Becoming Aware, Taking Control and Connecting with Self in Reflexive Music Therapy: An Adult Woman's Journey Toward Therapeutic Change

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Becoming Aware, Taking Control and Connecting with Self in Reflexive Music Therapy:

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by

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Abstract

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Adult individuals seeking non-pharmacological, therapeutic support for situational mental health challenges have emerged as a population group that is unrecognized and underserved by the mental healthcare system in the US. Music therapy is known as a beneficial treatment modality for these individuals, but accessible treatment methods for this group of consumers is narrowly represented in music therapy literature. This case exploration was conducted to gain insight into the experiences of one member of this population as she engaged in a series of music therapy sessions involving reflexive, participant-led therapeutic music experiences facilitated by a supportive music therapist. The clinician, who was also the primary investigator in this study, employed research methods based in transcendental phenomenology during collection and analysis of rich, descriptive data. The research process ultimately resulted in synthesis of the essential, structural elements of a phenomenon that emerged organically from the participant's therapeutic process. The essence of the phenomenon, Therapeutic Change, is defined by the intersection of Awareness, Control, and Connection within the therapeutic space. The researcher discusses implications of these findings and makes recommendations for development and future implementation of a new, integral model of music psychotherapy that emerged as a result of this work, called Insight-Oriented Music Facilitated

Psychotherapy (IMFP). The researcher believes the ethical application of IMFP will empower and inspire music therapy clinicians to expand their services to meet the mental health treatment needs of this emergent group of consumers.

Dedication

I present this work in dedication to my research participant, whose deep and thoughtful engagement in her own Self-work has become a model for supporting a future generation of growth-seekers and healers.

Acknowledgments

I wish to graciously acknowledge each member of my thesis committee for their kind support and engagement in my creative research process. Each of you have contributed meaningfully to my development as a clinician and as a researcher, and I am proud to reflect your guidance in my work. To Brent Beeson, MS, MT-BC, Caitlin Kraus, MT-BC, LPCC, and my advisor, Kamile Geist, Ph.D., MT-BC—thank you.

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Preface: The Researcher's Perspective

My goal when beginning this research process was to keep my participant and her therapeutic process the central focus of the work. As the primary investigator and clinical music therapist responsible for the design and facilitation of this study, I am honored to share the story of my participant, "Nicole," whose grace and strength will soon become evident. As you read this report, I hope you can view Nicole's beautiful therapeutic process as one which emerged organically, despite it being initiated as part of a pre-conceptualized research study. My intentions for sharing the results of Nicole's deep and emotional self-work are twofold. First, I present this case exploration with the intention to let it speak for itself as a representation of the great potential of insight-oriented music facilitated psychotherapy to serve as a means of primary support for individuals experiencing situational mental health challenges. Second, I intend for this work to exist as a first-person account of providing therapeutic support to an individual experiencing personal manifestation of universally understandable, existential dilemmas.

My personal and professional preparedness to engage with Nicole in work of this extent has been acquired in part as I have received a rigorous and personally fulfilling education in music therapy. However, my understanding of methods and indications for implementation of specific techniques—knowledge earned mostly through classroom study—is not what I feel is most relevant. Though my experience in professional practice in adult mental health settings has allowed me to develop a practical understanding of these ways of thinking and knowing, there still is an element of preparedness which I cannot attribute to my education and clinical experience.

I approached each of the sessions in this study intending to offer support that is reflective of my own eclectic philosophy of music therapy treatment, which is rooted in Jungian psychoanalysis (Jung, 1991), client-centered psychotherapy (Rogers, 1965), mindfulness-based stress reduction (Kabat-Zinn, 2003), Self-systems theory (Bandura, 1978), and developmental trauma-informed somatic psychotherapy (van der Kolk, 2005). I acknowledge that my personal philosophy of practice is one which is continuously evolving. I believe that this contributed to the development of the genuine and effective therapeutic relationship I was fortunate to have established with Nicole. I view our simultaneous growth as a symbol of the transpersonal element of music therapy practice that so many clinicians have lived, that still cannot be simply defined (Crowe, 2017).

Through engaging in my own process of self-discovery and growth, I have come to feel deeply connected with the concept of Self. I have become aware that beneath adopted barriers of knowledge, beliefs, and experiences lies my uninhibited and unwavering being. Through active reflection, acceptance, and release of unhelpful personal barriers, I have started to catch glimpses of my most genuine self. As I have grown to recognize when my own self-barriers are ready to be shed, I have learned to remain patient with myself and observant of my surroundings as I evolve within them. I feel that my understanding of my connectedness to the world around me is what has ultimately prepared me to support individuals not unlike myself and Nicole as they engage in their own processes of getting to know themselves from within. I am aware that my sense of self contributes to my understanding my work, and I appreciate the importance of this self-knowledge.

Chapter 1: Introduction

Incidents of untreated anxiety, stress, and depression in the general adult population within the United States have increased steadily over the past 3 decades. A 2008 national survey on drug use and mental health administered by the U.S. Department of Health and Human Services (HHS) showed 17.1% of non-institutionalized adults in the United States having reportedly met Diagnostic and Statistical Manual-IV (DSM-IV) criteria for diagnosable mental illness related to anxiety, stress and/or depression. The same survey showed that 5.2 million adults self-identified as having unmet needs relevant to the receipt of mental health care, with 43.7% of those reporting accessibility of treatment as their primary barrier to receiving care (HHS, 2008). The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2018 report on the National Survey of Drug Use and Health (NSDUH) shows 9.2 million adults having experienced mental illness that year (SAMHSA, 2019). As of 2019, an estimated 19.1% of non-institutionalized adults in the United States met DSM-V criteria for diagnosis of any mental illness, a nearly 12% increase from 2008 (SAMHSA, 2019). According to the United Health Foundation's annual Public Health Impact Report on Depression, the national rate of suicide completion increased by a staggering 23% between 2009 and 2018 (UHF, 2019).

The increases in prevalence of mental health issues and incidence of unmet mental health treatment needs in the U.S. has surged further as consumers have been faced with challenges of the ongoing COVID-19 pandemic. In April 2020, the Centers for Disease Control and Prevention began collecting data in a series of Household Pulse

surveys intended to collect mental health and wellbeing data relevant to COVID-19. The data collected in these surveys focus on reports of two symptoms—anxiety and depression— which indicate likelihood of diagnosis of relevant disorders. For comparison, the CDC's National Health Interview Survey from 2019 indicates that 10.8% of surveyed adults 18 and older had experienced symptoms of either anxiety or depression (Terlizzi & Schiller, 2021). The Household Pulse survey results from May 2020 indicate that 34.4% of adults 18 and older experienced those symptoms, with a decrease to only 30.1% the next year in May 2021 (United States Census Bureau, 2020).

The growing mental health crisis in the United States presents healthcare professionals with distinct challenges. The UHF's 2020 Mental Health Rankings report indicates that per 100,000 people in the U.S. population, only 268.6 mental health providers are employed or otherwise providing mental health services. Despite a 9% increase in mental health providers in the US between 2019 and 2020, the gap between accessible mental healthcare and the number of individuals who receive services continues to grow larger as mental healthcare consumers emerge amid the COVID-19 pandemic. The UHF identifies individuals living in low income, rural communities as being most affected by the shortage of mental health providers and least likely to benefit from emergency allocations for mental health funding provided to the public during the pandemic (UHF, 2020). These facts suggest the scope of resources available to over 15% of Americans is limited and insufficient (USDA, 2021).

Individuals across sociodemographic groups not seeking diagnostic services or pharmacological treatment who wish to work within a therapeutic relationship to meet

non-acute, personal needs are emerging as yet another group of consumers who are underserved by current mental healthcare services. This sub-population, made up of adult individuals who experience mild to moderate anxiety, depression or stress, has grown significantly over the last three decades. Data suggests this population is in need of a level of mental-wellness support that lies somewhere between physician-led, pharmacological psychiatric intervention and the self-guided wellness activities many individuals rely on as primary means for practicing personal mental wellness (Goodman et al., 2020; Bystritsky, Khalsa, Cameron & Schiffman, 2013).

A sociological phenomenon highlighted at the onset of the COVID-19 pandemic contributes to an interesting trend in the development of society as it exists today. As people across the world have been faced with the collective trauma of social isolation, socioeconomic strain, disgust propensity, and prolonged anxiety and fear, engagement in arts-based coping mechanisms has shown to be prudent (McKay et al, 2020; Mack, Fluharty, Fancourt, 2021). Early in the pandemic as performing and fine artists found themselves without opportunities to demonstrate in public, a surge of online performances, shows and exhibits became accessible to consumers previously not engaged in arts-based entertainment. As consumption of art increased, a downward trend in reports of loneliness and isolation emerged in ongoing data collection (Fancourt & Finn, 2019; Bu, Steptoe, Mack & Fancourt, 2020). Data shows that of the creative activities most frequently engaged in during periods of lockdown, music-based engagements such as singing and music listening were found to be most effective in promoting overall wellbeing (Kiernan et al., 2021).

Board-certified music therapists are uniquely equipped to support colleagues in healthcare by serving individuals who may not otherwise seek professional support. Music therapy exists as an option for treatment of anxiety, stress and depression that allows creative exploration, personal fulfillment and insight development, and also mental-health support from a trained therapist. Individuals who wish to explore their emotional selves in an expressive, holistic manner may be drawn to seek primary support from a board-certified music therapist. While conventional approaches to therapy such as cognitive behavioral therapy and psychodynamic talk-therapy are shown to be effective after several weeks, analyses of dropout rates indicate that approximately 26% of individuals receiving support via traditional therapy ceased service before the end of the indicated course of treatment (Fernandez, Salem, Swift, & Ramtahal, 2015). By serving as primary providers of mental health support, music therapists may help reduce the need for acute mental health treatment, which is often costly, narrowly focused, and only temporarily effective (van Dis, 2019).

Historically, music therapists are known to serve consumers across many demographics with varying degrees of need. The 2019 AMTA Workforce Analysis report indicates 24% of music therapists in the United States provide services to individuals receiving mental health services, mostly serving persons within group settings who experience acute symptoms. While many music therapists offer supportive mental health care within community settings, very few work in these settings at length with individual clients who are not seeking support for a primary diagnosis of psychiatric mental illness or cognitive, social, or physical impairment (AMTA, 2019).

Music therapists providing services to consumers in mental health settings often assist clients in achieving goals relevant to building coping skills, self-esteem, communication skills, stress management techniques and navigation of social scenarios (Silverman, 2005). Methods used by music therapists in many inpatient mental-health settings include music assisted relaxation, improvisation, lyric analysis, songwriting, and music and movement interventions (Silverman, 2005; Eyre & Lee, 2015). An updated survey constructed by Lillian Eyre & Jin-Hyung Lee in 2015 found that vocal and percussion based referential and non-referential improvisation, music and imagery and music and relaxation are among the most commonly implemented music therapy techniques employed by music therapists practicing in unspecified mental healthcare settings (Eyre & Lee, 2015). Silverman's 2005 work also indicates that most music therapist respondents reported implementing behavioral, psychodynamic and eclectic approaches in both inpatient and community mental health settings.

Mary Priestley's Analytic Music Therapy (AMT) is a theory of music therapy practice rooted in psychodynamic theory that is characterized by improvised musical representation and exploration of unconscious material (Priestley, 1980; Austin, 1996). This is one of few music therapy approaches that involve strategic implementation of method-specific music therapy techniques. While relevant in mental and psychiatric health settings, AMT is one of the least common methods of music therapy treatment reported by practicing music therapists, due in part to the advanced training it requires (Priestley, 1980; Silverman, 2005, AMTA, 2019).

While the majority of data relevant to adults receiving group music therapy services in mental health settings is collected in acute, inpatient facilities, music therapist-produced reports indicate that those working with individuals in community mental health settings do implement interventions consistent with care trends in acute settings (McCaffrey, 2019). According to a survey conducted in 2018, some of the most prevalent music therapy techniques implemented in inpatient mental health settings include song discussion, lyric analysis, songwriting and composition (Johnson, 2018). Music therapy literature relevant to community mental health settings shows prevalence of these same methods as well as Guided Imagery and Music, Music Assisted Meditation, and vocal and instrumental improvisation (Stige, 2002; Austin, 2008).

Individual music therapy sessions provided to patients admitted to general medical/surgical hospital units stand out as some of the only opportunities for adults without documented mental health diagnoses to receive mental health centric music therapy services. Individuals in these settings are referred to music therapy services for a variety of needs, but often report experiencing secondary symptoms such as situational stress, pain, anxiety, depression and grief throughout development of a therapeutic relationship with their music therapist. The benefits described by individuals receiving music therapy while admitted to general inpatient units include reduced pain, improved coping skills, increased sense of self, and increased satisfaction with overall care (Mandel et al, 2019).

A small population of music therapists with advanced and cross-disciplinary education find success serving clients using methods of music psychotherapy including

the Bonny Method of Guided Imagery and Music (Bush, 1995), Vocal Psychotherapy (Austin, 2008), and Meditative Improvisation (Austin, 1996; Lesiuk, 2016). Implementation of these methods by credentialed professionals are linked to benefits including decreased anxiety and depression (Bush, 1995; Lin et al., 2010), deepening of personal insight, increased self-empowerment and increased self-awareness and self-regulatory skills (Austin, 2008). These sessions, commonly provided in a series with goals based on pre-determined intentions, often result in deepened insights acquired by the client during what some practitioners refer to as breakthrough (Lin et al., 2010), or pivotal moments in therapy (Gavrielidou & Odell-Miller, 2017).

While literature supports the efficacy of music therapy treatment methods for supporting patients experiencing stress, anxiety and depression, few individuals outside of inpatient settings benefit from music therapy services that are provided specifically to target these issues. Due to limitations posed by lack of music therapy licensure in most U.S. states, music therapists are largely unable to bill directly for services, creating accessibility restrictions and obstacles for consumers and clinicians. Considering the socioeconomic positioning of many potential consumers prohibits self-pay, music therapy is not presently a widely accessible treatment option for many people. Because of these access limitations, the wide and diverse scope of music therapy practice lacks research validation for working with mentally and physically fit consumers outside hospital settings who seek support for mild to moderate symptoms.

Problem Statement

The United States has been experiencing a dynamic surge in the need for mental health providers since the 1990s. Over the last three decades, several factors have led to an increase in demand for services. In 2019 as the COVID-19 pandemic forced Americans to drastically alter routines of daily living, the demand for mental healthcare extended far beyond available resources. Though mental healthcare is one of the nation's most rapidly growing professions, the ratio of providers to consumers of mental healthcare is wide. While more practitioners of advanced psychiatric care are entering the field every day, the number of adults seeking support for non-acute mental health concerns is expanding. Though many different professionals are qualified to provide treatment to these consumers, little evidence is available to support music therapy as a primary source of support for consumers meeting these criteria.

The present researcher has become aware of the lack of research providing evidence for effective treatment of mild-moderate or situational mental health symptoms experienced by otherwise well adult clients. Noting the similarities in music therapy treatment methods provided to individuals in acute settings to those frequently implemented with individuals in community settings, the researching clinician sees an opportunity to support an underserved population group by drawing from treatment methods used in both settings. In a non-clinical, community setting, the present researching clinician facilitated music therapy sessions involving improvisational music making, music assisted relaxation and guided imagery and music. The insight-oriented approach to providing therapeutic support adopted by the present researcher allowed the

participant to introduce, explore, and resolve personal dilemmas as a safe, trusting, and supportive therapeutic relationship was developed. The researching clinician feels the results of the present study may support the expansion of music therapy services into community settings for well individuals experiencing situational mental health challenges.

The purpose of this study was to explore one adult participant's experiences of a series of individual music therapy sessions that involving varied applications of two types of music therapy techniques: mindful improvisation and guided imagery and music. As the researching clinician, I chose to conduct a phenomenological case exploration, employing Transcendental Phenomenology as the guiding research methodology (Moustakas, 1994). My initial goal was to observe the participant's responses during the music therapy sessions to obtain an understanding of the elements at play surrounding the participant's organic experiences. As the study progressed, my goal shifted from simply identifying specific contextual elements toward seeking insight into the emergence of elements which were found to be essential in the emergence of one invariant phenomenon. In collaboration with the research participant, four therapeutically significant moments were highlighted. Systematic analysis of the highlighted data, which included phenomenological reduction, thematic analysis, and imaginative variation (Moustakas, 1994), allowed the structural elements of the highlights to emerge. Further analysis of the structures provided a contextual understanding of the interplay among elements and their relevance in the emergence of the invariant phenomenon.

Chapter 2: Literature Review

Rates of anxiety, stress and depression in the United States have continued to increase over the last three decades. Sociocultural strain compounded by the ongoing COVID-19 pandemic has contributed to a surge in mental healthcare consumers. According to the United Health Foundation's 2020 Mental Health Rankings Report, the ratio of qualified mental health providers to citizens in the United States is broad (UHF, 2020). Recent increase in the demand for mental health services has placed ongoing strain on mental health practitioners and has left consumers without accessible options for routine support. A survey by The United Health Foundation (UHF) identifies individuals living in low-income, rural communities as being least likely to receive public support for therapeutic intervention for anxiety, stress, and depression (UHF, 2020; USDA, 2021).

Lack of transportation, reliable broadband and overall affordability of mental healthcare are determinants commonly cited as limiting accessibility for consumers in rural communities (Blank, Fox, Hargrove, et al., 1995). Prejudice, unawareness of warning signs and limited awareness of options for accessibility have also been identified in ethnographic review (Henderson, Evans-Lacko & Thornicroft, 2013). A 2013 review of the state of diagnosis and treatment of anxiety disorders states that lack of quality cognitive-behavioral therapists available to provide treatment contributes to nationwide under-treatment of anxiety disorders. The same review indicates that self-treatment of anxiety and stress disorders is largely ineffective (Bystritsky, Khalsa, Cameron & Schiffman, 2013).

One type of psychotherapy found to be widely practiced and highly effective in treating adults suffering with anxiety and depression is Insight-based Psychotherapy (Kivlighan, Multon & Patton, 2000). A longitudinal, randomized controlled trial involving measurement of interpersonal function and self-insight pre- and post-implementation of weekly insight-based psychotherapy after one year identified as an indicator of long-term change in psychodynamic oriented treatment of both anxiety and depression (Johansson et al., 2010). Hoglend & Hagtvet (2019) performed a dismantling randomized controlled study to determine whether both affective awareness and insight development are necessary for change in various methods of psychotherapy. The study found that both mechanisms are necessary for attrition of change, supporting insight-based psychotherapy as effective treatment when weekly intervention is conducted over a 1-year timeframe (Hoglend & Hagtvet, 2019).

As accessibility of services for adults seeking mental health services in rural America is limited, the once weekly, year-long treatment model implemented in both of the previously addressed studies is narrowly feasible. A need for accessible treatment options that allow for both affective awareness improvement and insight development exists. This combination of issues is compounded by the lack of available practitioners of therapeutic intervention in the United States (Bystritsky, Khalsa, Cameron & Schiffman, 2013).

Both insight development and affective awareness improvement are change mechanisms that are often the result of phenomena referred to as pivotal moments in therapy (Giorgi, 2011; Helmecke & Sprenkle, 2000). Also called breakthrough moments

(Helmeke & Sprenkle, 2000) or turning points (Lin et al., 2010), pivotal moments are defined as moments of positive change, resulting from self-exploration within the therapeutic context (Giorgi, 2011). In transpersonal psychology and many of its sub-practices, pivotal moments are often regarded as being inherently spiritual. In many cases, these transpersonal moments are referred to as peak experiences (Maslow, 1962; Ross, 2019). This descriptive label is also commonly found in Bonny Method of Guided Imagery and Music (BMGIM) literature (Grocke, 1999; Bruscia, 2002).

A descriptive comparison of reports of client-perception of pivotal moments in therapy was conducted by Barbro Giorgi in 2011. Giorgi analyzed the retrospectively collected data using Husserl's phenomenology research design (1931) and found that trust and safety within the therapeutic relationship were considered necessary for meaningful development of insight (Moustakas, 1994; Giorgi, 2011). Helmecke & Sprenkle (2000) conducted a similar review of pivotal phenomena in couples therapy and found that participants' identification of pivotal experiences was mutual with their partner-participants and the facilitating therapist.

