertive, their own safety was secured by such 'services' as lending baby clothes, and taking phone messages for others.

Some of the mothers were still in relationships where partners appeared to have tight control over the mother. Such mothers appeared to give priority to their partner relationship, and asked for their partner to be at the individual sessions, but I often wondered whether I was doing the right thing in inviting fathers to be there (the mothers in all of these cases stopped singing and interacting with their babies when partners were present). My journal shows a very real conflict between my desire to maintain a family-systems approach to therapy, and the necessity to recognising the vulnerability of the women and babies. Adapting the processes in both one-to-one and group programmes to ensure safety and inclusion for all was an ongoing challenge.

Differentiating self from baby

Many of the women in the programme seemed to have difficulty in seeing their baby as a separate person with her/his own needs and wants and preferences, and this went hand in hand with an apparent low ability to empathise (with baby or peers).

For some, there was strong projection of their own selves and preferences onto the baby (*She's bored. We need to go.* Esther with newborn: 1). The baby's appearance seemed important as an extension of the mother; some mothers frequently dressed their babies up in 'grown-up clothes' (e.g. heavy new toddler shoes on an infant) and a 'designer' hairdo, expressed annoyance and distress if the baby 'spilled' on their own or the mother's clothes, and insisted on interrupting the music session to make a complete clothing change of self and baby.

Along with this was a pattern of idealizing and 'stereotyping' of the baby and its responses which seemed partially driven by commercial advertising (for example in the frequent use of the advertising brand '*cheeky monkey*').

Interestingly, the women who did show curiosity about the separate personality of their baby were the same ones who were able to engage, notice and respond, in their interactions with their baby, and were also able to provide lyrics for a song about their baby's special characteristics.

Music therapy seemed useful in supporting differentiation, in not only helping in noticing the baby's signals, but also as a platform for drawing attention to the baby's individuality. An infant-directed music therapy approach[6] helped in activating curiosity about the baby's individuality of responses and helping 'bring the baby' into its own identity in the eyes of the mother.

4.1.2 Interactions

It was probably inevitable, given my research question, that much of my focus in the data would be on interactions. However I was surprised by exactly how much. As I searched for the words to encapsulated the key themes, I noted that so many of them were 'doing' words – all dynamic, and that all of these aspects were very powerful in bringing about (or in some cases inhibiting), movement and change in the therapeutic process of each session and individual

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[6] see Appendix 1.

programme. They are discussed here in linear order, but there is no hierarchy of order; rather I imagined them as a mandala of overlapping circles.

Engaging

In the context, I can best describe 'engagement' as the initial interaction between two interfaces that implies a level of 'interlock' or mutual attention, that assumes or enables there to be some kind of ongoing relationship. Engaging was a challenge for the women and myself on a number of different and parallel levels in the context.

First, was the engagement of the mothers with the facility, and with the music therapy programme. Given the mandated nature of most of the women's presence in the facility, and the power imbalance dictated by the strong monitoring and assessment role of the facility, there appeared to be strong ambivalence about attending both facility and programme (*I already know it all. I do it all. There's no point.* Sharee & Lenny: Group 3). Many women initially appeared to be engaged on some level, but I often felt were 'going through the motions', some were overtly compliant superficially but still quietly avoided engagement (*No, she needs to go to bed, she's unsettled.* Karina & Lily: 4*)* and there was occasional active resistance from some (*I don't do music. I don't like music. I've got more important things to do.* Renee: 1). I frequently noted that engagement in the sessions had to happen anew each time, until they knew me much better and trusted my presence in the house, in my non-assessing role:

2 days of feeling there would always only be beginnings with the women…I will always be in the rapport-building phase…(J:24 March).

Today, didn't manage to engage with R. at all. Not willing to 'give an inch'. Although I didn't sense rudeness, just closed…sat more or less mute until I said it was fine for her to go. Seemed to understand when I talked about confidentiality. I said she seemed upset. Said she was upset. Might be ok next time. (J:8 March).

My…connection with R. not happening - disjoint, hostility, suspicion…seemed triumphant (smile) afterwards. I want to take her a song that touches her. Something dark. (J, 9 March).

Alongside the above, was the difficulty mothers seemed to have with engaging with their babies in the music sessions, even when their babies were putting out strong signals of wanting to engage with them. They seemed to lack a desire or instinct to be face-to-face with their babies, and I habitually had to encourage them to turn the baby face towards them, so there could be eye contact (they typically held their babies on their knee, facing outwards). Mothers found it particularly difficult to comfort their babies physically when the baby was very distressed; they often became highly anxious:

MT came to offer a music session. Tammy declined. Pita crying hard, on back on mat. Tammy held against her shoulder – 'he needs to burp'. P. settled. She put him back on floor. P became distressed. T. picked him up, jigged him then put on back on floor, no touching. MT suggested maybe we could sing to him while T. held him, to calm him. T. declined. P. distressed, crying, 'urgent' focus on T. T. looking at him, not touching. (Tammy & Pita: 4).

I found that the high levels of anxiety in the women inhibited their engagement with their babies, with myself, and with the music. Reducing anxiety by ensuring a voluntary and low-key but encouraging framework for the sessions, one of just 'trying out' some music together, became a strong focus. As I became more confident and accepted the 'in- the-moment' and sometimes one-off nature of the sessions, I learnt better to use music to engage rather than conversation.

Sustaining/maintaining

This set of observations concerned the challenge of sustaining 'being there' – myself and the women in the service, the women in the room, all of us in the music; maintaining interaction, once initiated.

Mothers often found it difficult to sustain memory of songs, skills, simple actions that might go with the songs. It was also often a challenge to sustain a mother's engagement with her baby 'in the music' (*Esther made a small sound. Laughed. Jae still intent and responsive. Esther hurriedly closed session – 'I need to go'.*Esther & Jae:3). The mothers often seemed to 'zone in and out' like connecting and disconnecting circuits (*Anna was lively, making sounds, and smiling at the tambourine. Ria started looking at a book, and asked for copies of songs.* Ria & Anna:2).

I felt that fluctuations in connectedness were at different times and in different women related to levels of anxiety, physiological states including chemical influence, strongly variable emotional states, as well as what was happening with peers and staff in the wider house dynamics. Trying to discern the typically changing and fluctuating environment for each woman was an ever-present challenge for myself and also for all in the facility:

With Jacinda it feels like she's spinning round and round in the world…but they're holding her firm…she wants so much to succeed…maybe, if they can hold on to her long enough (J: 22 June).

To support mothers to stay connected in the programme, I found on a practical level I needed to simplify everything, reducing the amount of material we worked with, and increasing repetition. I also found that consistently giving authentic positive feedback and reflecting back narrative 'stories' of what the mothers and babies had already done together, helped greatly in

reinforcing the women's confidence in their memory and helped build a store of mother-infant memories that they could draw on and add to.

On a more psychological level, my 'being there' – turning up for every sessions, and on time, whether the women were available or not, came to feel crucial to me in engendering the women's trust in my commitment; my journal shows I became almost obsessive about that. However, sustaining the relationship always remained fragile; if a woman discovered she was about to leave the facility, with or without her baby, even if it seemed to me that we had developed a significant therapeutic and/or musical relationship she quickly disconnected from the music programme (*Jacinda was already 'gone' several weeks before, once knowing she could leave*. J:25 July).

It seemed a significant parallel process that the music therapy programme itself was not able to be sustained through the mother and baby's transition into the community – though we tried to initiate this. My journal notes how often I was envisaging such possibilities.

