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TITLE OF THESIS...HOW CAN A MUSIC THERAPY STUDENT FACILITATE CONTRIBUTIONS BY ADOLESCENT CLIENTS WHO HAVE PSYCHIATRIC DISORDERS IN GROUP MUSIC THERAPY?.................

DEGREE....MASTER OF MUSIC THERAPY......................

SUBJECT....MUSIC THERAPY..............................

YEAR....2009..

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How can a music therapy student facilitate contributions by adolescent clients who have psychiatric disorders in group music therapy?

A thesis presented in partial fulfillment

of the requirements for the degree of

Master of Music Therapy

At New Zealand School of Music, Wellington,

New Zealand.

Chit Yu Wong

2009

Abstract

This study explored ways in which a music therapy student could modify and improve her own clinical practice in order to facilitate client contribution in group music therapy in an acute adolescent inpatient unit. Through cycles of observation, evaluation, planning, and action, the music therapy student was able to examine her facilitation techniques in detail and modified them accordingly. There were six fortnightly cycles and in each cycle, the research journal, research notes, and video-recording were systematically reviewed by the music therapy student herself, and themes were drawn out to contribute to the planning of the next cycle. The results suggested that while direct questions predominated at the start of study, the music therapy student was able to adopt a variety of other techniques by the end of the research period, including self-disclosure, appropriate eye contact, and the shifting of responsibility. The music therapy student also found that her own anxiety level, which was often caused by periods of silence in music groups, also had an important impact on her ability to facilitate. The discussion addressed other factors that are believed to have contributed to the student"s ability to facilitate in group music therapy.

Acknowledgements

- **I would like to acknowledge the support of the facility where this research took place, and the supporting staff who assisted in my music therapy groups.**

- **I would like to thank my clinical liaison for giving me weekly supervision as part of my music therapy placement. The supervision sessions had enabled me to gain important insight about clinical issues that arose during the course of this research.**

- **I would also like to acknowledge the approval of the Health and Disability Ethics Committee (Central Region) for this study**

Approval Number: CEN/08/18/EXP

Table of Contents

Introduction ………………………………………….. 1

Literature Review ………………………………………….. 4

Methodology …………………………………………… 27

Results …………………………………………… 34

Summary of Findings …………………………………………… 57

Discussion …………………………………………… 59

Conclusion …………………………………………… 69

References …………………………………………… 71

Appendices …………………………………………… 78

Example of Video Transcript …………………………… 78

Example of Thematic Analysis ……………..…………… 90

Introduction

My research idea arose as I was preparing and planning music groups in an acute psychiatric setting for adolescents. I was interested in finding ways to improve my own clinical practice, especially in group facilitation skills or techniques.

The facility was a 12-bed inpatient unit. Client age ranged from 12 to 18 years old although most of the adolescents who attended music therapy groups were over 16 years of age while the younger patients attended health school. The predominant diagnoses of the adolescents at the facility were schizophrenia, depression, or bipolar disorder. Some of them were also at a high risk of self-harm or had previous suicide attempts. They were typically low in mood, with flattened affect and very low motivation. They were often lethargic and appear bored and under-stimulated. It was difficult to facilitate their contribution in groups and although this is one of the main purposes in therapeutic group, it was not always being achieved. This caused me to wonder how I could improve my own clinical practice over time in order to encourage contributions from this population during music groups. Adolescents who have psychiatric disorders can be difficult to engage in musical and verbal exchanges. However, I felt more comfortable when I was facilitating musically. In contrast, when it felt important to pick up on something or to lead in a verbal way I became anxious. Both ways of working are important and I knew I needed to work on my verbal facilitation. Action research provided a means for me to do this in a rigorous

way.