Though experiencing a pivotal moment is not typically the primary goal for therapeutic engagement, these incidents of personal emotional, physical and cognitive discovery are found to leave clients feeling empowered and open to considering their situations with flexibility and self-compassion. These insight developments were found to have profoundly positive influences on the lives of participants who sought support for treatment of depression (Lin et al., 2010).

Literature indicates that individuals receiving support for complex mental health challenges such as anxiety, stress and depression should commit to regular therapeutic engagement for at least eight weeks to receive optimum benefits from treatment. However, pivotal moments in therapy have been reported as early as the first session (Forde et al., 2005). These considerations indicate that individuals experiencing anxiety, stress or depression who have limited options for accessing long-term mental health care may benefit from lower-commitment, insight-based therapeutic intervention.

Sociological analysis of trends in coping techniques of adults experiencing isolation during periods of lockdown amid the COVID-19 pandemic indicate that individuals who engaged in arts-based coping activities reported fewer feelings of loneliness and isolation (Fancourt & Finn, 2019; Bu, Steptoe, Mack & Fancourt, 2020). Those who engaged in self-guided, musical coping activities were found to have experienced the most significant increases in perception of overall well-being (Kiernan et al., 2021).

In various settings, music therapy has been found to effectively reduce client perceptions of symptom severity of anxiety (Robb, 2000; Richards et al., 2007; Lesiuk, 2016), stress (McKinney, Antoni, Kumar, Tims & McCabe, 1997; Lesiuk, 2016), and depression (Bush, 1995; Heiderscheit & Madson, 2015; Lesiuk, 2016). Literature involving both qualitative and quantitative measures of the effects of music therapy on these symptoms includes treatment in settings such as medical oncology (Richards et al., 2007; Lesiuk, 2016), music therapy clinic/laboratories (McKinney, Antoni, Kumar, Tims & McCabe, 1997; Maack & Nolan, 1999; Robb, 2000), and outpatient mental health and

substance use facilities (Heiderscheit & Madson, 2015; Gavrielidou & Odell-Miller, 2017; Hicks, 2020). Music therapy treatment methods employed in these reports include improvisation, re-creation, music listening and music and movement (Austin, 1995; Metzner, 1999; Mossler et al., 2012), Guided Imagery (Bush, 1995; Grocke, 2002; Lin et al., 2010), and Progressive Muscle Relaxation (Robb, 2000; Heiderscheit & Madson, 2015; Hicks, 2020).

The medical model of music therapy has proven to be effective in facilitating pivotal experiences within the first session, as patients typically spend a limited amount of time in medical settings and often do not receive follow up music therapy sessions. Susan Mandel (2019) conducted a controlled case study involving single-session treatment and termination of patients receiving care in a hospital emergency department. This work showed that patients experienced reduced stress and pain after just one music therapy session where active music engagement was the primary method of intervention (Mandel, 2019). A survey conducted in 2007 indicated that patient satisfaction improved significantly between groups where treatment groups received music therapy from a board-certified music therapist while receiving inpatient care in acute hospitalization settings (Richards, Johnson, Sparks, Emerson, 2007).

A discovery oriented, phenomenological study of clients receiving music therapy intervention via the Bonny Method of Guided Imagery and Music (BMGIM) for treatment of depression was conducted in 2010. This research team conducted thematic analysis of transcriptions of 40 BMGIM sessions involving five clients. Three overall descriptive themes related to experiencing pivotal moments in BMGIM as identified by

participants emerged: “Pushing aside the barrier,” “gaining new insight,” and “moving forward.” These themes, which are indicative of insight development, were relevant to client identified pivotal moments in each case (Lin et al., 2010).

A 2015 article outlining the state of mental health related music therapy service provision in the United States introduces a comparison between the empirical, symptom-oriented care approach widely adopted by medical practitioners to the human-centered recovery and existential models employed by many music therapists (Eyre, 2015; Kogstad, Ekeland & Hummelvoll, 2011). Eyre (2015) highlights the connectedness of mental health symptomology to the existential dilemmas many consumers find themselves experiencing in response to situational factors that both contribute to and are the result of mental health challenges such as depression and anxiety. The article details the numerous ways music therapy is posited to support individuals by promoting resolution of these dilemmas, specifically citing Solli et al (2013), who identified music therapy as an approach which offers recovery-oriented care and centralizes the development of empowering therapeutic relationships through shared experiences in music.

A self-growth-oriented recovery perspective is offered by Jackson (2015), who provides insight into the integration of positive psychology interventions (PPI) in music therapy for individuals with Chronic Mental Illness through presentation of a series of case vignettes (see Seligman, 2007). Jackson’s work, like Eyre’s (2015), also highlights the necessity for self-development in mental health recovery, identifying resolution of

issues of self-concept and self-efficacy as examples of those which allow individuals to define “new identity beyond mental illness” (Jackson, 2015).

The experiential space introduced to the field of music therapy by Carolyn Kenny (2006), which is produced at the intersection of music, power, creative process, particular state of consciousness, ritual, and aesthetic, is one which serves as a safe, shared environment for engaging in these types of recovery-centric self-development. Nancy Jackson discusses a creative musical space similar to Kenney’s Field of Play (2006), and identifies the therapeutic music made within this type of space as a human experience, rather than a tool for improvement (Jackson, 2015). The development of self-knowledge, insight, strengths, and empowerment within these musical spaces is the focus of resource-oriented music therapy (Rolvsjord, 2010). This orientation is well aligned with insight-oriented therapy (Hoglend & Hagtvet, 2019) and recovery oriented mental healthcare models (Kogstad, Ekeland & Hummelvoll, 2011).

Each music therapy session involved in the present study was approached by offering therapeutic support that was reflective of the researcher’s own eclectic philosophy of treatment, which is rooted in Jungian psychoanalysis (Jung, 1991), client-centered psychotherapy (Rogers, 1965), mindfulness-based stress reduction (Kabat-Zinn, 2003), Self-systems theory (Bandura, 1978 and Sullivan, 1955), and developmental trauma-informed somatic psychotherapy (Reich, 1945; Perls, 1969; Lowen, 1976; Herman, 1992; Payne & Levine, 2015; Van der Kolk, 2015). The music therapy experiences involved in the present study were also informed by the concept of flow (Csikszentmihalyi, 1990). Nakamura, Tse & Shankland (2019) describe flow as “an

optimal psychological state characterized by the enjoyment of deep absorption in what one is doing. This psychological state is autotelic (i.e., rewarding in itself); experiencing flow intrinsically motivates individuals to engage in activities that are conducive to it." Flow has been discussed widely within resource-oriented motivational psychology literature (Csikszentmihalyi ,1993; Ryan & Deci, 2000; Nakamura, Tse & Shankland, 2019), and within music therapy literature specific to musical improvisation in therapy (Wilhelmsen, 2012; Silverman & Baker, 2018).

Music therapy specific methods that the present researcher drew from as the music therapy sessions progressed included Analytic Music Therapy (Priestley, 1975; Scheiby, 2020; Aigen, Harris & Scott-Moncreiff, 2021), Guided Imagery and Music (Bush, 2002; Beck, Hansen & Gold, 2015), improvisation (Bruscia, 1987; Lee, 2000; Albornoz, 2011), mindful instrumental and vocal improvisation (Fidelibus, 2004; Lesiuk, 2016; Hicks, 2020), and the Iso-principle (Rider, 1997; Rider, Floyd & Kirkpatrick, 1985; Lee, 2005; Heiderscheit & Madson, 2015). Each of the treatment methods presented here have been shown to be clinically effective in reducing client reports of symptoms of anxiety, stress or depression in either inpatient or community mental health settings.

The integration of these theoretical foundations, methods of application and the insight-centric recovery orientation outlined previously allowed the sessions involved in the present study to include music therapy experiences which supported the participant as she introduced, explored, and in some cases, resolved, personal dilemmas as a safe, trusting, and supportive therapeutic relationship was developed. I observed the participant

closely throughout the present study, identifying therapeutic events which resembled the positive change characteristic of pivotal moments. Later description of data selection and analysis will provide insight into the participant's experience and identification of these moments of insight development and growth.

Chapter 3: Methodology

Purpose

The purpose of this study was to explore one adult participant's experiences of a series of individual music therapy sessions that involved varied applications of two types of music therapy techniques: mindful improvisation and guided imagery and music. As the researching clinician, I chose to conduct a phenomenological case exploration, employing Transcendental Phenomenology as the guiding research methodology (Moustakas, 1994). My initial goal was to observe the participant's responses during the music therapy sessions to obtain an understanding of the elements at play surrounding the participant's organic experiences. As the study progressed, my goal shifted from simply identifying specific contextual elements toward seeking insight into the emergence of elements which were found to be essential in the emergence of one invariant phenomenon. In collaboration with the research participant, four therapeutically significant moments were highlighted. Systematic analysis of the highlighted data, which included phenomenological reduction, thematic analysis, and imaginative variation (Moustakas, 1994), allowed the structural elements of the highlights to emerge. Further analysis of the structures provided a contextual understanding of the interplay among elements and their relevance in the emergence of an invariant phenomenon.

Recruitment

To allow for in-depth exploration of the participant's experience, I recruited one participant for this study. To begin the recruitment process, I collected a convenience sample of my proximal area by advertising for willing participants within my community. I advertised for recruitment using physical flyers, which were posted in community settings such as retail stores, coffee shops, libraries, and community centers (Appendix A). The recruitment flyer was also shared with three instructors across two contrasting academic departments at a small liberal arts college located in my city of residence. I also posted the recruitment flyer on my personal social media accounts.

I sought to collaborate with an individual who would represent the adult population in my community, which is a low-income, low health-literate geographic region in the Eastern Midwest region of the United States. As respondents contacted me, I used a pre-prepared phone screening document to guide discussions with each interested individual (Appendix B). Potential for rapport building and participant intentions were factors I considered beyond general inclusion eligibility. Caution was taken to ensure that individuals known to me personally were not included in the screening process. During the phone discussions, I asked a standardized set of questions and answered all questions and concerns from each respondent.

Inclusion Criteria

Requirements for inclusion included the following: 1) The participant should be aged 18 or older, 2) The participant should be without a formal diagnosis of any psychiatric or mental disorder, but may presently be experiencing symptoms commonly

associated 3) The participant should presently be seeking support during their journey toward wellness, through transition/loss, personal growth or exploration, or to aid in coping with mild to moderate anxiety, depression or stress, 4) The participant should not have significant hearing or sight impairment, 5) The participant should be available to commit to, without compensation, 2-4, ~2 hour sessions over a 5-10 day period, 6) The participant should have at least beginner proficiency on one, non-winded, recreational musical instrument (i.e., three chord knowledge on guitar, keyboard, or ukulele, ability to repeat patterns using a hand drum or accessory percussion instrument, or intermediate proficiency on any electronic/synth instrument).

Five respondents who self-identified as meeting the advertised inclusion criteria were screened for eligibility. Ultimately two individuals were identified as ideal participants based on their eligibility, my anticipated ease for rapport building, and our mutual availability. One of the two potential participants was informed of their alternate status and the other was contacted to schedule the music therapy sessions.

Nicole was selected as the ideal candidate for several reasons. First, she was the only respondent to meet, without exception, each of the requirements for inclusion. Next, I ranked Nicole higher than all other respondents on each of the rapport potential scales included on the phone screening document. My initial impressions of Nicole were that she had a genuine interest in engaging in my study for her own therapeutic benefit, and that she demonstrated a level of self-awareness that I felt to be conducive to engaging in meaningful work in a relatively short period of time.

Though the individual chosen as the alternate also demonstrated a genuine desire for participation, I did not rank confidence in my ability to support their needs as highly as I did Nicole's. The three remaining respondents all met the majority inclusion requirements, but each presented questionable eligibility of at least one criterion. The remaining respondents were informed of their exclusion and were provided with personalized lists of alternative resources based on my awareness of opportunities and their indications of desire for such support.

Consent, Setting and Music Therapy Sessions

During this project, individual music therapy sessions were conducted with the same adult participant. The sessions were each conducted after Nicole's daily obligations at work and school concluded (beginning at approximately 6pm) over a 5-day period, with sessions 1 and 2 occurring on Monday and Tuesday, sessions 3 and 4 on Thursday and Friday. Prior to the start of the first session, the participant and I discussed consent terms and the participant provided written informed consent (Appendix C).

Each session included a pre-session epoch meditation, pre-session discussion, varied applications of either improvisational or guided imagery and music based therapeutic music experiences, and post-session discussion and processing. Sessions lasted an average of two hours from start to finish. All sessions took place in a clinic room available at the college located in my city of residence. The space ensured privacy of sight and sound, and allowed for adequate video and audio recording, instrument set up, and movement. The space and the positioning of objects remained consistent throughout the series of sessions. In compliance with direction provided my thesis

committee, a supervising MT-BC and representative of the local college was present in the building for the entirety of each session in the series.

Design

The execution of the project relied equally on my roles as the researcher and facilitating clinical music therapist, the participant's presence within and responsiveness to the therapeutic process, and our relationship and shared experience of the music and other session events. My dual role necessitated the use of a research methodology that allowed for extensive exploration of both roles as they exist individually (therapist and researcher). It is important for consumers of the present report to be aware that the research participant and I were equal collaborators in both the therapeutic and research processes.

The inquisitive, qualitative nature of this study lends itself to an instrumental case study research design (Mills, Durepos & Wiebe, 2010). However, given my intention to acquire insight to the phenomenological experiences of the participant throughout a series of reflexive, insight oriented therapeutic music sessions which I would facilitate, I employed data collection and analysis methods characteristic of Transcendental Phenomenological Inquiry (Moustakas, 1994). It was my expectation that the integration of this epistemological, ontologically driven research methodology with the insight oriented instrumental case design would allow me to immerse fully in the therapeutic process and later observe from an objective stance the emergence of the essential structural elements of phenomena occurring within the music therapy sessions.

I designed this case exploration with the anticipation of employing procedures of Moustakas's model of Transcendental Phenomenology (1994) during data collection and analysis. The present report will later detail the results of each phase of the project in such a way that highlights my method of discovering the essential structural elements of the participant's phenomenological experiences of the therapeutic process. Familiarity with the elements of this complex methodology is necessary for later realization of the significance of the study's results.

Research Methodology: Transcendental Phenomenology

Transcendental Phenomenology is a research methodology which was adapted by Clark Moustakas in 1994 from the philosophy of Edmund Husserl (1931). The focus of the methodology is to develop understanding of the human element of experience (Moustakas, 1994). The integration of Moustakas' Transcendental Phenomenology method in this study began with the epoch meditations that infiltrated data collection. The study procedures relevant to the method that were followed during analysis included phenomenological reduction, bracketing, horizontalization, imaginative variation, and synthesis (Moustakas, 1994). Below are descriptions of each of the procedural components of the methodology.

Epoch. The procedure that is perhaps most characteristic of transcendental phenomenology is the epoch. The epoch is a process involving the identification and subsequent abstinence from bias and presuppositions. Described as an introspective process of becoming aware of and then setting aside all material that may potentially influence perception of phenomena, the epoch is intended to avoid the projection of pre-

acquired knowledge into the data. In the context of this study, the epochs allowed me to view session phenomena as pure-conscious human experiences while still fulfilling my role as a present and reflexive facilitating clinician. Incorporating the epoch as a pre-session procedure allowed me to approach each session in the series with a fresh and unassuming perspective. In an effort to remain consistently unbiased throughout the session series, I engaged in a self-developed, visual art and mindfulness meditation-based epoch process before and after each session in the series (Appendix D).

Phenomenological Reduction. Phenomenological reduction is a multi-step phase of Moustakas' framework that occurs after all data has been gathered and organized (Moustakas, 1994). It included the process of reviewing the session recordings several times, creating memos, describing the events using rich, textural language, and then bracketing the descriptions to leave only material relevant to the research questions. The necessity to narrow down the expansive data acquired during the session series led me to identify small groups of meaningful data (called highlights) for closer analysis. This process began with a procedure called *bracketing*, which is the component of phenomenological reduction that involves reducing the data to leave only the content most relevant to the research questions. I was prepared to engage in unbiased bracketing of each music therapy session, in part because of my experience accessing a nearly objective view of the therapeutic process by engaging in the epoch meditations.

After bracketing each session's data content, I presented summaries of the contents of the bracketed material to the research participant during a post-series member-checking discussion. The participant helped narrow down the bracketed material

further. This resulted in the identification of four session highlights, which Nicole and I mutually recognized as being therapeutically significant series events. In a reflective process of reviewing each of the highlights and considering the session context from which they were removed, I named each highlight for ease of reference. Once data relevant to each of the four session highlights were compiled into groups called highlight pods, contents of each pod were uploaded into a qualitative data analysis software for analysis. The initial coding of each highlight allowed for *horizontalization* of the data contents.

The horizontalization stage of the phenomenological reduction of each highlight resembled coding of textual, qualitative data. In this stage, each element of data was coded according to its connectedness to each of the three equal and invariable elements present in each highlight (a) participant, (b) music therapist, and (c) music. Horizons were further coded to reveal invariant qualities of each highlighted phenomenon. It is notable that the first pass of coding following horizontalization resulted in the further categorization of horizontalized data into invariant meaning groups that were separate from the horizons themselves, but identical in label to the horizons. The secondary meaning groups included elements of each highlight (see highlight names). These meaning groups and their associated coded content became the focus of thematic analysis (Braun and Clarke, 2006).

During thematic analysis, each of the invariant meanings were organized into visual maps and grouped into *theme clusters*. Theme clusters were visually analyzed and combined, resulting in the emergence of main themes (individual textural qualities) of

each highlight. *Individual textural descriptions* were assigned to each highlight's main themes. *Composite textural descriptions* of each highlight were created by combining the individual textural descriptions of each main theme. The therapeutically significant session highlights (highlight phenomena) are represented in further analysis and by their associated composite textural descriptions.

Imaginative Variation. The *imaginative variation* stage of data analysis allowed me to reach a more robust understanding of the characteristics of the highlight phenomena by extracting further meaning from the results of the phenomenological reduction. This exploratory stage involved consideration of possible alternative meanings of the textural information relevant to each highlight phenomenon. A progressive synthesis and reduction of textural qualities resulted in the emergence of essential structural elements (structural themes) of the invariant phenomenon.

In working toward allowing structural elements of the highlight phenomena to emerge, I invited the following into the data: A) additional possible meanings of textural qualities, and B) additional perspectives of textural qualities. Revised textural descriptions were created and subsequently reflected upon during a period of free thought referred to as *free fantasy variation,* which resulted in identification of the structural qualities of each highlight phenomenon. Results of the variation procedures underwent thematic analysis, and emergent structural themes were assigned individual and composite structural descriptions.

Synthesis. The emergence of the essential structural elements (structural themes and descriptions) of the phenomenon and subsequent synthesis of structural and textural

descriptions allowed for inference of substantiated responses to each of my pre-determined research questions. The synthesis stage of data analysis involved the intuitive integration of composite textural and composite structural descriptions of the invariant phenomenon. This resulted in a description of the essences and associated meanings of a phenomenon found to have occurred organically within the context of all four music therapy sessions involved in the study series. Project results describe in detail the structural elements of the emergent phenomenon.

Data Collection Procedures

Data collection in this study occurred throughout the facilitation of each music therapy session. Raw data resulting from Sessions 1-4 included (a) session audio and video recordings and transcriptions, (b) pre- and post-session interview notes, (c) patient journal, (d) researcher's epoch journal, (e) researcher's fieldnotes. All physical project data was kept in an unmarked binder that I stored in a locked desk drawer in a private office between sessions and after the conclusion of the session series. Electronic material was stored on a password protected flash drive, which was stored with the binder of physical contents. Due to unanticipated equipment malfunction, audio recording of Session 1 was not obtained. For this reason, the data set from Session 1 includes a detailed session outline produced during review of video and physical session data in place of an audio transcription. Each session involved the following:

1. Pre-session Epoch,
2. Pre-experience interview/discussion,
3. Therapeutic music experience facilitation, and

4. Post-experience processing/interview/discussion.

Pre-Session- Epoch

I developed a personalized epoch process involving a combination of meditation (involving free-associative journaling and painting) and structured note taking (Appendix D). Implementing this protocol consistently throughout data collection helped me become aware of preconceived conclusions, biases and assumptions that had been formed after each prior interaction with the participant before facilitating each new session. The initial epoch allowed me to become aware of impressions made during the recruitment phone screening, allowing the first session to act as a first meeting with the participant.