Activating

I have used this term to describe a process I noticed in many of the women, which was not just about initial engagement, or sustaining an interaction process, but almost a mechanical process of turning on an 'activation switch' to get something started that the mothers clearly *had in mind* to do.

It seemed often that mothers wanted to take action, do something, to connect with their babies, had an idea about what they might do, but just didn't know how to *do*. I often felt as if my role was as a 'compost starter' – a tiny input that might allow a bigger chemical change to happen.

For some mothers the 'starter' involved helping the mothers make an initial body movement such as rocking or tapping the baby; once the mother's body was moving, she was often then able to retrieve the ability to sing.

For Maia, the enabling 'starter' was an opportunity for her to point out an error of mine (in pronunciation, lyrics or information) and have me acknowledge her discernment;

Maia seems to relax when she has established control. Today pointed out my errors about Microsoft copying policy – explained how to eliminate problem. I thanked her for the input. She immediately relaxed, smiled, started singing her favourite, 'Jesus at the Wheel'(Maia and Jed: 4)*.

For Letitia, a longer non-musical warm-up was needed at the start of each session. I listened each time to her same simple verbal narrative of grief and grievance; once acknowledged, she could move into the music;

Letitia needed to talk first about the loss of phone contact with her 4yr old. Her disconnection. Certainty about getting her back. I listened. Then she could do music. L & Amber: 4.

Ironically, there was a converse difficulty in 'de-activating' at the end of a session (*MT suggested time to close. Together sang goodbye song. Ria appeared reluctant to finish. Unable to leave.* Ria & Anna: 3). I learnt that closing the sessions needed to be done very routinely, clearly and positively, to enable the mother to leave. Closure of the sessions often felt sad.

Noticing

'Noticing' and 'responding' were key to initiating the mother/infant interaction, but encouraging mothers to independently 'notice' was the primary challenge.

I wondered in my journal whether difficulty in noticing might be related to a women's own range of repertoire of 'signals' for communication (sometimes I found it as difficult to 'read' the women, just as they appeared to have difficulty 'reading' their babies). Many mothers had difficulty in noticing what their babies were signaling physically, whether babies were distressed, or just trying to activate the attention of their mother. Sometimes mothers were not able to notice extreme distress. Frequently, the mothers were preoccupied with, and wanted to talk about, their own personal needs. I wondered often whether the mother's needs were simply too great for them to notice the baby's needs:

Jed's head kept lolling back. Maia not noticing. MT encouraged M. to keep an eye on it. Maia started poking at Jed's face, while she sang the action songs. J. asleep, pokes opened eyes, distressed. M. kept singing, smiling. (Maia & Jed: 6).

My journal reflects on the increase in capacity to 'notice' that I observed with women who stayed in the facility long enough for their babies to reach a developmental stage where their baby's responses became more overt, such as in eye following, smiling and reaching out their hands. Mothers' responses to this were not only positive, but attentiveness increased:

MT drew attention to Jae's eye focus – following E. around. E. noticing, attentive. Looked delighted. 'I hadn't noticed that before'. E. and MT smiled at each other (Esther & Jae: 5).

To aid bonding, it seemed important to keep mother and baby in the facility long enough for this to happen.

Responding

Even when mothers noticed something of what was going on with their babies, sometimes they found it difficult to respond at all (as noted above), or otherwise made a response that seemed late, or did not appear to align with the baby's needs (*Started play song. J. difficulty in focus. Wrapped in blanket. L. fretting. Wrapped tightly covered completely. Squirming. J. squeezing tight* (Jacinda & Lena: Group 1)).

In the music, these non-alignments were often manifest in differences of timing and pace:

Ria showed MT rock-a-bye baby. Very fast…baby started crying. MT suggested R try a little slower for soothing – R started talking very fast – 'I usually sing it slower' – Anna started crying again - R. gave her breast, moved from one to other, very fast switches, A. still distressed. R suddenly left room with her.(Ria & Anna:2).

Attuning

Attunement describes the emotional alignment between the mother and child. Many women showed wonderful moments of attunement with their babies. In many cases, these moments also included attunement with me as well; the women were generous in sharing their delight in their babies:

Pita was over Tammy's shoulder. Calm, asleep and snuggled in. Tammy talked to him – 'You're a tired little baby, aren't you? Soft and loving. We sang the hello song. Tammy glanced repeatedly at Pita, with little smiles (Tammy & Pita:4).

Typically in the sessions, a moment of attunement was recognized by the women and met by some kind of spontaneous expression of joy, sometimes of sadness. I found that the mother's attunement with the baby, and my own attunement with the mother, was more likely to occur when the mothers and I were both relaxed and anxiety-free:

We sang our song three times (gently fanning), slower and slower. Babies immediately quieting. The women held their babies. Last two songs [lullabies]*, beautiful quiet. Everyone looked around. Smiles. Moment of quiet together. M. 'We've put them all to sleep!'* [MT]*'Yes, you did it!'All smiled…slower to leave this time.* (Group: 4).

In contrast, a non-attunement (disconnect) between mother and baby was often noticeable;

Jed was fretting a little. MT suggested that maybe J. hungry? M. seemed unsure of where J. was in the [feeding] *cycle. We sang a lullaby together. No change in J., didn't help. M. brought out smartphone – 'my very favourite song – Jesus take the Wheel' –* [played] *long rap. Spoke words*

softly along with the track throughout. Seemed to know all the words. No eye contact or connection with J. (Maia & Jed:4)

We started to sing 'Hush a Bye'. Lily on lap. Karina started jiggling fast, and hard rubbing on Lily's back' (Karina & Lily: 3).

In the search for attunement through making music together, we worked hard to slow the pace to suit the baby, to keep a steady beat and rock the baby to the beat, to provide gaps and silences to allow the baby to respond, to stay with an interactive sequence long enough to get a response, to manage and enjoy repetition.

Being consistent

'Being consistent' is strongly related to the idea of 'sustaining', though it describes the ability to provide the same kind of response across similar situations (as opposed to sustaining that response).

The data shows high levels of unpredictability and inconsistency in the women's responses to their baby and to the music therapy programme. I found an ever-changing kaleidoscope of behaviours and emotional expression – often seeming to be in response to outside factors in the women's lives, such as in their intimate relationships.

Self-regulating

The findings showed that some of the women had difficulties in self-regulation of their emotions, to the extent where this might impact on the safety of the babies. This was especially evident with the group of women who had a strong sense of self. They were volatile and variable within and outside of the sessions. They appeared easily frustrated, brought to anger, and their moods strongly affected others (*I've got an attitude…*Maia: 1).

However my journal entries question whether any of this was over and above what might be a predictable response after the birth of a baby considering their youth, the unfamiliar and restrictive environment, the typically traumatic circumstances of entering the facility, and their damaging backgrounds. It seemed to me to be an amazing achievement to even come to the facility, and have their vulnerability exposed to others. Overall, I was more often surprised and humbled by women's attempts to repair any relationship destruction that might have resulted from their actions, and to regain control of themselves when they had 'blown it' (*I'm sorry I slammed the door. I was having a bad day… you can borrow Lena. She'll make you feel better.* Jacinda & Lena: 4). For me, these efforts to repair damage indicated the strength of their determination to prove themselves able to keep their babies, and a certain level of resilience.

Adapting

Perhaps because of the unpredictability and volatility of their circumstances and emotional climate, the mothers conversely seemed to have a strong need for predictability and routine in the music therapy programme, and found it difficult to adapt to changes. They became anxious when the times for their sessions had to change (even when they resisted the sessions). They (and I) found the frequent room changes disconcerting. It seemed also that there was so much changing, the mothers strongly needed control over what they could control. This was reflected in a typical need to have the song lyrics 'exactly right'. I was frequently chided for my habit of merrily substituting words in lyrics:

Brought Red Nose song [Maia had requested it]. *Maia pleased…sang along loudly (different tune). Stopped to correct MT twice for sing 'in the still of the night' instead of 'in the dead of night'. Seemed important* (Maia & Jed:3).