It is important to have a clear definition and distinction between the terms music therapy “procedures” and music therapy “techniques” before starting the research process. The term “procedures” refers to the activities used by the music therapist to engage the client in a therapy session whereas the term “techniques” is used to describe the actions which the therapist took to elicit a response from the client or to shape the client"s immediate experience (Bruscia, 1987). Previous researches have shown that adolescents with psychiatric disorders could benefit from music therapy using various music therapy procedures or activities, but little is described in those studies on how the music therapist delivered the intervention. Using an action research model, I was able to systematically monitor and modify my clinical practice by constantly evaluating the facilitation techniques I used within sessions. The aim of this study was to identify and develop therapeutic techniques used to facilitate adolescents" verbal contribution in a group music therapy setting.

This study was conducted over a twelve-week period with 6 fortnightly cycles. Clinical notes were written for all sessions in a cycle but research notes were written for one session (research session) per cycle which included observations made during the music therapy group. This was followed by a journal entry which included my reflections and comments about that research session. The research session was the second session of each cycle and the session took place on Wednesdays from 9:30 to 10:30am. In addition, video-recording were made in every odd-numbered cycle to provide data from an

objective perspective.

Each session was no longer than one hour and involved improvisation, song-writing, as well as music-listening.

Literature Review

Music Therapy in Psychiatric Hospital

Music therapy has been defined as the use of music as a therapeutic medium in clinical, educational and social situations to treat clients or patients. Potential music therapy clients may have a range of different needs, from medical, educational, social, to psychological needs (Wigram, 2000).

Music therapy interventions could be divided into 2 broad categories: active music therapy and receptive music therapy. The former includes activities that involves music-making, such as improvisations, song-writing, and group performances, whereas the latter includes music-listening. Music therapists have noted successful behaviour changes for both adult and adolescent psychiatric patients using both types of interventions (Waldon, 2001; de l"Etoile, 2002; Sullivan, 2003).

According to Davis, Gfeller, and Thaut (1999), there was already written documentation about the use of music to treat physical and mental disorders in the 19th century. It was around this time when music therapy was used in educational settings. However, the use of music therapy to treat mental illness only gained sporadical support during the 1940s when there was a change in treatment philosophy of mental health patients (Davis, Gfeller, & Thaut, 1999). Mental health facilities began to advocate a holistic treatment approach for patients, one that incorporates a range of treatment modalities.

With this shift in philosophy and increased written documentation about its effectiveness, music therapy eventually became one of these treatment modalities in hospital settings. Clinical uses of music therapy in psychiatric setting could vary greatly because of the flexibility music has. Patients could be engaged in musical activities in different ways, including music listening, lyrics analysis, improvisation, and song-writing or composition (Unkefer, 1990).

There are many different theoretical orientations to the treatment of psychiatric disorders. The most commonly known of these models include behavioural, cognitive, and psychodynamic (Unkefer, 1990). Each of these models has different implications on music therapy treatment in hospital settings. The behavioural model believes that all human behaviours are learned via reinforcement, including the way one expresses his feelings, and the way one relates to others. Thus professionals working within the behavioural model would use reinforcement to increase desired actions and reduce negative behaviours by eliminating any reinforcement of those actions (Corey, 1996). The multi-discplinary team would set behavioural goals for the clients and different members of the team will approach these goals differently. An effective reinforcement that music therapists may use is music itself, and for a client who enjoys music, music activity can be used as a reward to help change his/her behaviour in the desired direction (Lathom & Eagle, 1984). However, therapy with a behavioural emphasis is not widely supported by mental health professionals as they believe that behavioural theories failed to explain fully many types of human behaviour (Davis et al., 1999). Cognitive model stresses the importance of cognitive or mental processes as

determinants of human behaviour. A music therapist working within the cognitive model may utilise the lyrics and content of songs to help the group or the individual to explore their beliefs and emotions, subsequently challenging the disordered thinking (Bryant, 1987, cited in Davis et al., 1999).