I began each pre-session epoch with meditation. Some of my meditations were strictly contemplative, while others involved actively creating visual art in my epoch journal. I began each meditation by renewing my intention to engage in the coming music therapy session deeply, and to observe Nicole's process through unbiased eyes. I intentionally engaged in mindfulness-oriented meditation because of my personal experience with the practice and my familiarity with the method's progression from *drawing awareness* to *letting go*. Each meditation allowed me to become aware of lingering personal thoughts and impressions from the previous interaction. Through bringing awareness and engaging in reflection, I allowed myself to acknowledge the decisions and connections Nicole had shared, and the early conclusions I made as a result. I practiced intentional non-judgement of both my own and Nicole's thinking. As I came to sense that the contents of the previous interaction had been sufficiently acknowledged and considered, I allowed myself to accept the experience for what it

offered, then I engaged in the act of letting go of the biased knowledge through visualization and deep breathing. I did take notes after each meditation in a dedicated epoch journal, which allowed for post-series compilation of epoch material.

Pre-Experience Interview/ Discussion

Each of the four music therapy sessions facilitated during data collection involved pre-experience discussions which were guided by a pre-determined interview guide document (Appendix E). Though the questions were not asked in a standardized order, I did prompt Nicole to provide answers to these general questions as needed in the context of the pre-experience discussions which were largely guided by the participant.

Each encounter began with this discussion-based check-in, during which Nicole required very little prompting. In data review, it was revealed that I unintentionally opened each of the four pre-session discussions by asking "How was today?" Nicole was consistently forthcoming and did share about her impressions from the previous encounter without being directly prompted to do so. The pre-experience discussions transitioned into the facilitation of the therapeutic music experiences organically, and each of the pre-experience discussions involved a fair amount of verbal processing of personal concerns shared by Nicole that were relevant to her therapeutic intentions. The content of these discussions helped me determine how to proceed with facilitation of the therapeutic music experiences.

Therapeutic Music Experience Facilitation

The music provided in each session was reflexive of Nicole's moment-to-moment responses during each therapeutic experience, and as a result was largely anti-climactic

and included only moments of subtle dynamic and textural shifting. The music involved in each experience served as an agent for inducing relaxation, sustaining directed attention, and signaling therapeutic attunement. Varied applications of two music therapy experiences were implemented during the session series—mindful improvisation and guided imagery and music. Nicole engaged with these experiences both actively and passively, and I provided verbal guidance throughout each experience. Detailed reports of music experiences relevant to each highlight are included in the results section of the present report.

Post-Experience Processing/Interview/Discussion

As each session's therapeutic music experience was led by Nicole's response, each began and ended organically. Post-experience processing after each session was different, but each allowed Nicole the choice between processing verbally, by journaling, or by taking a break prior to engaging in a more formal post-session interview. After session one, Nicole processed verbally while lying on the floor. Session two was followed by a period of journaling, during which Nicole and I entered in our own journals while remaining in the session space together. Session three ended with post-experience discussion that began directly after Nicole's improvisational drumming gradually stopped, and Session 4 was followed by a lengthy discussion about how the contents of the session allowed for a satisfying end to the session series as a whole. Though I encouraged Nicole to engage in reflective journaling between session meetings, her journaling was inconsistent throughout the series, however, thoughtful.

Similar to the pre-experience interview, the post-experience interview and discussion were loosely guided by a pre-determined set of prompts. The post-session interview guide included the following types of prompts (Appendix F).

1. Tell me about what you noticed during the music experience.
2. Describe what you heard, felt, saw, or sensed during the music experience.
3. What emotions do you remember experiencing?
4. What do you want to remember from today's work?

Data Organization and Analysis Preparation Procedures

The raw data resulting from data collection were organized in preparation for systematic data analysis after the series of sessions concluded. Organizational procedures included dividing of audio video recordings into ~15-minute segments; development of auto-generated transcription of each session's audio/video recordings; typing of handwritten session documents including pre- and post-session interview notes and researcher fieldnotes; and creation of digital copies (scans) of physical participant journal entries and researcher epoch materials. All digitized project data was uploaded and stored in an encrypted cloud-based drive, to which only I have access. Per the signed consent agreement, I do have Nicole's permission to safely store electronic data for possible later use. The agreement does state that I must receive permission from the participant to share the data for any purpose other than reporting of the results of the present thesis project (Appendix C).

Post-Series Downtime, Feasibility Practice and Memo Revision

After the conclusion of the session series, I spent an intentional period of ten days engaging in informal, personal, arts-based processing and reflection. During this period of downtime, I allowed myself to disengage from the therapeutic process to promote objectivity during data analysis. After the post-series downtime, I began to engage with session material slowly. Random review of Session #2 content served as an opportunity for me to assess the feasibility of data analysis. My awareness of the extensive amount of data collected prompted the decision to narrow down the data for analysis to ensure thorough analysis of data most relevant to research questions (Moustakas, 1994). This informal feasibility review of Session 2 also allowed me to narrow down the scope of the memo protocol document to be used later during data analysis (Appendix G).

Data Analysis Procedures

Data analysis involved procedures characteristic of Transcendental Phenomenology, which were defined in detail earlier in the present report (Moustakas, 1994). An outline of data analysis procedures is included below.

1. Phenomenological Reduction
    a) Bracketing
    b) Horizontalizing
    c) Data Coding
    d) Thematic Analysis
2. Imaginative Variation
3. Synthesis

Step 1: Phenomenological Reduction

The initial review of data involved a review of session audio/video, during which I took detailed notes and created outlines and summaries of each of the four sessions within the series. Subsequent reviews of the session recordings allowed me to draw connections between observable content apparent in the recordings, transcripts of each recording, and physical data created before, during and after each music therapy session. Forms of physical data involved in these initial reviews included content from the participant's journal, handwritten session notes, handwritten notes collected during pre- and post-session interviews, and contents of my epoch journal. After this point in the review process, I assigned names to each of the 4 sessions in an effort to sustain familiarity with the contents of each session. As an emergent goal of mine was to preserve Nicole's identification with and perspective of the therapeutic process in later reporting, each name assigned was comprised of a direct statement made by Nicole during each respective session. Session Names are as follows:

1. "I can listen to my body."
2. "I am in control."
3. "I didn't let it move me."
4. "I want to make myself happy.

Bracketing. After each session's data was reviewed thoroughly, I intuitively bracketed sections of each session that stood out during the review and summarization process as being notable or especially relevant to the overall therapeutic process and/or research questions. These significant moments were identified as *highlights*.

Member Checking. After the bracketed material (highlights) was summarized, it was presented to the research participant during a post-series member checking discussion. This discussion served as the primary measure of validity in this study (Motulsky, 2021). It also allowed me the opportunity to re-connect with Nicole to learn about her lasting takeaways and perspectives of her therapeutic process. The contents of each highlight were discussed with the participant, who confirmed and clarified her memory and understanding of each session and the associated highlights. The participant's post-series insight allowed to narrow the bracketed material further and select one highlight from each session. In a reflective process of reviewing each mutually agreed upon highlight and considering the session context from which each was removed, I named each one for ease of reference. The highlight names are as follows:

1. Release of Holding,
2. Letting Go of Expectation,
3. Connecting with Self through Taking Control, and
4. Intentionally Integrating.

Development of Memos. One additional data preparation procedure occurred within the content analysis stage. After highlights were chosen for analysis, I reviewed the audio/video content of each highlight and took notes in the form of memos. Memo forms were added to each highlight pod and were analyzed along with all relevant session content during coding and subsequent thematic analysis. The inclusion of memos as data for analysis ensured that the researching clinician's perspective of the highlighted

material and original thoughts resulting from session content review were represented in the data in a structured way (Appendix G).

Horizontalizing. Once data relevant to each of the four session highlights were compiled into groups called highlight pods, contents of each pod were uploaded into a qualitative data analysis software for analysis. The initial coding of each highlight allowed for *horizontalization* of the data contents. In this stage, each element of data was labeled according to its connectedness to each of three equal and invariable elements present in each highlight, (a) participant, (b) music therapist, and (c) music. These three invariant elements were identified as *horizons* (invariant meaning groups) and were further coded to reveal invariant qualities (*meanings*) still relevant to each highlighted phenomenon, but lower ranking in terms of the coding hierarchies established in the following stage.

Data Coding. Though the invariant meaning groups (horizons) were identified before the textural analysis shifted from horizontalization to thematic analysis, I did include the meaning groups and their associated highlight codes in the coding hierarchy during data coding. The first pass of data coding following horizontalization involved further coding of the horizontalized data. This resulted in the assignment of the first set of parent codes within the coding hierarchies of each highlight, below only the horizons themselves. I refer to these parent codes as *secondary invariant meaning groups*. The secondary invariant meaning groups that emerged from the data were noticed to be representative of the elemental components of change identified earlier in the data analysis process as being present in each highlight. These secondary meaning groups and

their associated coded content became the focus of thematic analysis (Braun & Clarke, 2006).

Thematic Analysis. Near the end of the data coding stage, each of the invariant meanings and their associated codes were organized into visual maps (Wheeldon & Ahlberg, 2019) and grouped into *theme clusters*. Theme clusters were visually analyzed and combined, resulting in the emergence of main themes representing each highlight. *Individual textural descriptions* were assigned to each highlight's main themes. *Composite textural descriptions* of each highlight were created by combining the individual textural descriptions of each main theme. The therapeutically significant session highlights became represented in further analysis and interpretation by their associated composite textural descriptions.

The results of the thematic analysis process include four composite textural descriptions which are representative of the emergent themes found in each highlight. Further analysis of the commonalities and interconnection between main themes across all highlights was completed (see Results- Table Annotations). This resulted in a set of composite (textural) themes and descriptions.

This set of composite textural themes, which is representative of the combined emergent themes from each highlight, was organized by rate of occurrence, Tiers 1-4. Two main themes were found to be present in 3 of 4 highlights, and thus were identified as Tier 1 Themes. Three main themes were found to be present in 2 of 4 highlights, and thus were identified as Tier 2 Themes. 8 main themes were found to be present in 1 of 4 highlights, and thus were identified as Tier 3 Themes. One secondary theme was found to

emerge from analysis of 3 of 4 highlights, and thus was identified as Tier 4 Theme. In the context of the following data analysis step, imaginative variation, the main themes associated with each tier are referred to as *textural qualities* of the set of highlighted phenomena. Because of this, I chose to focus only on Tier 1 Themes (Control and Awareness) during imaginative variation due to their equal representation of each highlight.

Step 2: Imaginative Variation

My process of *imaginative variation* first involved visual mapping of possible alternative meanings of each of the emergent Tier 1 Themes. Next, I considered the meanings of the textural qualities from the perspectives of each of the three roles involved in the therapeutic relationship (the participant, the music therapist, and the music itself). After this variation of perspective, revised textural descriptions (meanings) of the textural qualities were reflected upon during a process referred to as *free fantasy variation.* During this period of free thought, I identified qualities of each highlight phenomenon that seemed evocative of the textural qualities (i.e., pre-coded content within the original coding hierarchies that were characteristic of the main themes of highlights 1-4). I further reflected on the highlight content and imagined the impact that removing or changing the listed qualities would have on the phenomena.

This intuitive, imaginative process resulted in the creation of a list of *structural qualities* of the composite Tier 1 themes (i.e., essential elements of main themes from each highlight). The list was later organized into *theme clusters*, which were intuitively synthesized to reveal a set of *structural themes* representative of the combined structural

qualities of the Tier 1 themes. Universal structural elements of the clusters of themes emerged during thematic analysis of the structural qualities, which allowed me to consider each emerging theme as being representative of the essential, structural elements of the set of highlights (one invariable phenomenon), rather than of individual highlight phenomena. As four individual structural themes emerged from the thematic analysis of the listed structural qualities, the invariant phenomenon was identified as one of the themes and labeled with a universal descriptive name. *Individual structural descriptions* of each structural theme were created.

Below, Table 1 provides an overview of the language Moustakas (1994) uses to distinguish each process within imaginative variation. Note later that only Tier 1 themes were included in the imaginative variation process, as they are the composite representations of the main themes associated with highlights 1-4. In further description of analysis procedures, Tier 1 themes (Awareness and Control) are also referred to as *composite textural qualities*.

Table 1

Imaginative Variation Terms Defined

Stage	Term	Description	Relevant Procedures
--	Textural qualities (Tier I Themes) *	Main themes emerged from phenomenological reduction and thematic analysis of highlights 1-4.	(See relevant results within description of phenomenological reduction and thematic analysis procedures)
A	Meaning variation	Variation of possible meanings of composite textural qualities	Visual mapping (Wheeldon & Ahlberg, 2019)
B	Perspective variation	Consideration of the highlight phenomena from the varied perspectives of roles relevant to the therapeutic relationship (music, participant, music therapist)	Written textural description of Tier 1 themes from varied perspectives
C	Free fantasy variation	Identification of the structural qualities of Tier 1 Themes (Awareness and Control)	Free thought: -Listing of possible structural qualities of Tier 1 Themes -Contemplative variation of those qualities -Identification and listing of confirmed structural qualities
-	Structural qualities	Essential elements relevant in the emergence of textural qualities	(Elements found to be essential to the existence of the textural qualities of highlights)
-	Theme clusters	Clustering of structural qualities (meanings) of the invariant phenomenon into theme groups	Hand coding of the list of structural qualities derived from free fantasy variation
-	Structural themes	Emergence of universal structural elements essential to the existence of the invariant phenomenon	Visual mapping and further reduction of theme clusters into broad themes that offer universal representation of all elements of the invariant phenomenon

Step 3: Synthesis

The final step of the multifaceted transcendental phenomenological data analysis procedures involved the intuitive integration of composite textural and composite structural descriptions of the invariant phenomenon. After the invariant phenomenon was identified, each of the individual structural themes identified through imaginative

variation were assigned *individual structural descriptions*. From these, a *composite structural description* of the invariable phenomenon emerged. The emergence of the essential structural elements (structural themes and descriptions) of the invariant phenomenon and subsequent synthesis of structural and textural descriptions allowed me to infer substantiated responses to each of the research questions characteristic of the present project. The result of synthesis is a description of the essences and associated meanings of the phenomenon found to have been organically represented within the context of all four music therapy sessions involved in the study series. Project results describe in detail the essential structural elements of the invariant phenomenon.

Chapter 4: Results

Session Space

Each of the four music therapy session took place in a private clinic room situated in an enclosed hallway in a low trafficked building on a small college campus. Sessions, which took place over a five-day period, began at approximately six o'clock in the evening in early April, the sun just beginning to set each day as my participant, Nicole, made her way from across campus to our meeting space. The room was lit by a row of slightly dimmed, canned ceiling lights and a narrow window in the corner of the room furthest from the door. The walls were colored in soft, light beige, and deep grey, textured carpet spanned the floor. In the room were two chairs placed approximately four feet apart, two tubano drums placed between them, an upright piano and bench, a small wall mirror and various additional musical instruments including my guitar, two conga drums in stands, and assorted small accessory percussion. Video cameras were visible in two corners of the room, one behind Nicole's chair, the other behind mine. Next to my chair was a music stand holding organizational materials, a guitar tuner and capo.

Therapeutic Music Experience Facilitation

I began the music making portion of each session by encouraging Nicole to engage in deep breathing while intentionally bringing awareness to the present moment. I intuitively determined the music therapy experience to be used in each session after engaging with Nicole during each pre-experience discussion. Nicole's topics of concern, her demonstrated level of energy and comfort, and my intentions allowed for context-dependent determination of the music therapy techniques to be implemented. The first

goal of each music experience was to assist Nicole in reaching a grounded mental and physiological state. In the context of this study, grounding should be understood as a mechanism for offering the participant an external task to remain oriented with in the present moment as they become increasingly engaged with the topic of intention (Witte et al., 2020). As each experience progressed, I encouraged Nicole to remain active in exploring her intention topic by giving prompts and suggestions for focusing her awareness.

Each therapeutic music experience involved in the session series consisted of live, improvised music intended to serve as means for grounding while reflecting Nicole's experience. I approached these music experiences from both human-centered and mindfulness-oriented approaches (Rogers, 1965; Robb, 2000). Each session did involve varied implementation of either mindful, improvisational music making (with both the participant and music therapist using tubano drums), or music assisted relaxation with guided imagery and music (supported by improvised guitar and vocal music provided by the music therapist). I employed additional therapeutic techniques in each session, including progressive muscle relaxation with autogenic suggestion, positive affirmation, referential and non-referential improvisation, and verbal techniques including reflection, asking questions, confronting, focusing and verbal tracking (Gooding, 2017).

Each therapeutic music experience relied on the therapeutic and musical relationships between Nicole and me. As Nicole engaged with each experience, I responded to fluctuations in her somatic rhythm while continuing to prompt her to remain grounded in her intention and awareness of her present moment (McFerran et al., 2020).

As we breathed together, I reflected Nicole's tempo of breath and incorporated guiding language inclusive of the content of the previously discussed session intention, i.e., "Allow your ear to tune into the rhythm of the drum—notice its tone, its movement, its depth," "Allow yourself to slow down and sink in," "Give yourself permission to make space for exploring your anxious feelings," "Notice any tension you may be holding in your body," etc. (Grocke, 1999; Helmecke & Sprenkle, 2000; Bruscia, 2002; Lin et al., 2010; Giorgi, 2011).

The music involved in each experience served as an agent for inducing relaxation, sustaining directed attention, and signaling therapeutic attunement. The music provided in each session was reflexive of Nicole's moment-to-moment responses during experiences that were largely relaxation-based. The result was anti-climactic music that included frequent, subtle shifts in dynamic and texture. The participant-directed nature of the music experiences allowed Nicole to identify or demonstrate at least one instance of perceived change in her engagement in each experience (Lee, 2000).

Case Exploration: Nicole's Process

"Nicole," (she/her/hers) is a 19-year-old cis-gender female who is calm in nature, bright, well-spoken, highly determined, and immensely self-aware. She is tall and physically fit, and she has long, light brown hair, light, grey-blue eyes, and fair white skin. She wears casual, trend-consistent clothing, and typically has slouched posture and congruent affect. Nicole self-identifies as bi-sexual, and she maintains a happy and supportive relationship with her current partner. Nicole is a full-time undergraduate Health Sciences major, a highly competitive collegiate athlete, and a hard-working

financial contributor to her own educational and social endeavors. She recently began a new role as a resident assistant (RA) at her college and has found a new passion for supporting new college students as they navigate life transitions. Nicole finds personal confidence and comfort in competing in her sport, casually playing her violin, journaling, and engaging in art. She sought therapeutic support for ongoing stress management and self-growth through participation in the present study.

Nicole shared that she had been experiencing a high level of stress in the ~18-months preceding her participation in this study that she was aware had been negatively affecting her motivation, self-image, personal relationships, and her ability to participate meaningfully in everyday life. Contributing factors to Nicole's ongoing stress included, beginning to process historical and recent interpersonal, sexual, medical, and social trauma; balancing full-time studies with an 80-minute commute from home to school, part-time work, and collegiate athletics obligations; navigating new and old personal relationships; and managing family, financial and time-management related stress. Nicole shared that she had experienced a range of emotional and mental states in coping with these stressors prior to seeking support, including social-isolation, depression, frustration, fear, neutrality, avoidance, and most recently, anxiety. Nicole began our session series determined to "not set expectations," and she acknowledged feeling that she came to this experience "ready to begin processing but needing a nudge." Nicole set a series intention to become better at coping with the persistent physical and emotional anxiety that she felt to be the result of the ongoing stress.