To a lesser extent, I found myself experiencing a parallel difficulty in adapting to the ever-changing context; the 'not knowing' of whether and for how long, women would remain with the facility, whether they would be keeping their babies or not, whether they or their babies would be at the session. I had to work hard to stay constantly adaptive, flexible and focused on working 'in the moment'.

Loving

The data shows that I often asked myself what was the role of maternal love in all of this. What was maternal love? I felt that I might identify it by observing interactions of affection and empathy between mothers and their babies.

There was much evidence of underlying affection there for many of the relationships despite this often being masked by high levels of anxiety (*I dreamed about Tammy's tender but anxious vigilance of her little Pita,* J: 25 June). There were many moments of joy. This provided a positive backdrop, and a feeling of hope, in the face of all of the above identified difficulties. There was much dedication from the mothers and desire to protect, and for some, the baby's needs and schedule took priority to an almost rigid extent. Many had a huge will to prove themselves as good mothers (though competing with this was a common priority given to romantic love relationships).

In general though, the data shows a low ability level of the women to empathise with their babies. I questioned whether love could exist without a sufficient level of empathy.

4.1.3 The impact and role of the music therapist as 'third'

The explicit role of the music therapist was to support the mother-infant bonding process – that is, to support strengthening of a dyad. Nevertheless, the presence of the therapist also created a triadic dynamic, as well as introducing two extra potential dyads (the mother and myself, the baby and myself).

Findings show that I was greatly preoccupied with achieving ongoing dynamic balance of all of these relationships, in a way that could give priority to the mother-infant dyad.

First, it seemed that the greatest success in reinforcement of the dyad (and ultimately the triadic relationship) lay in my consistent offering of delight in the baby, while at the same time consciously refraining from interactions that would strengthen the baby-therapist dyad. This meant not holding the baby unless with permission (which mothers loved to grant), and even then just to very briefly demonstrate something, minimising physical contact with the baby in general, and when singing and sharing songs proactively encouraging the mother to use her voice in some way, to hold and touch her baby and to maintain her eye-contact with baby. Giving authentic and frequent positive feedback also helped.

Second, the building of the mother-therapist relationship was crucial to the success of the programme, and this was a dyad I consistently worked to strengthen throughout. In this relationship I found myself fighting the stereotypes of a 'social worker' or 'teacher'; those people who 'know best' and could 'report back'. Although I felt I was able to share many pleasurable times with the women, sadly in no cases did I feel I had ever established a relationship of trust sufficient to make any real therapeutic difference; the clearly temporary nature of our relationship worked against trust-building. I did, however, hold onto some hope that a brief intervention might still be effective on some level.

Third, I clearly had a different role in one-to-one sessions than in the group education sessions. There were some ways in which I found the educational purpose at odds with the therapeutic purpose. However, I ultimately found that both of these formats worked well together, each offering different strengths in supporting the mother-infant dyad. In particular, the group sessions offered an effective and uncomplicated role way of musical resourcing, which became significant, as stated above.

4.1.4 The context

Aspects of the context need their own mention, as they had such a pervasive impact on all of the other findings.

On an emotional level, the context was one of trauma, grief and tragedy. In particular there was constant risk of re-traumatisation, as any baby removal was not foreshadowed with the mothers (presumably for safety and protection of all) and the unexpectedness and suddenness of an 'uplifting' affected everyone in the facility (including myself – *I felt sick to the stomach:* J:24 March). The women expressed both grief and fear and a sense of the hopelessness of their own situation whenever someone else had their baby taken off them (*She's lost her baby. I'll be next:* Lena: 3)*.* When women left (with or without baby), there was often a response of *extreme disconnection, disintegration* (J: 8th March). The tragedies appeared to be amplified by the context.

On a structural level, the enmeshment with external legal and child protection issues and the dual function of support and of monitoring and assessing created a situation of ongoing tension. Women felt that there was no room for a 'mistake', and frequently expressed that the system was against them (*M. lost her baby. Now I'm losing mine…The staff lied about me…It's all a big set-up*. Erena & Zak:2).

As a result of the legal context, and the high risk situation for babies, on an environmental level, the facility was often in crisis. There was an ever-changing environment with women and babies leaving, new people arriving, and continuous adaptation and adjustment of schedules needed. This worked against the family oriented and supportive goals of the facility, and the facility's attempt to help women develop routines for themselves and their babies. This instability was inevitably reflected in the delivery of the music therapy programme, where both timetables and spaces for working changed from day to day.

Finally on a family and community level, although family and wider whanau were encouraged to visit and support their family member, many of the women seemed to be estranged from their families and communities, though sometimes necessarily for the protection of their babies. Many faced the prospect, on leaving the facility, of living in a state-provided flat by themselves as a single parent in an unknown community. They often expressed fear of this transition. In this context, the peer group, and/or a relationship with a boyfriend, was, for them, especially important; however these relationships were frequently also unstable and changing.

4.1.5 Patterns across the data set

Looking across the data set, it is possible to see a larger pattern in the extent to which each aspect is shared by other women and their babies. In the category of interactions there is strong consistency across all themes for nearly all the women and babies. In the category of identity, women tend to fall into two contrasting and distinctly different groups for each theme/aspect.

Although it is not possible within the scope of this research to draw causal inferences from these patterns, it was interesting to note that during my placement, of the six women who left the facility with their babies still in their care, all displayed strong sense of selves, some strong positive memories of a parental figure and early music experience, were able to envisage a future with their baby, showed confidence in interpretation of their baby's needs, had a higher overt enjoyment of reciprocal interaction with their babies, and were mostly able to differentiate themselves from their babies.

Across the clinical data for all of the women, helping build the mother's confidence, helping mothers see their babies as separate individuals, helping them participate in 'stories of interaction' with their babies, and helping resource them (showing what they might do, sharing songs and ideas) emerged as the four most consistently useful things the music therapy programme could do.

4.2 Findings from the attachment theory literature

A brief background to the development of attachment theory has already been provided in the literature review above. For this further analysis, I looked specifically at more recent writings on attachment theory. This search was limited to journal literature (both primary research and reviews) from 2005 onwards that I felt might be applicable to my context; these all included enlightening critical historical reviews offering birds-eye views of the many pathways taken in attachment theory's development. I also included in this extra search a much referred to review by Bretherton (1992), and an important retrospective review of the theory by Bowlby himself (1977), both of which solidified my understanding of the earlier development of the theory.

In this analysis I sought to draw together what I found continued to be shared core concepts and principles of attachment theory over time, as well as identifying some key contemporary developments and debates.

4.2.1 The core elements of attachment theory

As identified in the initial literature review, the theory holds that to thrive emotionally, every infant needs a committed, close and continuous care-giving relationship with one - or sometimes a few - people (Bretherton, 1992). This caregiver is called an attachment figure, and whoever is primarily 'mothering' a child becomes the child's principal attachment figure (Bowlby, 1977, p.203). Thus the attachment figure is most often the mother (and for ease, will usually be referred to as such below). However, any relationship partner can serve as an attachment figure 'if he or she becomes a reliable source of protection and support' (Mikulincer, 2012, p.4).