The psychodynamic model of treatment is one that is adopted by mental health facilities as it has a psychological emphasis. This model is based on Freudian theories (Corey, 1996) and psychodynamic therapists believe that emotional problems are a result of internal conflicts that have resulted from negative events mostly occurred in early childhood. The music therapist aim to assist the client in gaining awareness of unconscoius conflicts and help relating these to present anxieties. Ruud (1980) suggested that music, as a non-verbal form of expression, can be used to explore unconscious feelings and can also be used as a medium for one to express anger in a constructive way. Moreover, by involving in successful musical improvisations or other musical activities, the client can experience a sense of mastery and control which ultimately would lead to an improved self-esteem (Ruud, 1980).

Due to improvements in pharmcalological treatments and changes in health care policy, hospitalisation for a mental disorder has become relatively short in duration (Sarafino, 1997). This change in the length of hospitalisation has resulted in a change in the manner in which music therapy is delivered (Davis, Gfeller, & Thaut, 1999). In short-term psychiatric settings, group therapy appears to be more cost-effective than individual therapy. Although antipsychotic medication reduces the most common symptoms of mental

illness, the patients" ability to perform daily life skills are often impaired due to the presence of the illness. Christman (1967, cited in Wolfe, 2000) proposed that music therapists should focus their interventions in social system terms, including communication and learning. The therapists should conduct groups that aimed to help clients in exploring their problems and also to help develop functional, relevant skills that could be applied in daily living (Jellison, 1983; Bryant, 1987). Communication, a skill which is crucial for normal functioning in society, is often an important goal in short-term music therapy as it can be achieved in a relatively short period of time (Powell, 1985).

Acute therapy groups have a number of common characteristics. Membership in these groups is brief and group members often have diverse individual levels of functioning (Wolfe, 2000) The ultimate goal of short-term treatment, including music therapy, is to support and facilitate patient"s return to the community by assisting with the learning of skills for coping when returned to the society. Members are often encoruaged to give as well as receive support from one another (Maves & Schulz, 1985). Other goals in short-term intervention suggested by Yalom (1983) included increasing self-esteem, reducing anxiety and problem-solving.

Music Therapy and Psychiatric Disorders

Music has long been associated with emotional expression. Music"s ability to evoke, reflect, and express emotions and feelings has been documented by many philosophers and critics. Davies (2001) suggested that emotion is

transparently immediate in one‟s experience of music and that it is not possible to dissociate the emotions from the musical experience. Music even has the capacity to mirror the complex and ambiguous nature of human emotions which could not be described using words (Goldberg, 1989). Meyer (1956) suggested that affective responses are a result of imagery, memories and associations arose from listening to music. Langer (1980) proposed that although these are not the primary functions of music, music is able to give pleasure, facilitate self-expression, evoke and relieve one‟s feelings. She suggested that "the real power of music lies in the fact that it can be „true‟ to the life of feeling in a way that language cannot; for its significant forms have that ambivalence of content which words cannot have" (Langer, 1980, p. 243). Radocy and Boyle postulated that the reason why music plays an important role in society is because it could serve as a medium through which ideas and emotions that are difficult to be expressed verbally could be expressed (Radocy & Boyle, 1979). Music could also be used to intensify the expression through words (Thayer & Levenson, 1983; Galizio & Hendrick, 1972). Several writers have proposed theories in attempts to explain how emotions arise from musical experiences. Berlyne (1971) suggested that the degree of emotional response one has depends on the level of complexity and familiarity one has for a particular piece of music. Music that is too complex may result in a state of confusion, chaos and discomfort in the listeners, whereas music that is too simple or familiar may result in a state of boredom. From a neurological perspective, studies have supported the existence of specialised neural networks for music processing (Peretz, 2001) and have also suggested that the processing of music takes place in centres of the brain that are associated

with emotional response (Peretz, 1996). These findings and theories have laid the foundation of the use of music as a therapeutic tool in various settings, including mental health facilities.