Nicole and her two younger sisters were raised by their parents in a middle-class home in a suburban town in central Ohio. Nicole's father worked as a contractor most of her life, and recently transitioned to working as a full-time, at home farmer. Nicole shared that she has had a consistently supportive and mutually caring relationship with her dad her entire life. Her mom is considered the breadwinner of her family, as she works full-time as an advanced healthcare practitioner. Nicole shared that her relationship with her mother is one that is strained and emotionally distant, having involved emotional neglect and verbal abuse from early childhood to present. Nicole shared that her two younger sisters are a source of comfort, joy, concern, and stress in her present life. Nicole felt it important to note that one of her sisters has a long-time diagnosis of Autism, which she feels has sometimes placed additional strain on the already complicated family-emotional dynamic in their home. She considers herself to come from a cold and unaffectionate household, which she remembers as having provided very little praise and encouragement. She shared that this description is still accurate and present in her young-adult life.

Nicole's senior year of high school and freshman year of college were significantly inhibited by the onset and continuation of the COVID-19 pandemic. During her first year of undergraduate study, she experienced an injury requiring surgery and an extended recovery time which caused her to sit out a significant portion of her first season as a member of the track and field team. During that same year, Nicole was raped by a classmate with whom she had been friends for over five years prior to attending college at the same institution. Shortly after, one of Nicole's former friends reported the

assault on her behalf without receiving permission from Nicole to do so. This caused Nicole to face harsh criticism from her former social circle, as well as from her rapist. The decline in mental health she experienced after these events the previous school year caused her and her family to make the decision for Nicole to live at home (80 minutes from her college) for sophomore year, rather than returning to a potentially dangerous living situation on campus. Nicole acknowledged that the separation of school and home was helpful at first, but as she has come closer to the end of her sophomore year, she has been anxiously awaiting the next school year so that she can avoid having long periods of down-time on campus in between obligations. She shared that she has historically been able to effectively self-manage stress and anxiety but noted feeling "stuck" prior to seeking support via participation in the present study.

Epoch material from my journal will be shared as appropriate within the remainder of this case study report. Figure 1 depicts epoch material that was created before session 1 and is reflective of my impressions of Nicole after our initial phone screening discussion.

Figure 1

Epoch Material Created Before Session 1

Session 1- "I Can Listen to My Body"

Nicole came into our first session after having just left a class during which she unexpectedly engaged in an anxiety producing activity. During the pre-experience discussion, Nicole shared that this experience was one that caused a sense of lingering anxiety, despite the fact that she felt she successfully coped with the anxiety at the time of the experience. She shared that she is "an expert speed processor," but that she often feels discouraged when she realizes her anxiety stays present in her mind and body sometimes even hours after she experiences a stressful event. After lengthy discussion about Nicole's relationship with anxiety, I guided her to set an intention for the day's session that would allow her to make space for the lingering anxiety, rather than disregarding its presence. With support, Nicole set a therapeutic intention for our first session to "Explore what it feels like to be anxious."

During session 1, Nicole engaged in guided relaxation and mindful breathing supported by live, improvised guitar and vocal music. This was Nicole's first lifetime experience engaging in guided relaxation. She began the experience seated in a chair, but quickly requested to lay on the floor in the session space. I observed Nicole shift her body's position anxiously as she began to engage with my gentle prompting. The purpose of each verbal prompt provided during the experience was to encourage Nicole to become aware of and remain present with both her cognitive and somatic states while establishing a safe context for introspective exploration. Nicole demonstrated several active, somatic responses during this music experience, which were marked by apparent voluntary and involuntary movements through her entire body. After the experience,

Nicole acknowledged noticing a variety of dramatic shifts through affective states during the experience, noting that she had not anticipated a non-linear process. She indicated that some of these states were welcome and comforting, while others unfamiliar and overwhelming. Ultimately, Nicole experienced several energetic and emotional releases during the passive music experience which resulted in free tearfulness, deepening of breath, awareness of mind-body relativity and development of insight relevant to her primary self-identified problem, anxiety.

Nicole's takeaways from session 1 included her wanting to remember that she is "safe, strong, and capable," and that she is "in control." Nicole did share that she was aware of shifting colors throughout the experience, to which she was drawn, but made no major connections with. Nicole noted feeling very aware of a twitching and shaking sensation in her body during the experience. She shared that she felt deeply connected to two concepts introduced by the music therapist as she was guided through the experience (a) "I can ask myself, what do I want to hold?" and (b) "I like the idea of inviting the movement." When prompted to share what she would take from the day's work, Nicole stated, "I can listen to my body." In the post-series member-checking interview, Nicole shared that she considers our first session to have been a "pivotal moment in [her] ongoing trauma processing," as it allowed her to develop familiarity with "being open and allowing [herself] to experience each emotion entirely."

Session 1 Highlight- Release of Holding. The highlighted content from session 1 that was included in data analysis captured one of several instances of Nicole demonstrating energetic and emotional release during the music experience. Nicole's

demonstration of physically releasing held energy and emotion spanned approximately 17 minutes of the session recording, and the associated highlight pod included data gathered from the following: Session 1 Timeline document, Post Session 1 Interview Notes Document, Participant Journal (Post Session 1), Session 1 Video (No Audio), and Session 1 Memo Document. The music provided in session 1 during the highlight involved improvised guitar and vocalization of affirmations. I played a simple guitar progression in C Major, which included stepwise ascending and descending arpeggiation of the tonic chord, intermittently including subtle hammer on/off embellishment of 1st and 6th scale degrees. The dynamics were consistently pianissimo with little variance, time remained in 3/4 except during periods of transition to 4/4 when Nicole's physical response was notably more active.

Session 2- "I Am in Control"

Our second session began with a discussion about Nicole's experiences during session 1. She made several connections between what she had experienced in the session and how she viewed them as relevant to her ongoing experience of anxiety. After a lengthy discussion about setting intentions rather than expectations, Nicole identified a personal tendency to judge herself for avoidance and procrastination that she considers to be "secondary symptoms of the anxiety." With support, Nicole set an intention for our second session to "Explore the balance between Self-kindness and accountability."

In an effort to demonstrate the benefit of letting go of judgement as a form of self-kindness, I encouraged Nicole to engage in an unstructured, improvisational drumming experience. She was challenged to participate without projecting expectations for

musicality, content, quality, or result throughout the process. Nicole shifted between and explored several affective states by engaging with resonant drum tones during guided, mindful improvisation that resulted in her experiencing visual and proprioceptive imagery. Nicole's exploration was supported by empowerment-centric verbal prompting and reflexive, improvised accompaniment, which I played on a lower sounding drum. During the experience, Nicole demonstrated what she later labeled as "hesitance" toward engaging in improvisation, noting that she experienced physical and emotional discomfort throughout the experience. After the improvisation concluded, Nicole shared that she had been engaged with a childhood memory-based image from the first moments of the experience through its end. Her imagery involved "passively replaying" a childhood memory of her first solo violin performance, which entered her awareness as she noticed she had been tapping the fingering pattern of the solo piece on the drum as she worked to allow herself to make sound on the instrument in the session. In the post-experience interview, Nicole shared that the context associated with the memory of playing the particular piece of music is one of her earliest memories of feeling emotionally neglected by her mother. After discussion, Nicole chose to process the experience via mixed-media journaling.

Nicole's takeaways from session 2 were reflected in her post-experience journal. The journal included notes to herself to remember a) to just breathe, b) she is in control, c) healing is not perfect, d) to be open, e) to give kindness to herself, f) to figure out how to find/make peace. Nicole also noted sensing vibration in her chest and an eventual sense of calmness. She shared that she connected each of our drum tones with emotions.

The most clearly defined connection was the lowest tone representing anger. Nicole's journal also included small drawings of two images that she was aware of during the experience, the first a gradient swatch of coral-pink colored silk fabric, the second a depiction of her tubano's drumhead with nested, concentric circles representing the vibrations she experienced while drumming.

Session 2 Highlight- Letting Go of Expectation. The highlighted content of the second session captures Nicole transitioning from hesitant engagement with improvisation toward free, confident playing. The transition itself was demonstrated over 14.5 minutes, but Nicole's post-experience description of her experience was also included in analysis. Documents included in the highlight pod for session 2 are (a) Highlight 2 transcription document, which is an excerpt from the Session 2 summary with added detail, (b) post-session 2 interview document, (c) Participant journal 2, and (d) the researcher's memo document.

The music relevant to highlight 2 involved me and Nicole engaging in active instrumental improvisation, each playing a tubano. Nicole chose to play the smaller of the two, which she noted to have a more pleasurable, higher tone. I played the lower sounding drum, which Nicole noted felt warm and comforting. After I demonstrated playing basic bass, tone, and slap tones for Nicole, she indicated understanding of how to create different sounds on her drum by playing each back to me several times. I began the music experience by encouraging Nicole to listen and join in playing a simple four-count rhythm, which I demonstrated casually while audibly breathing in time with the beats at approximately 70 bpm (inhaling 1-2-3-4, exhaling 1-2-3-4-5-6-7-8).

Nicole engaged with her drum by gently tapping her fingertips near the outside of the drumhead, always returning to her "prime" position with her palms cupped around the outside rim of the drumhead. Eventually I began playing a syncopated rhythm, still in 4/4, and Nicole began playing steady quarter notes to fill in my rhythm using her middle three fingers. I noticed that Nicole's hands began to make increasing contact with the drum, and eventually her fingertip to three-finger playing transitioned into one flat, open palm resting in the middle of the drum. I prompted Nicole to allow herself to sink into the present and reminded her that the drum was safe to explore as deeply as she felt she needed to. Nicole's head nodded slightly as she continued to breathe with her eyes closed, and she began to play steady downbeats with one open palm at the drum's center. She continued to explore the drum with open palm and fingertips, and by swirling the back of her hand on the drum.

I continued to prompt Nicole to notice all that was present for her during the improvisation, offering vocalized affirmation when her playing became more consistent. Eventually Nicole's playing became more confident, and I matched her rhythm and tempo with my playing. I often added backbeats to her rhythm. In a brief check in during the improvisation experience, Nicole made me aware of a sensation she felt in her chest that she noted to be the vibration of the drum in her body. I encouraged Nicole to allow herself to experience the vibration and reminded her not to judge her body's response to the music. She began playing consistent, strong downbeats with the heel of her palm, accenting her own rhythm with her other hand using a relaxed, three-finger slap tone.

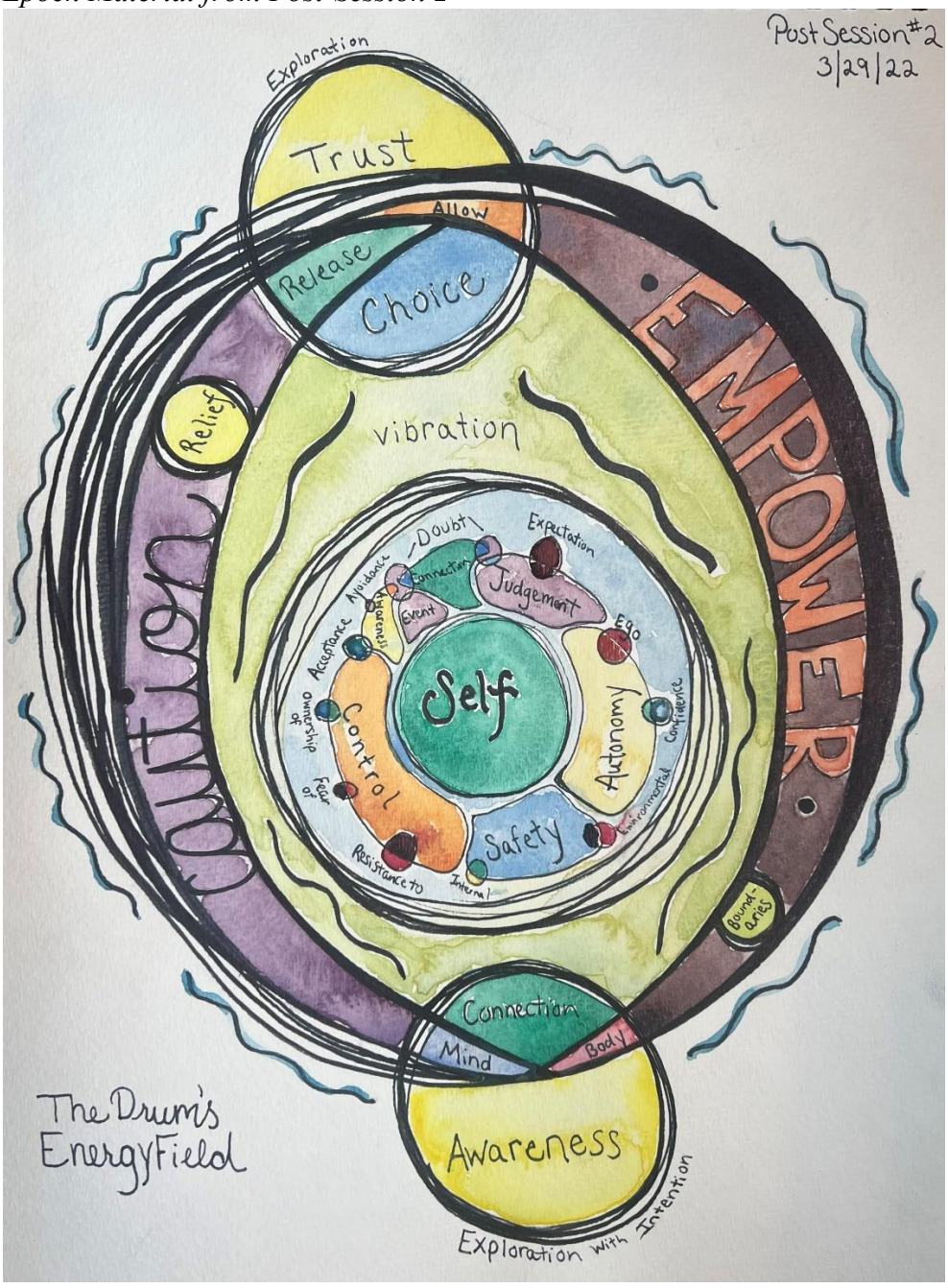
Nicole breathed deeply as she engaged with the drum, and gradually stopped playing as her face shifted from neutral to smiling.

In the post-series member checking discussion, Nicole shared that she later realized that her playing in the session became less hesitant when she remembered the sense of joy she feels when she plays her violin. She shared that she actively engaged with the positive moments associated with the otherwise traumatic memory, which she says are equally as relevant to her life today. Nicole noted that the connection she made to the memory allowed her to understand that "[she] is in control of the memory and [her] reflections on it."

Figure 2 depicts epoch material created during post-session processing of Session 2.

Figure 2

Epoch Material from Post-Session 2



Session 3- "I Didn't Let it Move Me"

Nicole's intention for session 3 was to "Explore what it feels like to take action." She entered the session and began sharing about how she felt she had a productive and fulfilling day. In sharing about her day, she informed me that she had taken a step toward healing herself earlier in the day, and she indicated that the work she had done in our previous two sessions allowed her to make a decision that she had not yet fully realized the significance of at the start of our session. During this third session, Nicole explored a newfound sense of empowerment by actively narrating referential imagery while engaging in mindful improvisation on a low sounding tubano drum. Nicole demonstrated confident and dynamic improvisation throughout the session, and later acknowledged feeling a "sense of readiness" to "not hold back" in this session. Nicole's narration of a real-life event that occurred earlier in the same day was supported by her own active improvisation as well as mindfulness-oriented verbal prompting and reflexive, improvised accompaniment, which I played on a higher sounding drum. The purpose of each verbal prompt provided was to encourage Nicole to become aware of the entirety of her lived experience, which involved making and seeing through the decision to remain in close proximity to her rapist for the first time, rather than allowing his presence to disrupt her day. Nicole chose to process the contents of her imagery verbally after the experience, eventually acknowledging a connection with "an overwhelming sense of pride and growth." Post-experience discussion involved Nicole considering how this sense of pride, along with her realization of her sense of control helped her feel more

empowered to process through other personal traumas (specifically those from childhood).

Session 3 Highlight- Connecting with Self through Taking Control. The highlighted content of session 3 captures Nicole's verbalized realization of the significance of what she had allowed herself to do earlier in the day. The excerpt was taken from the post-experience processing discussion and was supported in analysis by (a) highlight 3 transcription document, (b) session 3 audio/video, (c) post-session 3 interview document, and (d) the researcher's memo document.

The highlight includes the moments that Nicole verbalizes her feeling of "overwhelming pride and growth," and her awareness that the music experience allowed her to "take a piece of [her] real self back." These realizations prompted further verbal processing during the post-experience discussion relevant to Nicole's desire to continue learning about her real self, who she identifies as the part of her that is not affected by her post-traumatic anxiety. During post-experience processing of the improvisational music making and narration experience, I prompted Nicole to verbalize "what it was that [she] did earlier that day." Nicole's response was accompanied by a release of emotion as she slowly and tearfully said, "I didn't…let it…move me," through a beaming smile. I supported Nicole's release of emotion by prompting her to repeat that phrase, which she did several times. I encouraged her to emphasize her own control as it was present in the phrase by demonstrating to her to accent the word "let," as in, "I didn't LET it move me." Our discussion about Nicole's newly realized sense of control and awareness of Self continued. Figure 3 depicts epoch material created after Session 3.