Attachment behavior is behaviour that involves seeking proximity to an attachment figure when distressed (Bretherton, 1992, p.20, Zeanah et al, 2011, p.1). The theory holds that attachment behavior has an evolutionary purpose – that is, to protect from danger and ensure survival of the child. Thus, the child uses what are termed proximity-seeking behaviours (such as sucking, clinging, following, smiling, crying) to keep the mother nearby (Mikulincer et al, 2012, p.5).

However, the process of attachment is not just about the baby's behavior; it is also about the mother's behaviours and responses. Attachment is believed to develop through the accumulation of reciprocal interactions between mother and infant and 'positive' attachment (or 'secure' attachment) occurs when the attachment figure is not only *nearby*, but also *accessible* (including emotionally) and *attentive* (italics are mine)(Mikulincer et al, 2012, p.3).

Once attached, the attachment figure provides an important dual function; she is both a safe haven for the child to which to return for reassurance, as well as a secure base from which the child can explore the world (Bretherton, 1992, p.20). These purposes are clearly antithetical – one inward and safety-seeking, the other exploratory and outward venturing. A desirable attachment will thus allow the child to move backwards and forwards as needed between the two.

The theory holds that initially infants display attachment behaviours fairly indiscriminately to all caregivers, but as they grow older, become 'increasingly focused on those primary figures who are responsive to the infant's crying and who engage the infant in social interaction' (Bretherton, 1992, p.20). Nine months is considered the approximate age by which an infant can be said to be 'attached', but at any time until the end of the third year, attachment is considered readily able to be activated (Bowlby, 1977, p.204).

I found in the literature that theorists often ascribe a positive connotation to the idea of 'attachment'. However, this is clearly not always the case; for example Bowlby notes (1977,

p.204) that an attachment can still develop, despite repeated punishment from the attachment figure.

Mary Ainsworth, who worked both independently and with Bowlby on mother-infant attachment, developed (through empirical observation in her longitudinal studies) a system classifying styles of attachment which is still used today by many (Bargiel, 2004, de L'Etoile, 2006, Forough et al, 2012, Bergin, 2009). She based this on the Strange Situation Interview (SSI), a controlled situational experiment, which looked at infant responses to separation from and return of the mother, and of interactions with a stranger 'mother-substitute'. It was the SSI classification which introduced the concept of **secure** attachment (the desirable 'norm', and believed to be experienced by approximately 60% of children). Other less desirable styles were identified as **ambivalent** (or anxious-resistant) attachment and **avoidant** attachment styles. A fourth style, **disorganized**, proposed later by Mary Main, was also later introduced into the classification.[7] Thus attachment styles can be formed that have negative consequences. Such attachment style classifications can, and have been, further empirically tested (Bretherton, 1992, p.17; Zeanah, 2011, p.3).

The theory and associated empirical evidence show that maternal sensitivity (usefully defined by Brandon et al as the 'degree of engagement' of the mother with the 'emotional world of the baby' (2011, p.2)) is crucial for the development of infant-mother attachment patterns. Attachment theorists seem to agree on what are the important factors that might determine the level of maternal sensitivity. These include: attentiveness to the child; the mother's ability to appropriately interpret the child's behaviours; the ability to respond appropriately to the child's needs; the ability to react sufficiently promptly to the infant's needs so as to limit inappropriate frustration (Fraley, 2010, p.3). The use of the term 'appropriately' is interesting, given that it is clearly open to flexible interpretation, and very dependent on social and family culture values. I was unable to find any discussion on this aspect in any of this literature.

A further key aspect of attachment theory is its development of the idea of an 'internal working model'. The theory holds that based on the nature of the early interactions between the attachment figure and the child, the child develops an internal working model (a kind of idea of the 'self'), which sets up expectations as to how others will respond to them, and them to others, in the future. Such a model holds the child view of 'self' as either 'valuable and reliable' or as 'unworthy and incompetent' (Bretherton, 1992, p.23). The model also represents 'the other' as either trustworthy or untrustworthy, in personal interaction (McLeod, 2007, p.2). Theorists use a range of metaphors to describe this internal working model – originally a

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[7] See Appendix 1

'blueprint', later a roadmap, an orientation system; all trying to convey the deep significance of the personal internal working model in shaping the child's future life.

It is considered difficult, but not impossible, to 'reorient' an attachment style, once established; Bowlby himself held that attachment tends to endure for a large part of the life cycle (Bowlby, 1977, p.203), and Fraley (2010, p.5) suggests that similar patterns of attachment exist at different points of the life span.

Finally, attachment theory has important things to say about grief, separation and loss. Separation anxiety is believed to be experienced by infants and children when attachment behaviours are activated, but the attachment figure is unavailable (Bretherton, 1992, p.12; Fraley, 2010, p.1). Further, grief and mourning processes appear in children and adults when 'attachment behaviours are activated, but the attachment figure continues to be unavailable'. This is called maternal deprivation (McLeod, 2007, p.2; Tizard, 2009, p.2). Through maternal deprivation the attachment system may be deactivated, and the child may display features of dissociation and repression that may signify pathological mourning.

4.2.2 Some recent developments and debates around attachment theory

As further research tools have been developed, there has been an expansion of attachment-based research.

There now seems to be wide acceptance that a non-secure attachment style can be 're-orientated' or 'repaired' (Zeanah, 2011, p.9 & Mikulincer et al, 2012, p.13), that multiple attachments can take place over a lifetime (Bretherton, 1997) and that the internal working model may change as a result of real life experiences (Beijersbergen, 2011, p.2). These findings taken together give solid ground to attachment based psychotherapy in which the psychotherapist becomes an attachment figure (i.e. the safe and secure base) to enable client exploration and/or re-orienting of their internal working model.

Attachment research also appears to have shifted focus to consider the broader human lifespan. At one end of the lifespan there has been increasing research on infant foetal attachment, now widely accepted in the theory (Brandon et al, 2011). At the other has been particular emphasis on adult attachment, where Mary Main's and others' research have established a strong correspondence between adult and infant attachment patterns and classifications.

Main also developed the AAI (Adult Attachment Interview) which is still used today as a self-report assessment for ascertaining adults' attachment style (Bretherton, 1977, p.27). Hazan and

Shaver (1987) also developed a much used self-report questionnaire on attachment styles in adults (Fraley, 2010, p.4).

Such models for measurement are clearly important in considering issues of transgenerational transmission of attachment, and have provided a base for several research projects correlating particular adult attachment styles with the likely attachment type of their infant (beginning with M. & H. Steele's research described in Brisch, 2002, p.35). Bretherton also claims that internal working models have a role in such transmission (1992, p.3).

Sound measurement tools have also been important in looking at 'high risk' contexts, for example in research showing correlation between adult non-secure attachment and child abuse (Brandon et al, 2011), insensitive caregiving (Brandon et al, 2011), and substance abuse (Suchman et al, 2013). (Suchman's research also interestingly suggests that when working with an 'at risk' mother-infant dyad, the attachment issues of the mother need to be addressed first (2013, p.484)).

Many so-called 'new' developments of attachment theory appear to be just changes in areas of focus. For example Crittenden & Dallos (2009) developed what they call the Dynamic Maturational (DMM) model – which sees attachment as dynamic and subject to change, rather than stable, and recommends interventions that focus on information processing (such as reflection) in dealing with insecure attachment (all ideas found in Bowlby's early thinking if not research)[8].

Finally are newer areas of interest which are being promoted by key researchers. These include Marvin (in Erdman & Caffery, 2000) and Forughe, Mirisse & Muller(2012) who highlight the problem of *activating* attachment. Bell (2012) also talks about activation, but also introduces the concept of *capacity* for attachment, and suggests that a historical weakness of attachment theory is that it fails to address and provide a way of measuring *strength* of attachment. Rutter encourages a distinction between maternal deprivation and privation when looking at attachment (McLeod, 2010).