It is music‟s ability to influence thinking and emotional patterns that increases the potential music therapy has in promoting mental health (de l‟Etoile, 2002). Rubin (1973) believed that music therapy has the capacity to serve as a source of motivation for clients who are initially unmotivated. It is commonly known that patients with mental illness are typically low in mood, with flattened affect and very low motivation. Fulford (2002) suggested that what makes music therapy successful in achieving goals that may be difficult in other forms of therapy is the use of musical techniques such as improvisation, musical games, song-writing and moving to music. Through the use of these techniques, positive expression of feelings could be promoted, at the same time improving the patient‟s awareness of him/herself as well as his/her self-esteem. Positive group interaction could also be fostered (James & Townsley, 1989).

Music therapy also focuses on the patient‟s interpersonal communication skills, whether it is between the patient and the therapist, or between the patients themselves (Morgenstern, 1982). It is believed that music therapy has a very high potential to facilitate the development of social skills if the patient could learn how to transfer such skills from music therapy to other situations (Langdon, Pearson, Stastny, & Thorning, 1989).

It is common for psychiatric patients to have trouble expressing their emotions, or expressing their emotions in a constructive way (Shultis, 1999), and thus facilitating self-expression has always been a common goal in music therapy in psychiatric settings. MacIntosh (2003) investigated the reasons why music therapy was effective with psychiatric patients who have been sexually abused. She specifically explored the use of song-writing interventions in her study and concluded that such activities increased group cohesiveness as song writing offers an opportunity which is safe, structured and flexible for the client to develop better self-expression abilities. It also enabled the client to receive support and approval by other group members in a safe and confidential environment.

Shultis (1999) suggested that another common problem that is almost always found in acutely psychotic patients is their inability to connect with reality. She suggested that music is a time-based link to reality. While one may physiologically respond to music without conscious listening, it is not possible to respond to music purposefully without listening over time. For patients with psychotic symptoms, listening over time is a means of establishing connection with the external world. Thus in acute psychiatric settings, one of the music therapy goals may simply be to keep the patients engaged in music and rhythmic experiences for as long as possible so as to help the individuals establish contact with reality (Shultis, 1999).

Researchers have investigated the perception that psychiatric patients have towards music therapy (Thaut, 1989; Nall, 2004). Thaut (1989) examined

psychiatric patients" self-perceived changes in the insight of their psychiatric disorders, as well as in their states of relaxation and emotions after receiving music therapy interventions. Results of this study revealed significant improvements in all of the variables, with the biggest improvement found in the patients" self-perceived relaxation states. However, it has to be taken into account that the data of this study was based on self-report scales, which may suggest a lack of objectivity in the findings. In a study examining psychiatric inpatients" ratings on music therapy and other forms of treatment including art therapy and recreation therapy, Heaney (1992) found that music therapy was rated significantly higher than other forms of therapy on the pleasurable/painful scale, although insignificant differences were found in the other scales including the good/bad, important/unimportant, successful/unsuccessful scales. This study nonetheless suggested that psychiatric patients found music therapy an enjoyable form of intervention.

De l"Etoile (2002) examined the effects of music therapy in a short-term facility for patients suffering from chronic psychiatric disorders. Participating patients attended six once-a-week music therapy sessions and were invited to complete a rating scale which involved ratings on the perceived helpfulness of music therapy to various skills. The researcher concluded that music therapy was perceived by the psychiatric patients as useful especially in terms of group cohesion and their attitudes toward help-seeking.

Sullivan (2003) found that through group performances, the cohesiveness between peers increased. The results of his study also suggested a decrease

in impulsivity, improvement in attention span, and an increase in the tolerance of others. Sullivan also suggested that the group-singing activity also provided a sense of hope for the future since this is an activity associated with "normal" lifestyle outside the hospital setting. This in turn would promote expectation in patients, thus preparing them for eventual discharge from the inpatient unit.