Figure 3

Epoch Material Created After Session 3

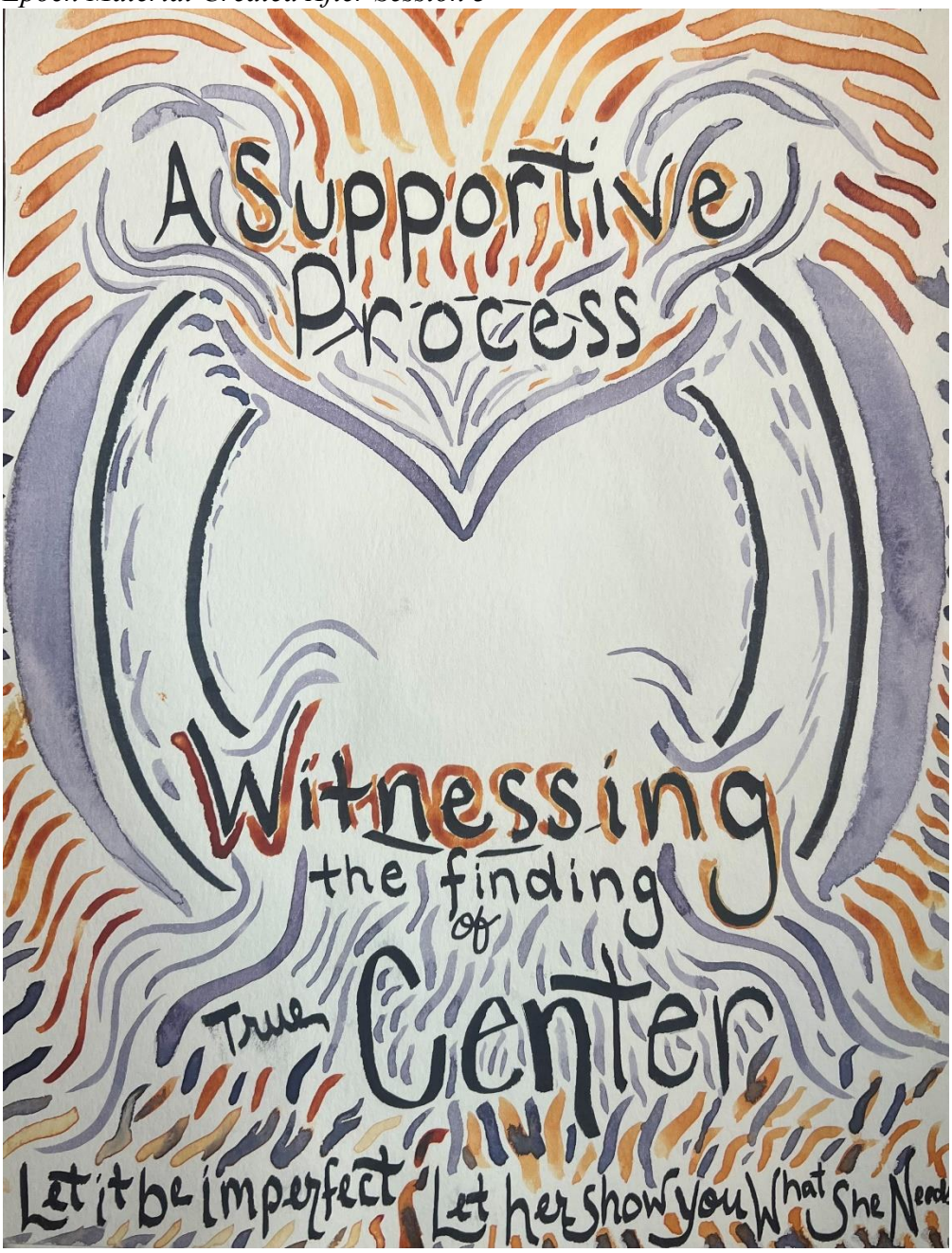
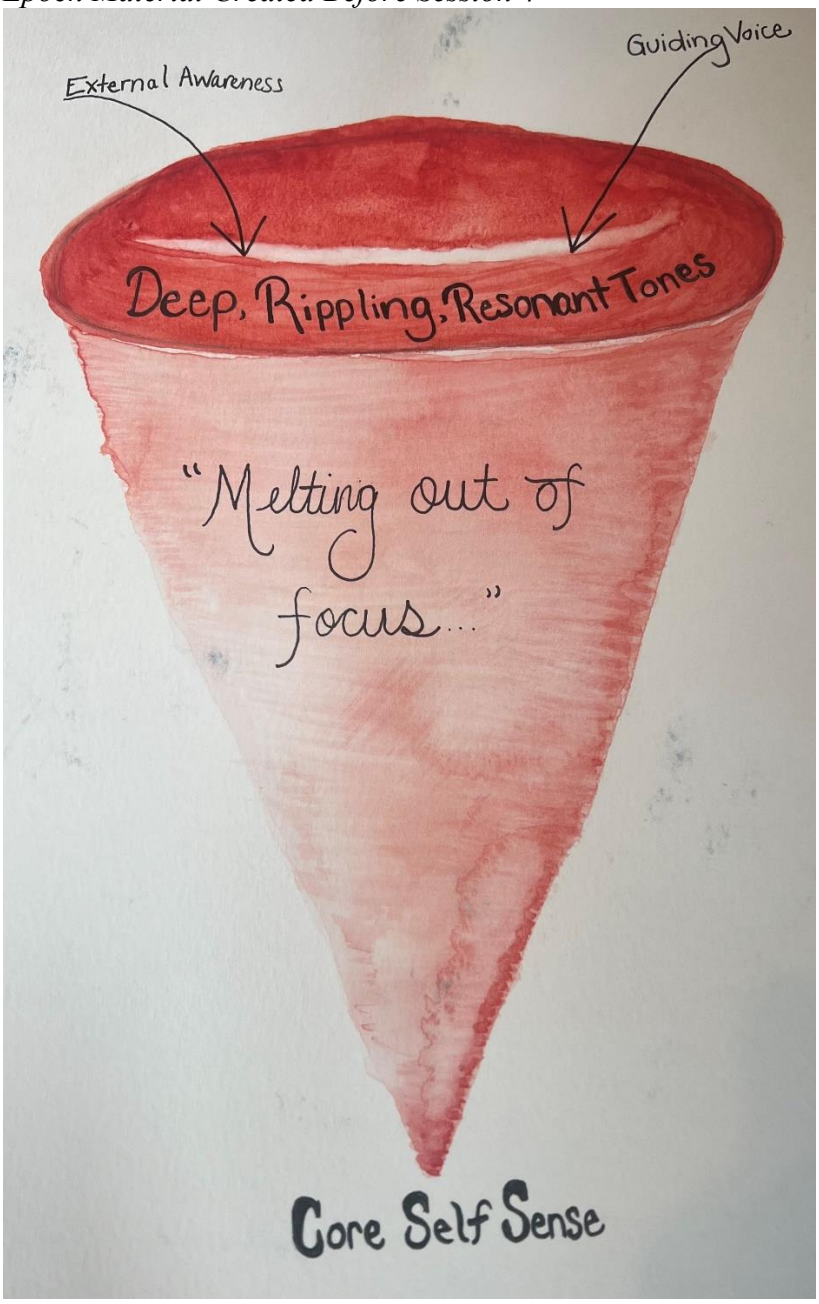


Figure 4 depicts epoch material created before Session 4.

Figure 4

Epoch Material Created Before Session 4



Session 4- "I Want to Make Myself Happy"

Nicole's intention for session four was to "Explore what it feels like to be calm." Session 4 began with Nicole sharing that the state she noticed experiencing most of the day was a sense of "calm." She shared that she was still feeling "calm and relaxed" as the session began, noting that she had an "easy, cruiser day." One of many insights Nicole shared in the pre-session interview was a "new awareness" of how her body experiences emotion before her mind is aware of the emotion's presence. She was prompted to explain "how [she knew] that what [she was] feeling [was] calmness." In response, Nicole recalled a recent experience of creating her own sense of calm during a "day off" hike she took with her partner. She described both her mind and body experiences of the feeling, integrating "I feel" and "I sense" language with "I think" and "I know" language. This memory became the foundation for a guided imagery and music experience, which was supported by referentially improvised acoustic guitar music and vocalized affirmations. During the experience, Nicole stated, "I think the calm is actually a bit of happiness. I'm feeling closer to happiness." In the post-series interview, Nicole shared that she felt this was the first time she "very intentionally connected music with a visual." This was also the first session in which Nicole shared about her felt experiences during the music without direct prompting.

Session 4 Highlight- Intentionally Integrating. The highlight of session 4 is supported in analysis by the following documents: Session 4 audio/video, Session 4 summary document, Participant journal 4, Highlight 4 transcription document and the Memo 4 document. This highlight captures Nicole's process of verbalizing her intention

to commit to making herself happy by remaining aware of "…how different things make [her] feel through [her] whole body." The integration of newly acquired self-insight into her post-series intention reflects the numerous personal connections and steps toward self-growth Nicole had experienced throughout the course of the session series.

The music relevant to the session 4 highlight involved improvised, reflexive guitar music which I provided as I guided Nicole to engage with the imagery of the hiking memory she introduced during the pre-experience discussion. The music involved alternation between two guitar chords, Aadd4 and bm9/11, which I loosely Travis picked in 6/8 time at approximately 65 bpm. As the music and imagery experience began to transition slowly into the post-experience discussion, I prompted Nicole to set an intention for moving forward in her journey of self-growth. Nicole engaged with her intention by engaging with the mantra, "I want to make myself happy." As this highlight progressed, Nicole developed her plan for putting her intention into action. She detailed her plans to "be present and aware of causes of the happiness and stay open to it...in [her] whole body…always."

Results of Phenomenological Reduction

After the initial review of data and member checking, four moments of therapeutic significance were identified. Prior to member checking, eight moments within the series had been identified as session *highlights* and were then further reviewed and summarized. After member checking, four highlights remained, which both Nicole and I agreed were most representative of the participant's lived experiences and lasting takeaways. Nicole and I mutually recognized each of the four session highlights as being therapeutically significant series events. Characteristics of the eight initial and four subsequent highlights included:

- Of the participant, an observable demonstration of physical (body movement or breath) or affective (tearfulness or laughter) release,
- Contextual engagement with imagery (experienced within the highlighted moment itself or directly referenced during post-session discussion),
- Verbalized identification of insight gleaned during or after the therapeutic music experience.
- Of the participant and of the therapist, active or passive engagement with reflexive, improvised music, and
- Of the therapist, active use of mindfulness-oriented (awareness of physical, cognitive, and ideal selves) guiding or prompting.

Each highlight is representative of a single occurrence of the emergence of the overarching phenomenon observed during each of the four sessions in the study series. In a reflective process of reviewing each highlight and considering the session context from

which they were removed, I named each one for ease of reference (See Table 2). Later in the thematic analysis process, the names of each highlight ended up also representing emerging themes. These themes were included in subsequent coding and thematic analysis and were found to exist as elements of change experienced by the participant within the context of the highlights.

Table 2

Music Therapy Session Names and Names of Associated Highlights

Highlight	Session	Highlight Name
1	"I can listen to my body"	Release of Holding
2	"I am in control"	Letting Go of Expectation
3	"I didn't let it move me"	Connecting with Self through Taking Control
4	"I want to make myself happy"	Intentionally Integrating

Data relevant to each highlight was organized into sets, referred to in results as *highlight pods*. Highlight pods were uploaded into NVIVO qualitative data analysis software and were involved in horizontalization and thematic analysis. Data sources in each highlight pod includes (a) Audio/video transcription documents, (b) session summary documents, (c) memo documents, (d) post-experience interview guide documents, and (e) participant journal entries.

The horizontalization stage of data analysis revealed three horizon groups, under which all subsequent codes were grouped. The groups identified as horizons were (a) Participant, (b) Music Therapist, (c) Music. It should be noted that further coding revealed the horizons to be extant within each highlight's coding hierarchy as individual meanings as well. Below, the results of thematic analysis of each of the four highlights

are presented, along with the composite textural descriptions associated with each set of themes.

Results of Thematic Analysis

The results of the thematic analysis of Highlights 1-4 are provided in the following section of this report. Tables 3, 5, 7, and 9 list the main themes that emerged from thematic analysis of each highlight's content, along with the individual textural description of each theme. Textural descriptions were created by considering the context from which the main themes were derived. Associated codes that contributed to the development of the textural descriptions are also presented in the tables. These parent codes serve as representations of individual meanings found in the raw data and they encompass numerous meaning units which are representative of the lowest level of codes in the coding hierarchy. Tables 4, 6, 8, and 10 list the secondary themes that emerged from thematic analysis along with the parent themes of the same highlight from which they were derived.

Highlight 1- "Release of Holding." Highlight one resulted in 4 main themes, which are comprised of 21 different associated codes. Five associated codes were found be directly associated with more than one of the four main themes, and thus were identified as secondary themes. Results of the thematic analysis of highlight 1 are listed in Table 3.

Table 3

Results of Thematic Analysis of Highlight 1

Main Theme	Individual Textural Description	Associated Codes from Theme Clusters
Connecting[2]	Communicated awareness of the relevance of insight to self, the therapeutic process and control.	Awareness°
		Self°
		Holding*
		Process
		Control*
		Mindfulness*
		Communication
Supportive Presence[2]	Awareness of being supported in the musical space by the music therapist who fosters empowerment by offering encouragement while guiding toward mindfulness.	Support
		Music Therapist
		Empowerment*
		Encouragement
		Mindfulness*
		Music
		Space
Allowing[3]	Awareness of having the power to choose to allow release of emotion, energy and expectation while feeling empowered to resist closing.	Control*
		Empowerment*
		Closing
		×Releasing
		Change*
Releasing[3]	Allowing change by remaining open to experiencing emotional and energetic shifts.	Opening
		×Allowing
		Emotion
		Energy
		Expectation
		Insight Development+
		Change*
		Holding*

* Denotes secondary theme

°Denotes connectedness to main theme(s) in other highlight(s) in the series

+Denotes connectedness to secondary theme(s) in other highlight(s) in the series

×Denotes connectedness to main theme in current highlight

[1, 2, or 3]Indicates the theme's associated Tier, see Composite Themes section of this chapter

Table 4

Secondary Themes and Associated Main Themes of Highlight 1

Secondary Theme	Associated Main Theme (Highlight 1)
Control°	Connecting, Allowing
Change°	Allowing, Releasing
Holding	Connecting, Releasing
Mindfulness	Connecting, Supportive Presence
Empowerment+	Supportive Presence, Allowing

Note- See to the table notes of the previous table to reference denotation of annotation markers.

Composite Textural Description for Highlight 1. Highlight 1, "Release of Holding," demonstrated the participant's experience of releasing held energy and emotion. The process involved (a) the participant becoming aware of that which was being held, (b) the participant becoming empowered to connect with a sense of control over both the held energy and emotion and her willingness to allow a release of them. The participant engaged in this process of change while remaining mindful of elements of Self, all of which were brought into awareness by the music therapist, who offered support and maintained a safe, musical space for self-exploration.

Highlight 2- "Letting Go of Expectation." Highlight two resulted in 4 main themes, which are comprised of 15 different associated codes. 5 associated codes were found be directly associated with more than one of the four main themes, and thus were identified as secondary themes. Table 5 lists the results of analysis of Highlight 2, and Table 6 lists the secondary themes that emerged from the Highlight 2 analysis, along with the main themes of the same highlight to which they are associated.

Table 5

Results of Thematic Analysis of Highlight 2

Main Theme	Textural Description	Associated Codes from Theme Clusters
Control+°[1]	A felt sense of empowerment to act on the desire to change.	Expectation*
		Self-Judgement*
		Music
		Empowerment+*
		Self-Fulfillment
Change+[3]	A process of becoming aware of an undesired self-characteristic and choosing to overcome it by taking control.	×Control*+°
		Connecting°
		Letting Go
		Expectation*
		Self-Judgement*
		Empowerment+*
Exploration[3]	The act of noticing, considering, and experiencing.	Self*°
		×Control+°*
		×Awareness°
		Trauma*
		Self-Doubt
Awareness°[1]	Acknowledgement of elements of mind, body, self, and related processes	Connecting°
		Self*°
		Memory
		Trauma*
		Expectation*
		Self-Judgement*
		Supportive Presence°
		Safety

* Denotes secondary theme

°Denotes connectedness to main theme(s) in other highlight(s) in the series

+Denotes connectedness to secondary theme(s) in other highlight(s) in the series

×Denotes connectedness to main theme in current highlight

[1, 2, or 3]Indicates the theme's associated Tier, see Composite Themes section of this chapter

Table 6

Secondary Themes and Associated Main Themes of Highlight 2

Secondary Theme	Associated Main Themes (Highlight 2)
Expectation	Control, Change, Awareness
Self-Judgement	Control, Change, Awareness
Empowerment+	Control, Change
Self°	Exploration, Awareness
Trauma	Exploration, Awareness

Note- See the table notes of the previous table to reference denotation of annotation markers.

Composite Textural Description for Highlight 2. Highlight 2, "Letting Go of Expectation," demonstrated the participant's process of letting go of self-expectation by connecting the contents of a traumatic memory with her internalized self-doubt and exploring her newfound sense of empowerment to adopt a new perspective of the memory. Through engaging in the process of taking control over her interaction with the memory, the participant's engagement in improvisational drumming changed from restricted and hesitant to free and confident.

Highlight 3- "Connecting with Self through Taking Control." Highlight 3 resulted in 5 main themes, which are comprised of 20 different associated codes. 4 associated codes were found to be directly associated with more than one of the four main themes, and thus were identified as secondary themes. Table 7 lists the main themes and relevant content, and Table 8 lists the secondary themes with related content.

Table 7

Results of Thematic Analysis of Highlight 3

Main Theme	Textural Description	Associated Codes from Theme Clusters
Connecting°[2]	Communicated awareness of the relevance of insight to self, the therapeutic process and control.	×Awareness°
		×Control°
		Growth*
		Empowerment+
		Process*
		×Self+°
Self[2]	The interconnected system of essential, personal elements making up the participant's being.	×Awareness°
		Acknowledgement of Self
		Pride
		×Control°
		Anxiety
		Trauma+
		Self-Image+
		Self-Kindness+
Awareness°[1]	Acknowledgement of elements of mind, body, self and related processes.	×Self+°
		Process*
		·Support*
		Growth*
		×Control°
Control°[1]	A felt sense of empowerment to act on the desire to change.	×Connecting
		×Awareness°
		Holding+
		Empowerment*+
		Releasing°
		Letting Go
		Expectation+
		Growth*
·Supportive Presence°[2]	Awareness of being supported in the musical space by the trusted music therapist who fosters empowerment by offering support and maintaining a safe space for exploration.	Safety
		Trust
		·Support*
		Empowerment*

·Note- Support does not equal supportive presence

* Denotes secondary theme
°Denotes connectedness to main theme(s) in other highlight(s) in the series
+Denotes connectedness to secondary theme(s) in other highlight(s) in the series
×Denotes connectedness to main theme in current highlight
[1, 2, or 3]Indicates the theme's associated Tier, see Composite Themes section of this chapter

Table 8

Secondary Themes and Associated Main Themes (Highlight 3)

Secondary Theme	Associated Main Themes (Highlight 3)
Growth	Connecting, Awareness
Empowerment+	Connecting, Control, Supportive Presence
Process	Connecting, Awareness
Support	Awareness, Supportive Presence

Composite Textural Description for Highlight 3. Highlight 3, "Connecting with Self through Taking Control," demonstrated the participant's process of acknowledging a part of the Self that is not oppressed by anxiety or trauma. In the safe and supportive context of the therapeutic relationship, the participant detailed her lived experience with taking control of a situation directly related to her ongoing anxiety. She then drew a connection between her awareness of both self-growth and control and her internalized negative self-image.

Highlight 4- "Intentionally Integrating." Highlight four resulted in 7 main themes, which are comprised of 15 different associated codes. 6 associated codes were found to be directly associated with more than one of the four main themes, and thus were identified as secondary themes. Table 9 lists the main themes that emerges from analysis of Highlight 4, and Table 10 lists the secondary themes.

Table 9

Results of Thematic Analysis of Highlight 4

Main Theme	Textural Description	Associated Codes from Theme Clusters
Self[2]	The interconnected system of essential, personal elements making up the participant's being.	Self-Image*
		Self-Kindness*
		×Awareness°
		×Integration
		×Intention
		Growth+
		×Control°
Awareness[1]	Acknowledgement of elements of mind, body, self, and related processes.	×Self°
		Control°
		Self-Kindness*
		Allowing*°
		Happiness*
		Growth+
		Insight Development*
Intention[3]	Awareness of and commitment to growing toward a desired state of being.	Self-Image*
		Allowing*°
		Happiness*
		×Integration
		×Experience
		×Awareness°
		×Self*°
Integration[3]	Intentional application of elements of being to the present Self.	×Awareness°
		×Intention
		Experience
		×Control°
		×Self°
		Allowing*°
Experience[3]	Awareness of the existence of Self within the context of processes or states of being.	Therapeutic Relationship
		Memory
		Ideals*
		×Growth+
		×Control°
		×Awareness°
		Insight Development*
Control[1]	A felt sense of empowerment to act on the desire to change.	×Self°
		Happiness*
		Self-Kindness*
		Self-Image*
		Allowing*°
		×Growth+
		×Integration
		×Awareness°
Growth[3]		Self-Kindness*

	The result of identifying and exploring an area of need and shifting toward insight and integration.	×Intention
		×Integration
		Insight Development*
		×Awareness°
		Ideals*
		Self-Image*

***** Denotes secondary theme
°Denotes connectedness to main theme(s) in other highlight(s) in the series
+Denotes connectedness to secondary theme(s) in other highlight(s) in the series
×Denotes connectedness to main theme in current highlight
[1, 2, or 3]Indicates the theme's associated Tier, see Composite Themes section of this chapter

Table 10

Secondary Themes and Associated Main Themes from Highlight 4

Secondary Theme	Associated Main Themes (Highlight 4)
Self-Image	Self, Intention, Control, Growth
Self-Kindness	Self, Awareness, Control, Growth
Allowing°	Awareness, Intention, Integration, Control
Happiness	Awareness, Intention, Control
Insight Development	Awareness, Growth
Ideals	Experience, Growth

Composite Textural Description for Highlight 4. Highlight 4, "Intentionally Integrating," demonstrated the participant's process of identifying her intention to remain aware of and integrate elements of the Self discovered throughout the therapeutic experience with her desire to grow toward creating her own happiness.

Composite Themes (Highlights 1-4)

Analysis of the interconnectedness of the thematic content of each highlight revealed commonalities among the four highlights and their associated thematic contents. The superscript annotations included on Tables 3-10 represent these commonalities. As is outlined by the denotation notes for each table, many of the main and secondary themes

within each highlight are interconnected, and the same is true of main and secondary themes across highlights.

Themes annotated within Tables 3-10 by (*) and (×) have a special relationship within the highlight associated with their table. The (*) indicating that the annotated theme emerged as a secondary theme within the relative highlight, the (×) indicating that the theme is represented by one of the main themes of the relative highlight. In contrast, themes annotated within Tables 3-10 by (°) and (+) have an interconnecting relationship with themes in at least one highlight other than its own. The (°) indicates that the annotated theme is represented as a main theme in another highlight, and the (+) indicates an interconnected relationship with a secondary theme in another highlight.