Both foundation attachment theory and some of the more recent developments have provided data for the final stage of the analysis, as discussed below.

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[8] This aligns with the development of two widely used attachment-based interventions to increase caregiver reflection and 'maternal representations'; Circle of Security' and 'Watch, Wait and Wonder' (Suchman et al, 2013, p.484).

4.3 Looking at inductive analysis findings in the light of key concepts of attachment theory

There are some strong consistent connecting patterns between clinical findings and attachment theory, and these are reflected or demonstrated across a number of different levels; external structures, facility, programme structures, interactions and music within the programme. It would be hard not to find such connections, given the all-pervasive influence of this theory in so many areas. However, there are some areas of the findings that relate particularly strongly to attachment theory.

First, and importantly, attachment theory does appear to support in principle the facility's provision of a therapeutic programme in the first place, where the therapist might act as an attachment figure providing the secure base for client exploration. (In this context also, the facility or staff within the facility might also have attachment figure roles). The clinical data and attachment literature both suggest that the music therapist's ability to create a bond (if not an attachment relationship) with the mother is the primary enabling factor in assisting the mother and child attachment process. This suggests that perhaps the primary focus of music therapy should be on the mother.

Equally important, considering the goal of the programme, both clinical findings and attachment theory are strongly connected in both giving a central place to mother-infant bonding. However I discovered a wide gap between 'bonding' and 'attachment'. They are clearly not the same thing. Although positive bonding is a necessary characteristic of secure attachment, it is not the only characteristic. A secure attachment is built through repeated and reliable positive bonding over a period of time. Thus despite some strong evidence of 'bonding' in the music therapy clinical data, it is not possible within the time frame of this research to see that as evidence of 'attachment' as the theory defines it.

There is a very strong connection between attachment theory and the patterns in clinical findings relating to interactions, despite some language and labeling differences. Particularly noticeable are the observations connecting to the ideas of a dynamic reciprocal mother-infant relationship, of maternal sensitivity, and of a process that involves accumulation of experience and 'built' relationship. It seemed that the music therapy programme was a particularly good platform for observing, and supporting, all of these interactions. However, in my clinical data findings appear to go further in taking into account the 'high risk' context, such as in suggesting the important role of anxiety in inhibiting the ability of some mothers to activate an interaction sequence.

There are also potential strong connections of attachment theory with the findings on identity. I had originally noted that ability to self-regulate (which had a place in my clinical findings) was considered to be an outcome of secure attachment, and therefore linked with a positive internal working model. However in my deeper look at attachment theory, I was surprised at how closely my other findings on identity (see 4.1.1) could also be linked with Bowlby's theory of internal working models, though less directly. Issues around memory and reflection, creation and imagination of joint narratives of the mother-infant relationship, culture, differentiation and empathy, self-efficacy and having a sense of self, resilience….all could be related to the nature of the internal working models that the women brought to their infant-mother relationship, and many are preoccupations of attachment theory researchers in mother-infant research. Even 'resourcing' in its wider sense as used in the clinical findings, is about building the capacity of the mother, and through her the mother-infant dyad, to develop bonding beyond the music therapy programme, surely aligned to the idea of positive strengthening of the internal working model of the mother.

My own data does place more emphasis on resourcing, and on strengthening the mother-infant bonding through the creation of mother-infant narratives. In this respect theories other than attachment theory (such as narrative and resourcing theories) may well be more relevant. In addition, the strong presence in my clinical data findings of issues of self-differentiation does not seem to be either adequately addressed by attachment theory, or by the clinically-based music therapy research.

A further strong connection between clinical and theoretical findings became apparent as I better understood the essentially antithetical nature of the dynamic interplay between the 'safe haven' and the 'exploratory' aspects of secure attachment; one inward looking, one outward looking. This provided a link for me to the clinical data on significant songs, and what they might possibly represent; that is making connections between the lullaby (safe haven, intimate) and the play songs (exploratory, social), the desire of the mothers to be given both, and noticing how the mothers' significant songs conveyed both aspects (See Appendix 4).

The impacts of separation and loss are central to both clinical data and attachment theory findings, and are discussed further below because of their all-pervading impact in this high-risk context.

Other areas of clinical findings are not so easily linked with attachment theory. These include the impact of context on mother-infant relationships (although Bowlby does not deny the importance of context, the theory does not focus on that aspect). Related to this, although the attachment theory links with family systems theory, it does not provide much enlightenment on the effect of the 'third' in therapy, and of wider family systems and cultural contexts, including

collective cultures, on infant-mother attachment. The role of resilience as a factor in infant-mother bonding and attachment, and impacts of trauma, as queried by the clinical data, also do not yet seem to have been addressed and need to be, as part of further work on transgenerational transmission of attachment.

A great deal of the intriguing recent research raises many of the same questions that were also raised by the clinical findings, and expressed in my journal; whether you could 'repair' or change initial attachment and/or capacity for attachment, and what factors might be involved; what might be a sufficient level of attachment to ensure safety; whether there is a correlation of attachment styles with other 'at risk' factors, including self-regulation difficulties; whether and how reflection might be used to support positive attachment change.

In conclusion, attachment theory could be applied to any developmental or psychological context base, such has been the breadth and sustained nature of its influence. In this high risk context, the theory is overtly present in the foundational principles of the facility, and the interactional aspect of the theory can clearly seen to be played out in the data patterns of mother-infant interactions in the music therapy programme. As well, there may be underlying connections between the data observations around identity, and some of the attachment theory related to the building of internal working models. Many areas of potential future attachment based research could usefully answer questions raised by my clinical findings.

Chapter 5: Discussion

The strong links between attachment theory principles and much of the data in my own research findings (though sometimes disguised by different language and the natural limitations of the data) strongly support Zeanah et al's practitioner review claim that 'thorough understanding of attachment and its developmental course is essential in all clinical settings serving young children and their families' (2011, p.12). In principle, the underlying attachment-based principle of the facility appears sound, and a music therapy programme seems to fit well within this framework. The music therapy programme might, in fact, be considered an attachment based therapy, given its central purpose, and in this sense would align with Brisch's (non-music therapy) psychotherapeutic approach, in which an attachment framework is typically applied to both interpretation of client problems, and subsequent interventions (Brisch, 1999).

There are particular benefits of an attachment-based approach that might apply in this kind of 'high risk' setting. First, it provides a very clear and empirically-tested common framework and associated language that can underpin and unify all of the aspects of the facility's service; support, educational, 'training' and therapy. It is useful in *explaining* and *clarifying* things that are happening in a context which by its nature is often in crisis, transition, and a high state of trauma and emotion; in particular, it offers some insight into the basis of distress, issues of separation, grief and loss, and the effects of that on identity and relationship. Thus it can provide useful guidelines for some of the structural decisions within and outside of the facility, as well as the kind of support within the facility that might be most useful. The theory's emphasis on mother-infant interactions also provides pathways for assisting in bonding (that is, practical interventions that we can do and support right now, to provide opportunities for 'in-the-moment' positive interactions).

In this context, an attachment-based music therapy programme could ideally be very useful in several ways; in providing a platform for the mother and baby interactions, as well as close observation of such; in providing a flexible and responsive structure to support and help build positive mother-infant bonding; in helping increase the mother's capacity to bond with her baby by helping strengthen her own sense of self and self-confidence; by providing a trusting and sustained therapeutic relationship that could help re-orient the mother's 'internal working model' (especially providing a way of lessening anxiety and avoidance). The specific potential benefits of use of music as opposed to other therapies are that it offers a non-verbal approach, a familiar and potentially less threatening vehicle for therapy[9], quick engagement, ability to

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[9] Noting that for some of the women in this programme, working with music was frequently experienced as threatening.

engage on many levels (but especially emotionally), closely associated with movement and touch and play, quick in resource acquisition (songs, games and playing instruments), and easy and early 'success'. Findings also suggest that aspects of the music in mother-child interactions may offer immediate signals for interpreting 'in-the-moment' emotional states.