Cross examination of these commonalities allowed me to categorize the themes in such a way that discerns their level of connectedness, and therefore their quality of representation, of the overall textural context of each of the highlights. Main themes that were found to represent the composite thematic content of the series of highlights to some extent were categorized into Tiers ranging from most (Tier 1) to least (4) representative of the entirety of the highlight data. Tiers of these main themes are denoted in Tables 3-10 by (^{1}), (^{2}), (^{3}), or (^{4}).

Two themes were noted to have emerged as main themes in 3 of the 4 highlights. These two themes were identified as Tier 1 Themes. Similarly, those themes found to have emerged as main themes in 2 of 4 highlights were identified as Tier 2 themes. The individual textural descriptions associated with these Tier 1 and Tier 2 themes in their respective highlight contexts contributed to the development of one composite textural

description of each theme. Though little variation exists between textural descriptions of recurring themes, the development of the descriptions with specific regard for their context within each highlight did require use of differing language between some of the individual textural descriptions.

The composite textural descriptions of highlights 1-4 are listed, for ease of reference, in Table 11. Tables 12 and 13 list the Tier 1and Tier 2 themes, their composite textural descriptions, and the locations of each within the series of highlights, respectively.

Table 11

Composite Textural Descriptions, of Highlights 1-4

Highlight	Composite Textural Description	Main Themes
1	Highlight 1, "Release of Holding," demonstrated the participant's experience of releasing held energy and emotion. The process involved a) the participant becoming aware of that which was being held, b) the participant becoming empowered to connect with a sense of control over both the held energy and emotion and her willingness to allow a release of them. The participant engaged in this process of change while remaining mindful of elements of Self, all of which were brought into awareness by the music therapist, who offered support and maintained a safe, musical space for self-exploration.	Connecting, Supportive Presence, Allowing, Releasing
2	Highlight 2, "Letting Go of Expectation," demonstrated the participant's process of letting go of self-expectation by connecting the contents of a traumatic memory with her internalized self-doubt and exploring her newfound sense of empowerment to adopt a new perspective of the memory. Through engaging in the process of taking control over her interaction with the memory, the participant's engagement in improvisational drumming changed from restricted and hesitant to free and confident.	Control, Change, Exploration, Awareness
3	Highlight 3, "Connecting with Self through Taking Control," demonstrated the participant's process of acknowledging a part of the Self that is not oppressed by anxiety or trauma. In the safe and supportive context of the therapeutic relationship, the participant detailed her lived experience with taking control of a situation directly related to her ongoing anxiety. She then drew a connection between her awareness of both self-growth and control and her internalized negative self-image.	Connecting, Self, Awareness, Control, Supportive Presence
4	Highlight 4, "Intentionally Integrating," demonstrated the participant's process of identifying the intention to remain aware of and integrate elements of the Self discovered throughout the therapeutic experience with her desire to grow toward creating her own happiness.	Self, Awareness, Intention, Integration, Experience, Control, Growth

Table 12

Tier 1 Themes and their Composite Textural Descriptions

Tier 1 Themes	Composite Textural Description	Location
Control	A felt sense of empowerment to act on the desire to change.	Letting Go of Expectation
		Connecting with Self x Taking Control
		Intentionally Integrating
Awareness	Acknowledgement of elements of mind, body, Self and related processes.	Letting Go of Expectation
		Connecting with Self x Taking Control
		Intentionally Integrating

Table 13

Tier 2 Themes and their Composite Textural Descriptions

Tier 2 Themes	Composite Textural Description	Location
Connecting	Communicated awareness of the relevance of insight to self, the therapeutic process and control.	Release of Holding
		Connecting with Self x Taking Control
Supportive Presence	Awareness of being supported in the musical space by the trusted music therapist guides toward mindfulness and fosters empowerment by offering support and encouragement while maintaining a safe space for exploration.	Release of Holding
		Connecting with Self x Taking Control
Self	The interconnected system of essential, personal elements making up the participant's being.	Connecting with Self x Taking Control
		Intentionally Integrating

Cross examination of commonalities between the thematic material of the series of highlights revealed 8 main themes that were found to be present in only 1 of 4 highlights. These themes were identified as Tier 3 themes and are listed in Table 14 with their individual textural descriptions and associated locations.

Table 14

Tier 3 Themes and Their Individual Textural Descriptions

Tier 3 Themes	Individual Textural Description	Location
Allowing	Awareness of having the power to choose to allow release of emotion, energy and expectation while feeling empowered to resist closing.	Release of Holding
Releasing	Allowing change by remaining open to experiencing emotional and energetic shifts.	Release of Holding
Change	A process of becoming aware of an undesired self-characteristic and choosing to overcome it by taking control.	Letting Go of Expectation
Exploration	The act of noticing, considering, and experiencing.	Letting Go of Expectation
Intention	Awareness of and commitment to growing toward a desired state of being.	Intentionally Integrating
Integration	Intentional application of elements of being to the present Self.	Intentionally Integrating
Experience	Awareness of the existence of Self within the context of processes or states of being.	Intentionally Integrating
Growth	The result of identifying and exploring an area of need and shifting toward insight and integration.	Intentionally Integrating

During the same cross examination, one of the secondary themes was found to be present in 3 of 4 highlights, and thus was identified as Tier 4 Theme. No additional secondary themes were found to be recurring as secondary themes associated with other highlights, though several were found to be represented by main themes of other

highlights. Table 15 lists the single Tier 4 theme with its individual textural description and respective locations.

Table 15

Tier 4 Theme and Its Individual Textural Description

Tier 4 Themes	Individual Textural Description	Location
Empowerment	A felt sense of confidence and ownership	Release of Holding
		Letting Go of Expectation
		Connecting with Self x Taking Control

The cross examination of thematic content and the subsequent organization of the themes into Tiers 1-4 allowed justification for selection of thematic content to be included in the next step in data analysis, imaginative variation. Because I observed the deep interconnectedness of the network of themes representing the raw session data, I determined that thorough and meaningful imaginative variation of only Tier 1 themes would allow for adequate representation of the raw data. Thus, only Tier 1 themes were involved in the imaginative variation process.

Results of Imaginative Variation

For ease of interpretation of these results, refer to Table 1, which lists the stages within imaginative variation and relevant terms. Varying of perspectives was the first step included in the imaginative variation process. To consider possible alternative meanings of the composite textural themes (Tier 1), I wrote three new composite textural descriptions, which describe the set of Tier 1 Themes (Control and Awareness) from the perspective of each of three roles involved in the therapeutic relationship, (a) the

participant, (b) the music; and (c) the music therapist. This step involved a revisiting of the individual textural themes which emerged during earlier thematic analysis of each highlight (Tables 3-10). The revised composite textural descriptions relevant to each varied perspectives of the Tier 1 themes are included in Table 16 below.

Table 16

Revised Composite Textural Descriptions of Tier 1 Themes

Perspective	Composite Textural Description
Original	Acknowledgement of elements of mind, body, Self and related processes, including a felt sense of empowerment to act on the desire to change.
Participant	Acknowledgement of my shifting perspective of control from one which places anxiety in a position of control over me to one which allows me to view myself as capable of growing toward happiness by connecting my sense of control over my anxiety with my newfound understanding of using self-kindness as a tool for releasing self-judgement and expectation.
Music	Notable change in musical characteristics as a result of the participant disengaging from expectation for aesthetic sound and finding comfort with engaging in free improvisation through connecting with a personal sense of joy which is derived from the act of playing music for the sake of self-fulfillment.
Music Therapist	Empowering the participant and fostering her sense of personal control by encouraging awareness and self-kindness while guiding toward connection to her Self and her process.

Next, I compiled a list of possible structural elements of the invariant phenomenon represented by the revised composite textural descriptions (Table 16) by engaging in the intuitive process of *free fantasy variation*. This step allowed me to identify possible structural elements of the invariant phenomenon by imaging how the

therapeutic process would have been different if each of the identified possible structural elements had not been present.

My list of 16 possible structural themes (which was the result of free fantasy variation) was narrowed down via *thematic clustering*. The list was clustered into 8 main theme clusters, which were synthesized via visual mapping of the clusters. Table 17 lists the associated main themes of the 8 clusters of possible structural themes.

Table 17

Main Themes of Theme Clusters

Cluster	Main Theme
1	Letting go of hesitance
2	Allowing sensation
3	Awareness of Ideals
4	Sense of control
5	Connecting with Self
6	Opening to Change
7	Feeling empowered to change
8	Connecting with process

Synthesis of the 8 theme clusters and their contributing themes revealed 4 *structural themes* representing the emergence of the invariant phenomenon. Three of the four structural themes were noted during imaginative variation as being mutual, essential structural meanings associated with the fourth structural theme. The fourth structural theme was identified as the invariant phenomenon itself, and was assigned the universal descriptive name, Therapeutic Change. Each of the three structural themes were noted to relate to the invariant phenomenon in two ways: Relation via Self, and relation via Process. The 3 structural themes, along with the fourth structural theme, identified as the

invariant phenomenon itself, are listed in Table 18.

Table 18

Structural Themes

Structural Themes
1. Awareness (of Self), Awareness (of process)
2. Connection (to Self), Connection (to process)
3. Control (over Self), Control (over process)
4. Therapeutic Change*

*Structural theme 4 was identified as the invariant phenomenon itself

The significance of these findings will become clear as the results of the synthesis stage of data analysis is described. Before reporting the result of synthesis, which is the primary finding of this research study, relevance of the findings reported up to this point is shared in terms of the research questions that guided the design and implementation of this work.

Research Questions

Prior to conducting this study, I developed a set of five research questions that I felt would guide me toward acquiring sufficient insight into a participant's therapeutic process for identifying and describing the essence of that participant's experience. I knew that I could not formulate a question directly related to defining any particular phenomenological element of the experience, because at the start of this work I had only a conceptual "participant" and a hypothetical idea of what their "experience" might entail. Though I did have an idea of what I thought might occur when I supported the "participant" in the manner outlined in my intended procedures, I had no language to describe exactly what it was I hoped the participant would experience. Additionally, I did

not wish to impose my assumptions into the therapeutic process of my actual client. Therefore, I designed a study that would involve providing therapeutic support to an individual in a manner reflective of the conditions I knew to have resulted in an interesting and recurring response in clients whom I had supported in my professional practice.

I viewed my research questions as objectives that, when met, might bring me closer to understanding the type of response I had observed in my clients. However, I wanted to be careful not to limit the potential for emergence of any phenomenological information by designing my work around a hypothetical response phenomenon that may or may not have emerged. Throughout the course of the session series, I relied on my reflective epoch process to help ensure that I did not engage with my presupposed idea of what Nicole's response might look like based on what I had seen in my professional work.

In designing my qualitative study around answering the five research questions below, I was able to describe in detail Nicole's experience of receiving support under the conditions I had set. As is made clear by the presentation of results of analysis of Nicole's work, an invariant phenomenon did emerge within her therapeutic process (See Figure 5). The emergence and defining of this phenomenon, which did resemble the responses I had observed in my clients, is what I consider to be the primary finding of m research study.

After the conclusion of my series of sessions with Nicole, I was able to conclude responses to each of my five research questions. However, I waited to finalize these

responses until after I met with Nicole for member checking. Because I was unaware until the start of data analysis that session data would be narrowed to focus largely on highlights of each session, the language of my original research questions were altered slightly to reflect the analysis of highlights. The questions are answered below and supported with evidence from the combined data of each of the four highlights.

The first question I defined was, "What are the observed characteristics of the participant's and the music therapist's responses during each highlight?" In considering the totality of our responses, as represented by each of the highlights, I found that within each highlight the participant demonstrated at least one instance of releasing either emotion or blocked energy (see Lowen, 1976). I observed these releases in each highlight. They were identified in later data coding as either *affective releases* including (a) tearfulness, (b) smiling, and (c) laughing, or *somatic releases* including (a) deepening of breath, (b) involuntary movement, and (c) relaxation of tensed muscles. As for my own responses, I noted one response during audio/video review that occurred blatantly continuously in each of the highlights. I observed myself to have demonstrated active listening via mirroring (Arnold, 2014) of Nicole's responses to both music and verbal discourse. The observed characteristics of my mirroring response included (a) mirroring energy level, (b) mirroring facial affect, (c) mirroring vocal tone, (d) mirroring musical input and (e) mirroring posture.

The second research question was, "What musical elements are relevant to each highlight?" In considering the music relevant to each of the highlights, I found that the common element in each was *reflexivity* in music that was led by Nicole's moment to

moment responses. Reflexive music making (Bruscia, 1989) can also be described in terms of mirroring (Arnold, 2014), as it involves both active observation and reflection in music, specifically in improvisation. Not only were the therapeutic music experiences characteristic of each session and their associated highlights reflexive in and of themselves, my moment-to-moment reflections of Nicole's musical, energetic, affective, and postural responses were also. I observed reflexivity in music by (a) tempo, (b) dynamics, (c) rhythm, (d) meter, and (e) control. My observation of reflexivity of control was noted amid observation of each of the former elements and was demonstrated as Nicole's level of engagement and with each element of music varied.

The third research question I sought to answer was, "How do the participant's responses during each highlight vary in relation to the music?" I found my response to this question to be directly related to my responses to both research questions 1 and 2. As the music relative to each highlight involved reflexive, participant-led music making, Nicole's responses to the music simultaneously prompted me to reflect those responses with music as the experiences progressed. Therefore, my response to research question three is that the music varied as it reflected Nicole's responses to the therapeutic experiences, which were subsequently reflected in her engagement with the music. That said, I have also concluded that Nicole's level of engagement with the music in any given moment seemed to be supported by periods of active reflexivity, which often resulted in shifts in her level of engagement. As an example of the relationship between Research Questions 1 and 2, I provide the following analysis of my observations from Highlight 1.

In Highlight 1, Nicole demonstrated an instance of emotional and energetic release, characterized by deep breathing, tearfulness, and involuntary movement. Nicole demonstrated several shifts in her level of engagement with the music experience as her comfort with experiencing the noted releases pendulated. In three cases, Nicole took moments to disengage with the explorative process by opening her eyes and resetting her posture and affect. In these moments, I instinctively stopped playing the music. Here, I mirrored Nicole's affect, posture, and demonstration of control by providing music reflective of her shift in engagement. This demonstration of empathy and attunement (Rogers 1959 in Arnold, 2014; Bruscia 1989) reinforced Nicole's demonstration of control and led her to shift her level of engagement and return to her exploration. Responsive shifts in Nicole's posture, affect and energy level followed.

Research question four was, "What therapeutic techniques are employed by the music therapist within each highlight?" In addition to the two therapeutic techniques noted within the responses to research questions 1 and 2, I employed several others. Therapeutic techniques represented within each highlight were characterized in data coding as (a) mindfulness-oriented guiding, (b) positive affirmation, (c) reflexive music making, (d) mirroring, (e) asking questions, (f) reflecting, and (g) verbal tracking. Each of these techniques were grouped within a broader parent code represented in thematic analysis, supportive presence. Each of these techniques can be categorized as (a) therapeutic music techniques, or (b) verbal counseling techniques. Asking questions and verbal tracking are verbal techniques, and are the only techniques not noted to have been employed both musically and verbally. The commonality among these techniques as

represented within combined highlight data is their shared intention, which is defined by the emergence of supportive presence as a composite highlight theme.

My fifth defined research question was, “What are the lived experiences of the participant and of the music therapist during each highlight?” In reflecting upon a response to this question, I have concluded that rich descriptions of the lived experiences of both Nicole and I have been provided within this report in detail. I drew from each original data source associated with all four highlights and their respective sessions, as well as post-series data sources (i.e., memo documents and member checking transcription), in preparing the presentation of this case study. As a response to research question 5, I invite consumers of this research to reflect on the narrative and thematic content shared previously in this report before reading further to receive the results of the synthesis of the content of Nicole’s therapeutic process.

Synthesis

The imaginative variation process resulted in the identification of the invariant phenomenon (therapeutic change) and the emergence of three universal structural themes (awareness, connection, and control). Each of these universal structural themes represent the essential structural elements of the invariant phenomenon. The synthesis phase of data analysis involved the development of *individual structural descriptions* of each of the three structural themes, which are listed in Table 19.

Table 19

Structural Themes and their Individual Structural Descriptions

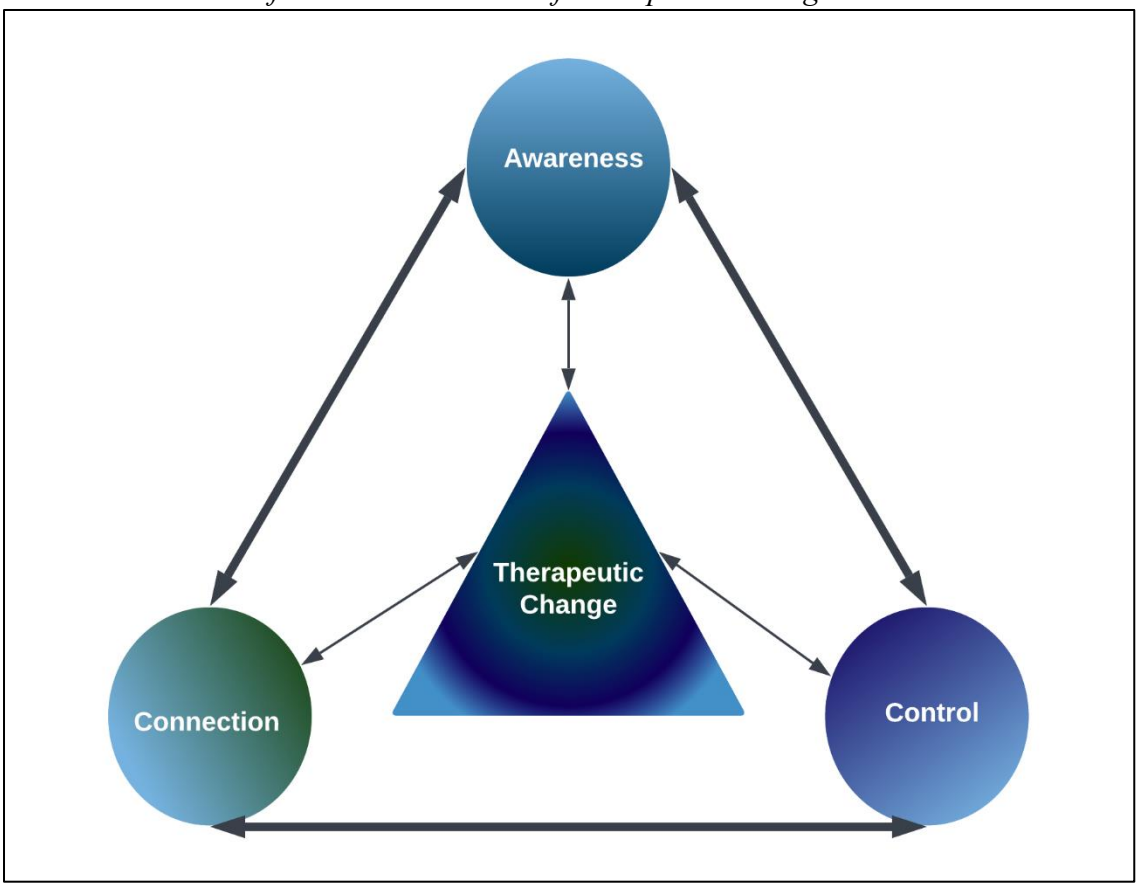
Structural Themes	Individual Structural Description
1. Awareness	Acknowledgement of elements of mind, body, Self and related processes.
2. Connection	Communicated awareness of the relevance of insight to self, the therapeutic process and control.
3. Control	A felt sense of empowerment to act on the desire to change.

Result of Synthesis: The Essence of Therapeutic Change

The individual structural descriptions of each structural theme (Table 19) were merged and synthesized with composite textural descriptions of the textural meanings that emerged during prior thematic analysis of highlights (See Tables 11 and 12). The result of this synthesis is the composite structural description of the structural themes. In other words, synthesis resulted in a definition therapeutic change as it emerged within the context of Nicole's work. The definition was developed by synthesizing descriptions of the three structural elements found to be essential to the emergence of the phenomenon. Figure 5 demonstrates the interconnectedness of the essential elements of the invariant phenomenon.