All of these factors can be seen to facilitate positive mother-infant bonding in a high-stress context, with the assumption that such bonding will also increase baby's safety, as well as promote secure attachment in the baby. In addition the potential for a music therapy programme to be sustained during and after transition into home and community is a significant benefit.

However, although an attachment based framework for looking at my data not only revealed many positives in my work, it also clarified and highlighted some of the dilemmas that preoccupied me during the placement, and continued to preoccupy me in the research, as expressed in both journals. Establishing relevance of attachment theory does not necessarily mean that an attachment based music therapy programme will necessarily work, especially given the structures and dilemmas associated with the very 'high risk' context.

First was my ongoing dilemma in delivering a programme which aimed to strengthen the mother-infant bond, at the same time as knowing that there was a high chance of the baby then being taken from the mother's care within the first weeks. Attachment theory provides relevant input here, with its theory of separation and loss and their impact on secure attachment; what would be the effect on the baby (quite apart from the mother) and the bonding process if it was suddenly terminated? And what if secure actual attachment was achieved (potentially at around nine months according to attachment theory), and the mother then had her baby taken from her care? The achievement of initial secure attachment may well provide a resilience factor for future loss, but could the baby then re-orient and attach securely to someone else?[10] This dilemma may well account for the facility structure that requires an early (eight week) review and decision as to baby safety with the mother.

My journal shows that I had an ongoing struggle both personally and with the inherent ethical issues in this dilemma. I could only manage to remain positive in this placement by focusing with hope on the 'in the moment' positive outcomes. However, this dilemma is likely shared by all involved in such a high risk service where child protection is paramount. Neither does attachment theory itself yet provide answers. Further research into different impacts of maternal deprivation and privation, as well as identifying factors leading to repair of non-secure

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[10] See 4.2.2

attachment, and for measuring strength of capacity to attach, are all important areas of recent attachment research that need further development, to be able to answer the question.

In the light of the above, one might also question whether in this context *any* therapeutic programme is able to be sustained long enough to be effective. If the therapist is to build sufficient rapport and trust to provide a therapeutic alliance with mother and baby then there needs to be the time to do so; that is, women and babies need to stay in the facility for longer (of course this principle immediately presents a conflict with the predominant child protection value). In addition, attachment theory's proposal that attachment takes place at around nine months for the baby suggests that, for secure attachment to happen, it is likely that the mothers and their babies would need to remain supported in the facility for at least that amount of time (I note again the positive outcomes found by Byrne et al's prison nursery research in having babies with mothers for at least a year. The average amount of time my nineteen women were in the facility appeared to be five weeks). If this is the case, then in a legal 'last chance' context, is there any role at all for attachment focused therapies? It appears likely that such an approach is more suited to a low-risk context. Or, alternatively, in this high risk environment, a different 'brief intervention' music therapy approach might be needed, which might still have mother/infant attachment as an underlying value, but where the programme focus might be oriented differently.[11]

A further observation needs to be made about my therapeutic role as it relates to issues of attachment. My journal notes record frequent frustration about my necessary isolation from the daily workings of the facility, and lack of information apart from what the women themselves elected to tell me. This isolation, though it caused problems at times, was essential to maintain the confidential 'bubble' of the therapeutic and non-assessing relationship. However, since I delivered the programme within the facility, I doubt that the women could ever have perceived me as completely separate from the facility, and from the monitoring and assessment process. Thus there was never likely to be the trust built to a level where I could be an 'attachment figure' for the mothers in the therapy, regardless of how helpful music therapy might be in promoting mother-baby bonding. Therefore though I never questioned the therapeutic role music might play in a bonding process, I did question an attachment-based therapeutic role for myself.

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[11] Shoemark & Dearn's (2008) discussions on the benefits of family centred music therapy with hospitalized infants provides some interesting ideas which may be useful for future programmes.

Such questions raised many inner debates about the relative value of my 'therapeutic' role in one-to-one music therapy, compared with the education and support role in the large group sessions. The questioning may also well explain why, as my placement progressed, I felt increasingly interested in the potential resourcing role of the music therapy programme (increasing confidence and self efficacy in the mothers), and the possibilities offered by a music therapy programme which could extend to support women as a 'bridge' and 'container' while they transitioned into the community and afterwards. Both of the latter aspects might be less directly relevant to attachment theory than to community and resource-orientated music therapy theories. They also suggest that I might work more effectively if the programme was focused more explicitly on the mothers, and the patterns that emerged from clinical data (section 4.1.5) would tend to support this idea.

Finally, are four observations related to limitations in the research process.

First, I noted in the clinical findings a deficit-oriented bias – a strong focus on what appeared to be missing (in the women, though sometimes in myself), or what acted as a barrier to bonding in the mother-infant relationship. This not only came across to me in the analysis as judgmental, but was also at odds with the stated strengths-based principle of the facility, and my own stated practice approach. On checking back, I noticed that the primary clinical data itself was in fact much more strengths-based and positive. I wondered whether the deficit bias of the analysis resulted from my initial view of attachment theory as being quite prescriptive and constraining. It was interesting to find that a deeper look at attachment theory itself enabled me to see the theory's more positive and expansive nature; that I could look at the data in different ways, focus on different things, that attachment theory offers many hopeful and exciting pathways for development of thinking. An opportunity to make another analysis of the clinical data might re-orient my findings to a less deficit- based framework.

Second, in both my practice and the research process, was an ongoing self-questioning of the establishment of a 'norm' in looking at the mother-infant data. How much of what I observed as a 'negative pattern' in the sessions differed in any way from the 'norm' of things that might be observed in any new mother and baby who might find themselves in a traumatic, unfamiliar and highly stressful environment? How is a 'norm' established and from whose cultural framework? I realized that that 'norm' in this qualitative research was ultimately decided by myself. This seemed an extra heavy responsibility, given the context.

Third, after completing the research process[12], I realised that I had created a barrier in both my thinking and my practice, by holding on to the original distinctions I made in the initial literature review regarding the importance of attribution of a primary risk factor to parent or infant. I had asserted the presence of a 'gap' in the literature concerning contexts where risk was formally attributed to both child and parent levels. I came to realize that such distinctions were misleading and not necessarily useful. By definition the dynamic and interactional nature of the attachment relationship meant that wherever the origin of damage, it would automatically impact on both parent and child and in fact the entire family system. Thus attachment repair was needed on all levels, regardless of origin of damage. (However such distinctions might still be useful in determining where interventions could most effectively be made in repairing the system).

Finally, it would be tempting to try to draw conclusions from the findings about the nature of the attachment styles of the mothers, and especially to speculate on negative attachment probabilities of the dyad in certain of the infant-mother relationships. Although there are tools for exploring these aspects (which might well already be useful for further research) the scope of this research could not possibly draw such conclusions.

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[12] And prompted by a personal comment by music therapist Dr. Daphne Rickson

Chapter 6: Conclusions

The research findings showed many strong links between key concepts of attachment theory, and the patterns that emerged from the placement data. These manifested on a number of different levels, from underlying principles and structures of the service, to patterns of personal and musical interaction. However some clinical patterns in the findings might also be usefully seen through the lens of other theories, such as narrative, trauma and resilience theories, resource-oriented music therapy and community music therapy.

Findings suggested that attachment theory provided a useful framework and language for describing and understanding the interactive behaviours and some of the issues of identity that appeared to work for or against mother-infant bonding. In addition, the music therapy programme seemed a particularly useful vehicle for providing opportunity for promoting positive mother-infant bonding in this high risk context, and there were features of the musical interaction that might also be useful in assessing levels and quality of bonding. However it was found that although the music therapy programme may have been able to assist to some extent in a positive mother-baby bonding process, there was no evidence to suggest that this would necessarily extend to promoting a sufficiently secure attachment relationship to keep the baby safe in this very high risk context. It may be that the theory is more usefully applied in a low risk support facility.

The findings suggested that certain factors are most likely needed to be present in the mother for sufficient safety (emotional and physical) of the baby, if not secure attachment. These included: a sufficiently strong sense of self and separate identity from their babies: the opportunity and ability to initiate, repeat and sustain positive bonding interactions: sufficient consistency with such interactions: the ability of mothers to regulate their emotional selves sufficiently: the cognitive ability to accumulate memory and create a shared narrative with their baby: the capacity to imagine themselves and their babies in the future. Most of these factors connect strongly with secure attachment theory. The absence of these factors may also reflect insecure attachment styles of the mothers, although establishing such links was beyond the scope of this research.

Music therapy may help in reinforcing many of these factors, and in addition variability in the mother's use of musical elements may be useful indicators of emotional states that may be impacting on the capacity of the mother to initiate and sustain a positive interaction with her baby.

There is sufficient evidence in the literature to suggest that women who have been insecurely attached themselves may still form a secure attachment relationship with their own babies. Under what conditions this might happen is still not well established. The research found that

all of the women in the music therapy programme wanted to be good mothers to their babies. However strong personal burdens such as addictions, cognitive impairment, abusive family contexts, and significant self regulation problems, as well as the legalistic facility context and the limited time spent by women in the facility, all appeared likely to work overwhelmingly against the formation of a secure attachment relationship, regardless of any strong affectional bond that might be evident between mother and baby.

The findings suggest that in this kind of 'very high-risk' context there may need to be alternative structures to hold and contain 'at-risk' women for sufficient time for secure attachment to happen to the level that is required for the baby's safety, as well as further supporting the transition back into the community. Structures that provide interactional programmes for mother and baby that can help in creating positive narratives of the relationship between mother and baby over a sustained length of time, could make a difference. A music therapy programme that combines one-to-one and group work, based on principles of attachment, but also focusing on resourcing and enabling the mothers, could be a useful part of making that difference.

There is therefore no doubt that attachment theory was relevant to the music therapy programme on many levels. However at the same time an attachment based therapeutic programme was not able to be fully effective in this complex and high risk context.

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Chapter 8: Appendices

Appendix 1 – Glossary of terms and definitions

Attachment based programme or approach: in this study, the term is used to describe a programme or approach which has as its primary values assumption, and purpose, secure attachment in relationship (as aligned with the principles of Attachment Theory).

Attachment behavior: 'any form of behavior that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser.' (Bowlby, 1877, p.203).

Attachment styles as related to Strange Situation Procedure classification (Mary Ainsworth)[13]**:**

- **Secure:** Direct expression of distress elicited by separation, active comfort-seeking, resolution of distress, resumption of exploration.

- **Insecure/avoidant:** Minimal response to separation from caregiver, though quality of exploration may diminish, ignoring or actively avoiding the caregiver on reunion.

- **Insecure/resistant:** Intense distress induced by separation, attempts to obtain comfort are limited, awkward or interrupted, little or incomplete resolution of distress on reunion, and resistance of caregiver attempts to soothe.

- **Insecure/disorganized-disorientated:** Anomalous reactions to caregiver that may include mixtures of rapid, incoherent sequences of proximity-seeking, avoidance or resistance, or fearful of the parent or other behaviours indicating failure to use caregiver as attachment figure.

Attunement (parental): The parent is aligned to the infant's current emotional state.

Infant directed music therapy approach: A responsive approach that is guided by the changing needs (including developmental), preferences and cues of each individual infant as observed in relationship. It is characterized by 'in the moment' work - close observation, flexibility and spontaneity.

Infant Directed singing: 'The particular ways of singing and speaking when interacting with infants in order to capture their attention and promote reciprocity' (Edwards, 2011, p.192).

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[13] From Zeanah et al, 2011, p.821

Research shows that infants show clear preferences not only for their mother's unique singing style, but also for specific musical characteristics (such as higher pitch level, more expressive performing style) that mothers tend to adopt when singing with their babies (de L'Etoile, 2006, pp 1-3). Infant directed (ID) singing is described by de L'Etoile as providing 'an "emotional grammar" through which mothers and infants can practice their most personal and meaningful interactions' (2006, p.3).

Uplifting: A term commonly given to the formal and legal removal of a baby from the mother's care.

Appendix 2: The music therapy programme participants

The following are the pseudonyms of the nineteen mothers and their babies in the programme. Ten women had their babies taken from their care during the time of my placement, and three left the facility with their babies. The average number of individual music therapy sessions attended by the mothers was five.

Lena and Rowan   Ria and Anna   Jody and Tracey

    Marney and Nina   Chrissy and Martin   Janice and Emma

Renee and Heather   Karina and Lily   Jacinda and Lena

    Liz and Corey   Erena and Zak   Tammy and Pita

Amber and Katherine   Carol and Luke   Maia and Jed

Letitia and Amber   Sharee and Lenny   Esther and Jae   Jess and Christie

Appendix 3 :Textual analysis example

Below is a piece of text from the music therapy clinical notes, with annotations showing how I analysed the text.

[Jae on E.'s lap. E. bottle feeding.]

MT singing first verse Red Nose, at E.'s request ← baby's motivation to survive

• *This time, baby took strongly. Fed strongly for couple of minutes*

Talked to J. 'Did you like that?'   mother noticing   Interpreting

MT establishing baby as individual with preferences   J. a bit squirmy. E. – 'She needs to burp.' Held J. up, smelt. 'She's pooed'. E. slight   reinforcing thus as pleasurable shared experience

Frown. ← shame?

'Oh, that's good, she must be relaxed. Let's sing this one again!' Looked at both and smiled.

← baby activating engagement

MT reducing shame.   J. made little 'Ah' sound. E. made tiny 'Ah' in response. E. held J. up over shoulder   ← responding

offering care ←   while MT sang. E. looking at J. J. lifting head, trying to turn back to guitar. E. laughing   → Exploring

with *pleasure*, watching. End of song, E. put J.back on lap. 'I need to go and change   ← Baby communicating

noticing ←   • her, she's getting grumpy'. J. looking intently at E. started little vocalizing. Burped.

Smiled at E.   → Interpretation. Projective identification? Shame?

'She's talking to you! Look!'

MT facilitating activation of mother & baby 'conversation   E. looked at J. and smiled. ← emotional attunement.

Encouraged E. to talk back. 'Try copying her!'   shared (reciprocal)

J. was mouthing, vocalizing, poking tongue out. E. copied mouth, without vocalizing.

MT excitedly 'Listen! She's talking! Can you talk back?'   Sudden disruption

supporting mother ←   E. made small sound. Laughed. J. still intent and responsive. E. 'I need to go.' –

Appeared embarrassed. Got up to go.   → responding. Joy

↓ Shame
'That's wonderful! Positive feedback for interaction, as E. left

Sang goodbye song briefly at door   → Abrupt termination. No closure.