Figure 5

Interconnectedness of Essential Elements of Therapeutic Change



Composite Structural Description of the Invariant Phenomenon

In essence, Therapeutic Change (TC) is a phenomenon which occurred during the participant's intentional process of self-exploration which was supported by the presence of a guiding music therapist. The emergence of organic therapeutic change required the participant to (a) bring into awareness elements of the Self through musically supported engagement, (b) develop a felt sense of control over 1, the Self and 2, the explorative process, (c) demonstrate control by allowing release of emotion or energy and d) connect the relevance of new insight to the existent self.

Chapter 5: Discussion

I believe the emergence of Therapeutic Change (TC) in Nicole's therapeutic process during the music therapy sessions in my study support the development of a new, integral model of music psychotherapy, named Insight-Oriented Music Facilitated Psychotherapy (IMFP), as a primary means of mental health treatment for adults in need of non-acute, non-pharmacological support. In this chapter, I will support this statement by describing existing models of insight-oriented music psychotherapy, that of Kenneth Bruscia (1987), and that of Barbara Wheeler (1983). In doing so, I will provide an example Nicole's experience with emerging TC to illustrate the relevance of IMFP in bridging gaps between those two existing models of music psychotherapy. I believe that the development of IMFP may empower and inspire music therapy clinicians to expand their services to meet the needs of this group of mental healthcare consumers who are presently unrecognized and underserved.

Insight-Oriented Music Facilitated Psychotherapy: A Modern Model of Music Psychotherapy

Insight-Oriented Music Facilitated Psychotherapy (IMFP) is a conceptual model of music psychotherapy that is characterized by insight-oriented practice wherein clients develop and work with emergent issues by engaging in reflexive therapeutic music experiences with a board-certified music therapist. Resolution of therapeutic issues in IMFP is marked by the emergence of insight, which the clients connect with organically as they receive guidance and support from the facilitating music therapist. In IMFP, insights may occur either within or in processing of experiential music interventions. I

view this integral model as a potentially beneficial tool for guiding the application of ethical music psychotherapy from a human-centered (Rogers, 1965; Eyre, 2015; Solli et al, 2013; Rolvsjord, 2010), trauma informed (van der Kolk, 2015; Payne & Levine, 2015; Lowen, 1976) perspective that is reflective of our modern society's prioritization of supporting individuals and their unique social identities (see Raskovic, 2020).

I feel IMFP could emerge as a model which is informed with great regard and respect for the contributions of Bruscia's (1998) and Wheeler's (1983) respective theorizations of levels of music psychotherapy practice. While I intend to draw comparisons between IMFP and these theories, I note that both theorists presented their work along with disclaimers that their classifications are not intended to be definite, as the emergence of therapeutic issues in live therapy cannot be entirely anticipated.

Levels of Music Psychotherapy in Practice: Two Existing Models

IMFP is characterized first by the role of music in its application (Bruscia, 1998). In his theorization of a psychodynamic orientation of music therapy, Bruscia defines four levels of music psychotherapy, which are reflective of the various applications of music in relation to psychodynamic therapy—Music *as* psychotherapy, music *centered* psychotherapy, music *in* psychotherapy, and verbal psychotherapy *with* music. Later work by Bruscia introduced the concept of Integral Thinking in Music Therapy (Bruscia, 2011), which involves practicing music therapy by integrating various theoretical orientations with regard for the levels (Bruscia, 1998) and their varied applications across populations. Bruscia has also defined levels of music therapy practice which classify work by the role of the music therapy itself in the client's overall treatment plan,

including auxiliary, augmentative, intensive and primary levels of practice (Bruscia, 1989; 2014). While IMFP centralizes insight orientation, it is reliant on the integration of orientations and treatment methods that each clinician identifies as most reflexive of their client's unique therapeutic process. Soon, I will detail my rationale for the development of IMFP as its own model after discussing its alignment with both Wheeler's (1987) and Bruscia's (1998) levels of practice.

Bruscia on Music's Role in Music Psychotherapy. In his *Introduction to Music Psychotherapy* (1998), Bruscia makes a distinction between two types of experiential therapy, insight-oriented and transformative music therapy. Bruscia notes that the designation of these types of music therapy is achieved by answering the question of "whether the change results from the experience itself, or from the insight developed during the experience." He defines insight-oriented practice as music therapy which involves the emergence of change as the result of the development of insight which is brought into awareness either during or in processing of the music experience. In contrast, he defines transformative music psychotherapy as involving change that is the result of the music experience itself. In Bruscia's definition of insight-oriented music therapy, insight is developed through music engagement with "verbally mediated awareness," while transformative music therapy involves the development of insight within the context of the music experience, which may or may not be supported by verbal input from the therapist.

In *Introduction to Music Psychotherapy* (1998), Bruscia defined four levels of music psychotherapy, by which both types of experiential music therapy can be

characterized. Bruscia's four levels include (a) Music *as* psychotherapy, (b) music *centered* psychotherapy, (c) music *in* psychotherapy, and (d) verbal psychotherapy *with* music. Bruscia considers insight-oriented therapy to be characterized only by levels 3 and 4. This implies that insight-oriented music therapy should not be classified by Levels 1 and 2, which Bruscia reserves for classification of transformative therapy.

A Discrepancy in Bruscia's Categorization

By Bruscia's definition, my work with Nicole would largely be categorized as Level 3, insight-oriented music *in* psychotherapy. In Level 3, the therapeutic issue is "accessed, worked through, and resolved through both musical and verbal experiences, occurring either alternately or simultaneously." The music in Level 3 is "used for its specific and unique qualities and is germane to the therapeutic issue and its treatment." He notes that words are used in Level 3 work "to identify and consolidate insights gained during the process."

However, In Bruscia's description of Level 2, the therapeutic issues are "accessed, worked through and resolved by creating or listening to music while verbal discourse is used to guide, interpret or enhance the music experience and its relevance to the client and their therapeutic process." The extent of the verbal guidance I offered Nicole leads me to view my work as also aligning closely with Bruscia's definition of Level 2, Music-centered psychotherapy, despite his stipulations for Level 2 excluding insight-oriented practice.

The music experiences characteristic of my work with Nicole involved both simultaneous verbal discourse which was used to guide and enhance them (aligned with

Level 2), and the use of verbal discourse to "identify and consolidate" insights developed during music making (aligning with Level 3). I do not consider the emergence of change in my work with Nicole to be reflective of Bruscia's transformative therapy (Levels 1 and 2), which would have involved Nicole's issues being resolved as a direct result of the music experiences. I found Nicole's issues to have been accessed and worked through within the music experiences (aligning it with Levels 2 and 3), with resolution occurring during the verbal processing of insights (which indicates only a Level 3 classification).

In other words, I feel that Nicole's process of accessing and working through therapeutic issues aligns with Levels 2 and 3, while the resolution of her issues (the emergence of therapeutic change) aligns with Level 3. Modification of Bruscia's language and intentions is necessary to develop a classification for IMFP in alignment with his theorization of the levels of music psychotherapy. As an example, I remind consumers of this report of Nicole's experience outlined in the Case Exploration of Session 3.

Case Example from Session 3, "I didn't let it move me." The highlighted content of Session 3 captures Nicole's verbalized realization of the significance of what she had allowed herself to do earlier in the day. The highlight includes the moments that Nicole verbalizes her feeling of "overwhelming pride and growth," and her awareness that the music experience allowed her to "take a piece of [her] real self back."

The emergence of TC is apparent in this highlight at the intersection of Nicole's awareness of her sense of control, and her connection of it to her

therapeutic issue, anxiety. This connection occurred during post-experience processing of the improvisational music making and narration experience when I prompted Nicole to verbalize "what it was that [she] did earlier that day." Nicole's response was accompanied by a release of emotion as she slowly and tearfully said, "I didn't…let it…move me," through a beaming smile. Our discussion about Nicole's newly realized sense of control and awareness of Self continued.

Defining Therapeutic Change

From analysis of my study's results emerged a composite structural description, or relative definition, of the invariant phenomenon, therapeutic change (TC). Therapeutic change as a universal concept is not defined in literature as a distinct process, but rather by identification of relevant elements of the phenomenon as it exists in various contexts. My composite definition of Nicole's experience of TC may contribute to the development of a standard definition, but it is only precisely representative of TC as it emerged in the context of her work. The recurrence of TC in my study suggests that the methods of implementation I employed are collaboratively effective in prompting and facilitating the emergence of TC. This notion is ultimately what inspires my proposal of IMFP as a model of music psychotherapy which is guided by its purpose to facilitate music therapy that allows for emergence of therapeutic change.

The therapeutic work involved in my study was approached from an insight-oriented theoretical perspective. I came to understand this orientation as thorough research into the role of self-knowledge in pivotal moments in therapy led me to literature

citing development of insight as an elemental component of pivotal moments observed in both music therapy and psychotherapy. This literature review provided me with a definition of pivotal moments as instances of positive change that are the result of self-exploration within the therapeutic context (Giorgi, 2011). I feel this definition is well aligned with the structural definition of TC that emerged in Nicole's work. Giorgi's definition also informed my recognition of the emergence of *change* as a theme during thematic analysis of Nicole's therapeutic highlights. The purpose of IMFP is the emergence of *therapeutic change*, which will herein be defined as positive change resulting from therapeutic self-exploration.

I want to acknowledge the helpfulness of Bruscia's theorization of music psychotherapy. Comparison of Nicole's process to Bruscia's levels and their intended classifications allowed me to conceptualize classification of the work characteristic of Nicole's process. As alignment with Bruscia's theorized levels does not result in an accurate or universally understandable description of Nicole's work, I feel that it is worthwhile to attempt to classify the work by observing its alignment with a different theorization altogether.

Wheeler's Continuum of Goals in Music Psychotherapy. IMFP is next characterized by the goal of the therapeutic music experiences involved (Wheeler, 1983; 1987). As the purpose of my proposed model is to facilitate music therapy that allows for the emergence of therapeutic change, it is necessary to consider the theoretical foundation for the goal of the model's application. Wheeler defines three types of goals in music psychotherapy. Wheeler's levels include 1) Music therapy as an activity therapy, 2)

insight music therapy with re-educative goals, and 3) insight music therapy with reconstructive goals. She uses these goals to define a continuum of indications for their application in practice. My analysis will focus on Levels 2 and 3 of Wheeler's continuum, which are informed by Wholberg's classification of psychotherapy (1977), and classification of music therapy practice as defined by a panel of music therapists (Canter et al, 1979).

In Wheeler's presentation of her continuum of procedures, she identifies insight music therapy as a practice which is centralized on music's elicitation of "emotional and cognitive reactions necessary for therapy." Wheeler cites Zwerling (1979), indicating that insight music therapy is reliant on the ability of music therapy and music therapists to help clients "tap deeper emotional levels than are normally accessible." Though both levels of insight music therapy involved in Wheeler's continuum rely on music to elicit responses, she distinguishes between Level 2 (insight music therapy with re-educative goals) and Level 3 (insight music therapy with reconstructive goals) by noting the differences in the accessibility of the insight material. Wheeler notes that Level 2 involves emotional or cognitive material that is "close to consciousness and can therefore be elicited through attention to the here-and-now." The music characteristic of Level 2 is used to stimulate discussion, with the focus of the therapy on the "insight achieved through discussion." Level 3 involves the elicitation of unconscious material by music, "which is then worked with in an effort to promote reorganization of the personality."

Insight music therapy with both re-educative and reconstructive goals are relevant to Nicole's therapeutic process. However, Wheeler presented her continuum with

guidance for the indications for applying each of the types of music therapy in practice. I feel the work done in my study is best characterized by Wheeler's second level of music therapy, insight music therapy with re-educative goals. However, one specific instance of the work in my study is unquestionably aligned with Wheeler's third level (insight music therapy with reconstructive goals). This specific instance (captured in Highlight 2, "Letting Go of Expectation") involved me supporting Nicole as she engaged in a non-referential improvisation experience that resulted in the emergence of unconscious memory material. During post-experience discussion, Nicole connected this memory with her anxiety and with her lifelong tendency to set harsh personal expectations.

Though Wheeler's guidance states that the level of therapy provided in each instance should not be narrowly classified during live therapy, the following case example of my work with Nicole is a practical representation of a grey area that I note to exist in the guidance Wheeler's offers for application of her theorized levels in practice. The following case example highlights an occurrence of Wheeler's Level 2 practice shifting into Level 3.

> *Case Example from Session 2, "I am in control."* Nicole's intention for the session associated with Highlight 2 was simply to "Explore the balance between self-kindness and accountability." My decision to engage Nicole in an unstructured, non-referential improvisation experience was made with the anticipation that Nicole would explore the instrument in various ways, discuss with me her conscious and somatic experiences in doing so, and then connect her experience with existing self-knowledge. Nicole's accession of an unconscious

memory she understood to have been developmentally traumatizing is what aligns this example with Wheeler's third level.

Results of a 1987 study by Wheeler, which analyze the relevance of her pre-defined levels of practice (1983) indicate that insight music therapy with reconstructive goals was linked to positive outcome projections with individuals experiencing "situational disturbances." In Wheeler's 1983 framework presentation, she indicates that insight music therapy with reconstructive goals is best suited for individuals whose disturbances are less severe. In my study, I aimed to work with a well-individual experiencing mild-moderate, situational mental health challenges. This type of participant, in terms of Wheeler's guidance on indications for each level of music psychotherapy, would be considered to be a "less severely disturbed" client "whose problems do not cause severe personality disorganization" (Wheeler, 1983).

Nicole was identified as the respondent most ideal for inclusion in my study. During our initial discussion, I asked Nicole if she had "any concerns about [her] readiness to explore any of the topics we [had] discussed" relevant to her therapeutic intentions. Nicole shared that she felt "open with [her] mental health," stating "I am actively seeking to bring out the things I've been struggling with so I can work through them. At the stage I am in with my mental health, this [exploration] seems like something that will be beneficial."

As I learned about Nicole's story and her intentions for seeking therapeutic support, her history of traumatization became evident. As Nicole

shared her personal insights before our work began, we discussed her primary goals, which she identified as improving her skills for coping with anxiety and stress and to engage in personal growth. In our phone screening discussion, Nicole had been forthcoming about her historically complex relationship with her mother, as well as her more recent sexual assault. However, Nicole's preparedness to begin engaging in processing of her personal traumas became evident to both of us only after our post-session discussion of the content of Highlight 2.

Later in the study, Nicole shared that she began our work knowing that she was "ready to begin processing but needing a nudge." She explained that she hoped engaging in my research study would give her that nudge, but that she did not anticipate the nudge coming about early enough in our process to allow for processing during our session series. In the same discussion, Nicole shared that she was surprised and relieved when she realized our sessions were a safe place for actually engaging in some of that processing. In the post-series member checking discussion, Nicole shared that hindsight helped her realize that she had been more prepared to process her trauma than she knew, and that she feels this helped her to feel comfortable processing the traumas within the context of our work together. Nicole also shared that she credits our therapeutic relationship for much of what she was able to get out of the experience. She noted that she quickly felt "comfortable, heard, and understood" by me, which are elements of

the client-therapist dynamic she had not previously experienced with former psychotherapists.

Analysis of Issues in Wheeler's Guidance for Application of Levels of Practice

Wheeler's guidance for the application of her levels of music psychotherapy notably include that those who provide insight music therapy with reconstructive goals (Level 3) must have extensive clinical training in at least one method of music psychotherapy requiring advanced training. This guidance suggests that I, as a clinician having no formal advanced clinical training in any method of music psychotherapy, should not have ethically engaged with Nicole in the type of processing toward insight presented in the case example. The above overview of my experience relevant to the progression of my work with Nicole from Level 2 to Level 3 practice was shared to provide context for three issues I have found with Wheeler's continuum which characterize the grey area noted previously.

The first issue I note is that I was not aware during facilitation that Nicole had transitioned from working within easily accessible conscious material (Level 2) to engaging with emergent, unconscious material (Level 3). Nicole did not share with me the content of her imagery until after the music experience concluded, despite frequent verbal check-ins throughout the experience.

Next, regardless of my awareness of her imagery, the participant-led, reflexive music therapy experience offered Nicole the freedom to engage with the music in whatever way she felt comfortable. Nicole followed her instinct to engage with the imagery without receiving direct encouragement from me to do so. Nicole did not

demonstrate any observable resistance to the therapeutic situation (Bruscia, 1987) as she engaged in the reflexive music experience, giving no indication that she felt unsafe and or uninterested in continuing. Later in the session, Nicole did share that she was hesitant to engage with the memory when it first emerged, but that she felt empowered to explore it in part because of her awareness of safety in therapeutic environment which she noted was reinforced by my calm voice and steady music.

The final issue I note relates to Wheeler's acknowledgement of one reason that the distinction between Levels 2 and 3 is not definite. She indicates that Level 2 work often employs the music as an agent for intentional elicitation of emotion. She explains that when emotions relevant to the therapeutic process are elicited and the emotions experienced become less consciously accessible, material that was previously unconscious is brought into the client's conscious awareness as free flowing thought. At the unrecognizable point that unconscious material transitions into consciousness, the music therapy transitions from Level 2 to Level 3. My view of this issue, which has been supported by the above case example, is that it is unreasonable to assume that music therapists who are fully capable of providing Level 2 music psychotherapy will not often be posited to support client processes that evolve organically into Wheeler's defined Level 3 practice. Given that the overarching orientation of Levels 2 and 3 is expectant of the development of insights which result in therapeutic change, I feel that Wheeler's guidance suggesting the necessity for advanced training for ethical delivery of Level 3 music therapy should be reassessed. My assessment of the need for reassessment of this model leads me to share the following considerations for the application of IMFP.

Considerations for Future Application of IMFP

After my comparison of Nicole's work to Bruscia's and Wheeler's theorizations, I came to the conclusion that the best descriptive title for my proposed theory is, "Insight-oriented music facilitated psychotherapy." I feel IMFP is an appropriate descriptive title that combines work characteristic of IMFP with both Bruscia's (1998) and Wheeler's (1989) levels, while also placing the client's process, rather than the music, at the center of the description (Bruscia, 1989; 2014). Consideration of the work with regard to the benefits and shortcomings of characterizing by determining its alignment with these extant theorizations led me to the following conclusion about the nature of my proposed model of music psychotherapy. IMFP is a potential model for music psychotherapy that is characterized by insight-oriented, music supported facilitation of psychotherapeutic processes including becoming aware of, exploring, and reaching resolution of salient issues which arise during or in subsequent processing of the client's reflexively supported experiences which may or may not involve simultaneous musical and verbal discourse.

My intentions for the application of this conceptual model are founded in my experience with supporting Nicole's therapeutic process in this manner, as well as in my cognizance of its partial alignment with two theoretical explanations of music psychotherapy that are well regarded and empirically supported within the music therapy community.

IMFP and Trauma Work

In addition to its connectedness to Levels 2 and 3 of Wheeler's theory, and to Levels 2 and 3 of Bruscia's levels, I view IMFP as being informed by models of trauma

processing that I am aware influence my personal theoretical approach to music therapy practice (see van der Kolk, 2015; Payne & Levine, 2015; Herman, 1992). These models are therefore inextricably linked to both the design and implementation of my research study, and the proposed model which emerged as a result of this work. As I propose the development of a new model of music psychotherapy, I wish to acknowledge that this model would not be recommended for application without being accompanied by an outline of contraindications. While the case material presented in this report does provide examples of positive indications for the implementation of IMFP, processing of therapeutic issues related to participant-identified traumatization was explored within the scope of my study only in the context of short-term, intensive music therapy.

Though I believe continuation of IMFP in Nicole's case could offer an effective opportunity for her to engage in further processing of her developmental traumas, this study only provides evidence for meaningful processing of Nicole's single-event trauma, which was invited into our therapeutic space only after she organically connected her therapeutic experiences with the event. With IMFP developing as a model which may be implemented by music therapists supporting individuals whose symptoms originate from unprocessed trauma, as was the case for Nicole, I do feel that further development of the model should include study of cases where clients receive IMFP as a method of processing longer-term, developmental trauma, which typically involves re-emergence of therapeutic issues as they exist in relation to the client's continuing lived experiences (Prochaska & DiClemente, 1983; Ogden & Fisher, 2015; Payne & Levine, 2015).