Categories from above themes   Larger Codes
• noticing • responding • activating   →   • Interactions
• shame • shelter • exploration • attunement   • Identity
• disconnection • interpretation • engaging   →   • Role of MT

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Appendix 4 : Textual analysis - Significant songs

The songs below are significant songs or parts of songs which were most frequently requested by all of the women. My notes show the way in which I looked at the songs in the light of attachment theory. I particularly noticed how the genres of lullabies and play songs so well represented the two antithetical 'safe-haven' and 'exploratory' aspects of secure attachment.

Little Peter Rabbit had a fly upon his nose,

Little Peter Rabbit had a fly upon his nose,

Little Peter Rabbit had a fly upon his nose,

And he flipped it and he flopped it and it flew right away!

Play song. Interactive ; touching, eye-contact demanded in actions. Mother helping baby engage with the world. Mother-infant interaction.

Soothing. Building security & trust, conveying love.

Moe moe te pepe, moe moe ra

Moe moe te pepe, moe moe ra

Sleep little baby, sleep baby sleep

Sleep little baby, sleep baby sleep

Slumber, slumber, O my darling baby,

Gently rocked by mother's loving arms.

Safely rest and softly slumber,

And her·love shall shelter you from harm.

Mother provides shelter & safe & secure base from which to explore

Twinkle twinkle little star,

How I wonder what you are?

Up above the world so high

Like a diamond in the sky,

Twinkle twinkle little star,

How I wonder what you are?

Mother and child together look out at the world → exploration. Can face the unknown from a secure base.

Appendix 5 : Example of creative work from the journal

Below is a piece of text taken directly from my journal. It shows my own sadness and struggle to understand what it might be like for the mother after she had experienced losing her baby.

you might think your little life

meant nothing to me

it came unexpected

like a butterfly on a branch

and then you left so quickly all silent

i went partying

i said to them it's all good no drama I just want to get on with it

i tucked thoughts of you away

 in my heart

Appendix 6: Letters of consent

Attached are letters requesting consent from (i) the facility to use my clinical notes as data in the research, and (ii) my supervisors to use my personal notes from our supervision sessions as data.

NEW ZEALAND
SCHOOL OF MUSIC

Stokes Valley

Lower Hutt 5019

Phone 021 02382899

15th July 2013

Dear   ,

Thank you for the opportunity you have given me in creating a student music therapy placement for me at your facility. I am now writing to gain formal permission for the research I am required to carry out in the second half of this year after closure of my placement (15th July). This letter is to clarify what the research will involve, and allow you to make a considered decision of consent or otherwise.

Background

As you know, I have been working in a 22 week full time placement with your facility, as part of the requirements for the second year of a Master of Music Therapy programme with the NZ School of Music. Some of this placement has been working with mothers and their babies, using music therapy to promote attachment in the parent/infant relationship. This is the proposed area of focus for my research report.

As part of the placement, I have been required to document clinical notes for my music therapy work (I understand that these remain the confidential property of the facility, and are also available to the clients on request). I have also kept an ongoing personal journal of reflections on my practice and relevant theory, and including personal creative responses to my work with the purpose of improving my understanding and practice (this journal remains confidential to me).

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As shown in my research proposal (attached, and as approved by the NZSM), my research will involve an analysis of the written data accumulated in the course of my clinical work with the mothers and babies, along with an analysis of relevant literature.

Ethics and safety

The Chairs of the Massey University Human Ethics and Health and Disability Ethics Committees have given generic approval for the secondary analysis process required in this research. I am aware, however, that there are particularly sensitive ethical and safety issues around not only my placement context, but also around any research conducted in that context. The following procedures will be put in place to ensure a safe and ethical process at all levels;

- Every care will be taken to ensure the anonymity, safety and well-being of the mothers, babies and their families, throughout the period of research;
- Every effort (including no use of real names or identifying characteristics) will be made to ensure that no mothers, babies or their familes can be identified in any way through the research report;
- Every effort will be made to preserve the anonymity of the facility and the facility staff;
- No case study or personal vignette will be used in the research report;
- Extra care will be taken with use and storage of documentation. All clinical documentation relating to the placement will remain in secure storage at the facility. On finishing the placement, I will take one copy only of the relevant clinical data, and keep it in a secure filing cabinet in a secure room, for the duration of my research. Once the research is completed, the clinical note copies will be shredded;
- Once the research report is completed, I will consult further with the NZSM supervisors and with you, about the appropriate levels of dissemination of the final research. It may be that it is not appropriate to make the final research report available publicy in full;
- I will undertake ongoing research supervision of my research work from the Director of the Music Therapy Programme, Sarah Hoskyns, at the NZSM. You may contact her at any stage if you have any concerns about my work.

I hope the above information is sufficient for you to make a final decision re permission to proceed with the research. If you have any further questions, please don't hesitate to contact me. And if you're happy to give consent, I would ask you to do so by email reply.

Many thanks for your consideration.

Best wishes,

Helen Ridley.

Information Sheet for Supervisors – review of written records as data in a research exegesis

Title of Research: Attachment theory and music therapy: What was the relevance of attachment theory to a student music therapy programme for 'at-risk' mothers and their babies?

Dear supervisor,

Thank you for the invaluable supervision support you have given me in my recent placement with   . As you will know, I have been taking brief notes at the supervision sessions, and after the sessions I have also made some notes in my personal journal reflecting on the issues brought up and discussed in supervision. This letter is to provide information about my research project and to request your consent to use those journal notes from supervision in my research exegesis, which I will be working on in the second half of this year.

As you are already aware from my research proposal forwarded to you previously, my research involves reviewing and evaluating a range of documentation generated by my placement at   . This documentation includes clinical notes on individual and group clients, my personal reflective journal, and relevant documents relating to the facility (such as policies and procedures). I am required to write an exegesis as well as present a case study to the examining panel.

Given the importance of supervision in the clinical process, I would like to be able to include in the analysis, where relevant, learnings/reflections from my supervision sessions.

Please refer to my research proposal (approved by the Academic Committee of NZSM) to remind you of the broader ethical procedures I am following in the research, in particular to preserve confidentiality and anonymity for clients, facility and staff.With regard to notes from my supervision sessions, the following specific ethical procedures will be followed;

- All names used in supervision documentation will be changed in the written analysis, and the location of the service will be disguised, in order to protect the identity of supervisors and clients;
- Records will be stored securely in a locked filing cabinet during the research analysis period;

- Following the completion of the research, data will be stored at the NZSM in a secure space for a period of 5 years, after which time it will be destroyed.

While I intend to preserve the anonymity and confidentiality of my supervisors and clients in this research there is a slight risk, because of the small size of the music therapy community in New Zealand, of your being identified, through the association with my practice. Please note that you are very welcome to ask any questions you have about the study, of me or my NZSM research supervisor (contact details below).

You will be able to request a summary of the completed research and a copy will be stored at following examination of the MMusTherapy thesis. Copies of the research exegesis will also be available at Victoria and Massey University libraries, subject to consultation with the placement facility manager.

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, which have been judged to be low risk and not separately reviewed by any Human Ethics Committees. The research supervisor named at the end of this information sheet is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact my research supervisor, or if you wish to raise an issue with someone other than the student or the research supervisor, please contact Professor John O'Neill (Director of Research Ethics, Massey University) by telephone on 06 350 5249 or via email: humanethics@massey.ac.nz.

Contact details

If you have any concerns or questions about the research, please do not hesitate to contact me (helenridley@clear.net.nz) or my research supervisor Sarah Hoskyns (sarah.hoskyns@nzsm.ac.nz) for further information.

Many thanks for your consideration.

Best wishes,

Helen Ridley