As a note on the potential for further development and future application of IMFP in practice, I offer my perspective on Barbara Wheeler's suggestion that music therapists engaging with clients in deep emotional work that is relative to resolving therapeutic issues through exploration of unconscious material. This issue is one that has been discussed widely within the field of music therapy, referred to in contexts including professional gatekeeping (Goodman, 2011), master's level entry (AMTA, 2018), scope of practice (AMTA, 2015), and scope of competency (AMTA, 2013; 2015b).

The American Music Therapy Association's Advisory on Levels of Practice in Music Therapy (2005) defines an advanced level music therapist as having

> …a Bachelor's degree or its equivalent in music therapy, a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT), professional experience, and further education and/or training (e.g., continuing education, a master's degree, a doctoral degree, or in-depth training in areas of specialization such as AMT, BMGIM, or NRMT).

By AMTA's (2005) definition, a music therapist similar to myself with no specific training in an area of specialization is qualified to practice as an advanced level practitioner due to combined professional experience and further education and training (advanced degree).

However, Barbara Wheeler's guidance on the indications for application of her third level of music therapy practice suggests that music therapists practicing her defined Level 3 music psychotherapy must have advanced clinical training in at least one method of music psychotherapy requiring advanced training (Wheeler, 1983), contradicting

AMTA's advisory. Nikki Cohen's *Advanced Methods of Music Therapy Practice: Analytical Music Therapy, the Bonny Method of Guided Imagery and Music, Nordoff-Robbins Music Therapy, and Vocal Psychotherapy* (2018) provides an overview of the four methods of music psychotherapy that presently require advanced clinical training.

My approach to the music therapy experiences facilitated within my study was informed by many of the same theoretical foundations as each of these advanced methods. I am aware that many of the techniques I employed in my work with Nicole are mutually characteristic of these advanced methods, but I do not consider myself to practice any of these methods specifically. I do not have formal training in any advanced method of music therapy practice, and my education as a music therapy equivalency and music therapy graduate student did not involve formal integration of any level of either of the methods of music psychotherapy requiring advanced training.

Still, my knowledge of the indications and implementation of techniques characteristic of these advanced methods allowed me to provide support informed by many of the same theoretical frameworks from which these methods were developed. This knowledge, paired with my personal experience with uncovering and processing unconscious material (see preface) equipped me with enough insight to recognize and respond effectively to Nicole's emergent response. The therapeutic alliance Nicole and I built allowed us to work within a therapeutic space that was augmented by reflexivity in the application of music and non-music techniques, Nicole's felt sense of safety, and my awareness of these parallel processes.

Therefore, I feel that my supporting Nicole in insight-oriented (Bruscia, 1998; Wheeler, 1983; Giorgi, 2011; Helmecke & Sprenkle, 2000) music facilitated psychotherapy that transitioned from Level 2 to Level 3 (Wheeler, 1983) was ethically and clinically appropriate. I credit this demonstrated competency to my knowledge base, which I view as a unique accumulation of my formal music therapy education, my professional clinical experience and my personal insight acquired throughout my own process of self-discovery and reconstruction. While I do feel that the support I provided to Nicole was ethically, technically, and effectually sound, I acknowledge that under different circumstances, I may not have been successful in providing safe and effective care.

With this in mind, I pose the question, how can we as music therapists ensure ethical provision of IMFP and similarly intensive work within our profession? My response leads me to make a recommendation for future research toward the development of a feasible application of IMFP. A common concern within our profession is that newly credentialed music therapists having limited clinical and life experiences are ill-equipped to provide the level of support necessary for providing safe, competent, and effective psychological treatment. The prevalence of this concern leads me to highlight an opportunity for improvement in current standards of music therapy education (AMTA, 2021). I feel that music therapy education should better prepare new clinicians by requiring development of equal levels of functional competency across all domains of functioning with a variety of population groups.

Recommendations

I recommend that music therapy educators come together, not to work toward agreement on which music therapists should practice which types of therapy, but to establish a plan for ensuring functional competency through integration of at least one method of music psychotherapy that presently requires advanced training into the standard curriculum in undergraduate and graduate music therapy programs. This plan may encompass the development of standardized areas of clinical specialization, as in the field of professional counseling (Fairburn & Cooper, 2011). I am in favor of this option, as it would narrow the scope of each clinician to ensure equally functional competency.

Implications: Music therapy and Mental Healthcare in the United States

I believe the results of my study, which led to the conceptualization of a new model of music psychotherapy, have positive implications for the future of music therapy and the greater context of mental healthcare in the United States. As addressed in detail previously in this report, a group of mental healthcare consumers that may benefit from the receipt of music therapy as a primary means of mental health support has emerged in recent years. There are presently very few music therapists who provide individual support to clients seeking support for mental health challenges not existing as co-morbid symptoms of other diagnoses requiring prioritization in therapy.

Accessibility of IMFP

My proposed model of IMFP provides a conceptual framework for current music therapists to support these individuals without stepping beyond their scope of ethical practice and without stepping beyond their personal scope of competency. My

recommendation for the future development of the model would result in a framework that empowers music therapists to engage in this type of practice early in their careers, which could initiate a swift response to the quickly expanding gap between available mental healthcare practitioners and consumers in need of their support. The integration of advanced practice training into music therapy curriculum will also produce a new generation of clinicians who are educated and competent in approaching practice from an integral perspective.

I project that as more music therapists begin providing support to these consumers, music therapists will be recognized as a group of underutilized mental healthcare practitioners. This recognition would allow music therapy to be identified across disciplines as a valid therapeutic option for individuals seeking support for mental health challenges. Recognition would likely initiate an influx of consumers seeking support from music therapists, prompting an increase in demand for quality music therapists in the U.S. Ultimately, expanding the provision of music therapy services to meet the needs of adult individuals seeking therapeutic support for situational mental health challenges may help to alleviate the strain on current mental healthcare services, improving accessibility of service nationwide.

Conclusion

In the course of my study, I identified a growing population of mental healthcare consumers who are underserved by the current mental healthcare system in the United States. I then conceptualized a method for supporting these individuals effectively through facilitation of four insight-oriented, reflexive music therapy sessions that

incorporated experiential music therapy techniques called mindful improvisation and guided imagery and music. To gain insight into how this method might support a recipient, I engaged with a research participant who is representative of the underserved population by conducting a phenomenological case study as the primary investigator and facilitating music therapist. The participant is an adult female whose primary intentions for seeking therapeutic support were to develop skills for coping with worsening anxiety and to engage in self-growth. The participant's therapeutic process emerged organically in the context of our shared therapeutic space, and she developed several personal insights that ultimately allowed her to recognize the part of her existent being that had not been afflicted by the anxiety which she identified in our work as having been a symptom of unresolved childhood trauma that had recently been compounded by a series of additionally traumatizing experiences. Throughout the processes of observing and analyzing my participant's experiences, I engaged in arts-based, meditative processing to ensure abstinence from my personal biases and pre-acquired knowledge.

In employing a hermeneutic, phenomenological research methodology, Transpersonal Phenomenology (Moustakas, 1994), I identified a trend in my participant's responses to the music experiences. Even though specific techniques of music therapy implementation were varied between sessions, a recurring phenomenon that was unvaried between occurrences emerged from methodical analysis of the data. Further analysis allowed me to gain a contextual understanding of the essence of that phenomenon, which resulted in a meaningful response to my overarching research question. The result of this work is a description of the emergent phenomenon, therapeutic change. This contextual

definition was derived from synthesis of descriptions of each element of the participant's therapeutic process found to be essential in the emergence of the phenomenon. Therapeutic change is defined in the context of this work as "a phenomenon which occurred during the participant's intentional process of self-exploration which was supported by the presence of a guiding music therapist. The emergence of organic therapeutic change required the participant to a) bring into awareness elements of the Self through musically supported engagement, b) develop a felt sense of control over the Self and the explorative process, c) demonstrate control by allowing release of emotion or energy and d) connect the relevance of new insight to the existent self."

Implications for the results of this work are outlined in discussion, where conceptualization of a new model of music psychotherapy is introduced. I justify the development of insight-oriented music facilitated psychotherapy (IMFP) by comparing my research participant's therapeutic process with extant theorizations of music psychotherapy, highlighting the shortcomings of each in accurately characterizing the type of music therapy that emerged in support of her work. My recommendation for the ethical application of IMFP as a potentially beneficial model of music psychotherapy is provided, and my projections for the implications of the integration of the model for the fields of music therapy and psychotherapy are outlined.

The personal development that I underwent as the conductor of this project set the pace for each step of the process. As I engaged in the development of a project of this capacity, I came to understand that reflexivity in the research process would be equally as important as the reflexivity essential to the therapeutic relationship developed within it.

As I reflect on the potential and greater implications for the results of this work, I am humbled by the awareness that my research participant, Nicole, engaged with me in what is just the beginning of her process of self-healing. I believe Nicole's process of becoming aware, taking control and connecting with her core Self will undoubtedly support more people than either of us will know in this lifetime.

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Appendix A
Recruitment Flyer

Is anxiety, depression or stress impacting your daily life?

If you are experiencing **mild to moderate symptoms** of anxiety, depression or stress as the result of **situational circumstances**, you may be a candidate to participate in this resesarch study. **Participants will receive two to four** therapeutic music sessions facilitated by a board-certified music therapist, **free of charge**. Sessions will be conducted in McKinney Hall at Marietta College, and will be scheduled at your convenience.

The researcher hopes to connect with potential participants local to Marietta, Ohio who are **presently seeking support** during their journey toward wellness, through transition/loss, in personal growth or exploration, or to aid in coping with mild to moderate anxiety, depression or stress.

Contact Primary Investigator

Abby Dodds, MT-BC
Music Therapist, Board-Certified
Graduate Student, Ohio University
740.491.3860 ad654515@ohio.edu

To participate, you must meet the following criteria:

1) 18 years or older

2) No current, formal diagnoses of anxiety, stress, or depressive disorders

3) No significant hearing or sight impairment

4) Beginner to advanced proficiency playing one, non-winded musical instrument

5) Ability to commit to at least two sessions lasting 1-2 hours each over the course of 5-10 days

ad654515@ohio.edu 740-491-3860 Research Participant Wanted

Appendix B

Phone Screening Questionnaire
(For Researcher Use During Recruitment)

I. Eligibility
   a. 1) Are you at least 18 years of age?
   b. Do you now, or have you ever been diagnosed with a mental condition including but not limited to; depression, anxiety, PTSD, Bipolar I or II, Major Depressive Disorder, Social Anxiety Disorder, Separation Anxiety, Generalized Anxiety Disorder, Panic Disorder, Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Dissociative Identity Disorder, Obsessive Compulsive Disorder, Acute Stress Disorder, Adjustment Disorder, Complex Bereavement Disorder?
   c. Are you currently experiencing at least one of the following: Anxiety, stress, depression, transition, loss, desire to engage in self-exploration, growth or improvement, desire to improve your overall personal wellness?
      i. Have you experienced this before?
         1. If so, what means of support did you rely on? (i.e., therapy, medication, self-management, positive/negative coping skills).
   d. Do you believe you have significant hearing or sight impairment that might impact your comfort, safety, and communication during a 1:1 music therapy session?
   e. Are you willing and able to commit to, without compensation, at least two, ~2-hour meetings in a 5-10 day period?
   f. Do you have at least beginner proficiency on one, non-winded, recreational musical instrument (i.e., three chord knowledge on guitar, keyboard, or ukulele, ability to repeat patterns using a hand drum or accessory percussion instrument, or intermediate proficiency on any electronic/synth instrument).

II. Intentions
   a. What led you to seek therapeutic support?
   b. How do you feel music therapy will benefit you?
   c. What is most important to you in terms of the benefit you will derive from participation?
   d. Do you have any concerns about your readiness to explore (the topics shared in response to above questions)?
   e. Is there anything else you'd like me to know about you?
   f. What questions can I answer for you about this process?

III. Rapport Scales

The researcher should rate her own level of comfort and impression of ease of rapport building after speaking with each potential participant by phone using the following scales.

   a. How confident are you that you and this participant will establish rapport that will lead to an effective therapeutic relationship?
      i. 0- Very little to no confidence in building effective rapport in the time available

1- Moderate confidence in building effective rapport in the time available

2- Confident that effective rapport will be built in the time available

3- Extremely confident/not concerned that effective rapport will be established in the time available.

b. How comfortable do you feel about supporting this participant's personal goals within the context of the present study?
    i. 0- Very uncomfortable with my ability to support this participant's personal goals

1- Moderately comfortable with my ability to support this participant's personal goals

2- Confident in my ability to support this participant's personal goals.

3- Extremely comfortable/not concerned about my ability to support this participant's personal goals.

Appendix C
Informed Consent

Working Title of Research: xxxxx
Researchers: Abby Dodds, MT-BC (PI), Kamile Geist, PhD, MT-BC (Advisor)

You are being asked by an Ohio University researcher to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks of the research project. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Summary of Study

The researcher is interested in learning about your experiences during a music therapy session involving a therapeutic music experience that includes mindful improvisation and guided imagery and music. You will participate by receiving 2-4 music therapy sessions facilitated by the researcher, who is a board-certified music therapist. Before and after each session, you will participate in short interviews with the facilitating researcher. You will also be encouraged to keep a journal for use after and in-between sessions on your own time, should you choose. The contents of your sessions, interviews and journals will be reviewed by the researcher after all sessions are completed and will be organized in a way that allows research consumers to understand your experience. Your privacy will be maintained throughout the process. Before the researcher finalizes and shares the results of the study, you will have the chance to review the study report.

Explanation of Study

This study is being done because the researcher is interested in studying the experiences of one adult participant who is experiencing mild to moderate symptoms of anxiety, stress or depression during the above-mentioned music therapy experience. The researcher will also be studying the music, therapeutic techniques, and session events relevant to each session. This study is being conducted as part of the researcher's graduate thesis project at Ohio University.

If you agree to participate, you will be asked to attend 2-4 scheduled therapeutic music sessions lasting at maximum 2 hours each. Participation is voluntary, and you will not be compensated for your participation. Before and after each session, you will participate in short interviews with the facilitating researcher, during which you will be asked to describe your experiences during each session. You will also be encouraged to keep a journal for use after and in-between sessions on your own time, should you choose.

You should not participate in this study if you are 1) Under the age of 18, 2) Have a diagnosed mental health condition of any kind (including formally diagnosed anxiety, depression, or stress), or 3) Have a significant sight or hearing impairment.

Your participation in the study will last between 5 and 10 days, depending on your mutual availability with the researcher. Full participation in this study is considered when at least two sessions are attended.

Risks and Discomforts

Risks or discomforts that you might experience are anticipated to be the same as what one may experience during individual psychotherapy. Discomforts associated with personal and emotional exploration may arise within the therapeutic context.

Benefits

This study is important to the field of music therapy because it will offer valuable insight to the lived experiences of yourself and the researcher during the specific music therapy experience noted above.

Individually, you may benefit from participating in this study as you will receive 2-4 music therapy sessions facilitated by a board-certified music therapist free of charge. You may also benefit from improvement of the symptoms you have been experiencing that led you to participate in the study. In addition to receiving education relevant to at-home relaxation and stress management techniques, you will likely note improved self-awareness and personal insight development throughout the course of the study.

Confidentiality and Records

Your study information will be kept confidential by remaining stored on a secure server. Your name and other identifiable information will be censored throughout data collection and organization, and the results of the study will include a pseudonym in place of your real name.

Future Use Statement

Identifiers will be removed from data collected, and after such removal, the data/samples may be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you or your legally authorized representative.

Contact Information

If you have any questions regarding this study, please contact the investigator *Abby Dodds, MT-BC, **xxxxx@ohio.edu**, xxx-xxx-xxxx,* or the advisor *Kamile Geist, PhD, MT-BC, **xxxxx@ohio.edu**, xxx-xxx-xxxx.*

By signing below, you are agreeing that:

you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
you have been informed of potential risks and they have been explained to your satisfaction;

- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study;
- you are 18 years of age or older;
- your participation in this research is completely voluntary;
- you may leave the study at any time; if you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature_____Date_____
Printed Name_____

Appendix D

Epoch Protocol
(For Researcher Use Throughout Study)

The purpose of the epoch is to allow the researcher to observe the phenomenon being studied in its purest form (Moustakas, 1994). This requires the researcher to be aware of any personal, environmental, and situational elements that may influence her own perception of the experience. Once the researcher is aware of these elements, she can engage in a systematic process of organizing the data in such a way that it can be recalled during the data analysis phase to ensure those elements are not integrated into the data before or during analysis.

The researcher, who is engaging in hermeneutic inquiry, must work to view session material objectively, while remaining open to allowing the client's unique, real-time interpretations to influence the course of the session as relevant. The researcher's dual role complicates this process, especially given the researching clinician's awareness of the importance of genuineness and empathy within the therapeutic relationship (Rogers, 1965). For this reason, the present researcher has chosen to engage in the epoch process not only before and after data collection, but within the collection process.

The epoch protocol outlined below is provided as a guide—each epoch was practiced with variation, and the researcher ultimately engaged in organic meditation guided by the elements included in this protocol.

Epoch Protocol

I. Meditation (informed by 7-Principles of Mindfulness, Kabat-Zinn, 2008)
    a. Intention Setting
        i. “See the process clearly, through unbiased eyes.”
    b. Bringing into awareness
        i. Reflecting
    c. Acknowledging
        i. Identifying
    d. Non-judgement
        i. Considering
    e. Accepting
        i. Discerning
    f. Letting go
        i. Setting Aside
II. Journaling
    a. Free associative journaling
        1. Engaging, reflecting, release through visualization

OR

    b. Structured journaling
        1. Contents of Reflection (Become Aware)
        2. Contents of Identified Influential Elements (Acknowledge)
        3. Thoughts on the benefits/risks of allowing influence, notes on the etiology of each potential influence (non-Judgement)
        4. Notes on self-agreement to set aside this information/personal thought process (Acceptance)
        5. Naming and listing of each potential influence for abstention (Letting Go)

Appendix E

Pre-Session Interview Guide

Guiding Questions for Pre-Session Interview

1. What are your intentions for today's session?
2. Why are these topics important to you today?
3. Is there anything you want me to know about before we get started?

Appendix F

Post-Session Interview Guide

Guiding Questions for Post-Session Interview:

1. Tell me about what you noticed during the session.
2. Tell me what you observed with your eyes during the session.
3. Tell me about what you heard during the session.
4. Tell me about your focus
    a. To what were you drawn to give your attention to throughout the experience?
5. Tell me about your actions—what do you recall doing?
    a. What compelled you to do this?
6. Describe your cognitive experiences
    a. What do you know, think, believe, connect, etc.
7. What emotions do you recall experiencing during the session?
    a. When did you notice them?
8. Describe your felt experiences.
    a. Do you know when in the session you experienced these?
    b. Where in your body did you feel your emotions? (Visceral sensation)
    c. What did you feel your body doing? (Kinesthetic sensation)
    d. What did you notice about your body's position? (Proprioceptive awareness)
    e. Did you notice any sensations such as change in temperature, tingling, pain or tension? (Somatic awareness)
9. What do you want to remember from today's work?
    a. What seems important?
    b. What did you learn about yourself?
    c. Did you make any new connections?

Appendix G

Researcher's Memo Template

1. What do you see?	**2. What do you hear?**	**3. What do you feel?**	**4. What do you sense?**
a. Participant i. Participant's affect ii. Participant's actions iii. Participant's body iv. Participant's attention b. Yourself i. My affect ii. My actions iii. My body iv. My attention c. Events d. Therapeutic techniques	a. Participant i. Participant's voice ii. Participant's music iii. Participant's body b. Yourself i. My voice ii. My music iii. My body c. Events d. Musical techniques/trends	a. Participant i. What did the participant report feeling? b. Yourself i. What do you recall feeling while facilitating? Note timestamps. 1. Affect 2. Actions 3. Body ▪ Visceral ▪ Somatic ▪ Proprioceptive ▪ Kinesthetic 4. Attention 5. Emotions	a. Participant i. Participant's emotions ii. Participant's instincts iii. Participant's awareness b. Yourself i. My instincts ii. My affect iii. My body 1. Visceral 2. Somatic 3. Proprioceptive 4. Kinesthetic 5. My awareness 6. My emotions

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