Music Therapy and Adolescents with Psychiatric Disorders

Previous research has been done to examine why music is important to the adolescent population (Arnett, 1995; Larson, 1995; North, Hargreaves, & O'Neill, 2000; Tarrant, 2002). Music plays an important role in the adolescent sub-culture. The type of music that adolescents listen to can be raw and emotional, often allowing the individual to express unspoken issues non-verbally. Music therapy work with this population has drawn on the non-verbal aspect of music to facilitate self-expression from troubled adolescents who have flattened affect, low motivation, and who are unable to engage in any form of verbal therapy. Adolescents tend to relate extensively to the music of their subculture, and also identify with various musical genres (Caplan, 1965, cited in Haines, 1989). It has been found that adolescents from 12 years of age through to their high school years embrace music through active engagement, and they are passionate consumers of music (Fine, Mortimer, & Roberts, 1990). Common motivations for adolescent involvement with music include the fulfillment of emotional needs, distractions from boredom, and the relief of tension and stress.

Tervo (2005) tried to reason why music therapy could support adolescent growth and development in a mental health setting with an emphasis on the use of rock music and improvisation. He suggested that rock music can enable adolescents to express and be in contact with a range of feelings such as anger, rage, grief, isolation. Rock music, being a popular musical genre among adolescents (Tervo 1985, cited in Tervo, 2005), also allow adolescents to experience closeness with others of the same age group. He also reasoned that improvisation in music therapy is the equivalent of free association in psychotherapy. The safe and supportive environment in music therapy enables the adolescent to freely experiment with various sounds regardless of the individual"s musical ability. In group improvisation, creating music with other adolescents also allows them to work together as a team, thus fostering social interaction skills. Through improvisation, the adolescent may also become in touch with his/her own inner world and express deeper feelings such as rage and deep sorrow in a secure atmosphere without the fear of being rejected. Given that adolescence is a stage in human development where a lot of psychological and physiological changes take place, resulting in frequent and difficult internal struggles (Blos, 1962, cited in Tervo, 2005), one may reason that music, with such a high affinity in adolescent culture, would be a suitable medium to promote adolescent growth and development (Tervo, 2005).

Wooten (1992) examined the effects of heavy metal music on the affect states in adolescents who were hospitalized in a psychiatric setting. The study

showed that heavy metal music exhibits a profound positive influence on the mood of the teenagers who enjoy listening to this type of music. Furthermore, the researcher concluded that music could be used as a common ground for establishing communication and building up a therapeutic rapport with this client population. It can also be used to help clients explore and understand their emotional issues.

In a study by Henderson (1983), adolescent psychiatric inpatients who were emotionally disturbed took part in a music therapy programme which was aimed to increase cohesion of the group as well as to increase their awareness and their ability to express emotions. The effects of music therapy on their self-esteem were also investigated. By comparing patients in the experimental group and control group, Henderson found significant increases in the frequency of pronouns used to express group feeling. Although the scores were insignificant in terms of group cohesion and self-esteem, the clients in the experimental group improved more than the controls in both measures. Staff members also reported increased signs of confidence in the experimental group during other activities and positive changes in behaviour and attitude were noted. The researcher also found that his clients‟ body language changed over the course of research, from displaying signs of resistance such as folded arms, crossed legs and other restrictive positions, to more relaxed and comfortable gestures.

Rickson and Watkins (2003) carried out a pilot study to examine the effectiveness of music therapy in promoting prosocial behaviours in

adolescent boys who had clinically significant aggressive behaviours. The study was carried out in a residential school setting and all participants had social, emotional, and learning difficulties. They were randomly assigned to two music therapy groups and one wait-list group. The music therapy programme consisted of two sessions per week for a period of 8 weeks and involved both active music-making activities and receptive music-sharing. They found that within session aggression was rarely observed for both music and control groups. The results suggested that music therapy might have the potential to improve interpersonal relationships in less structured settings. There was also a clear positive trend that adolescents in the experimental groups interacted more appropriately with peers over the research period compared to the control group.

In a study that examined the use of music interventions in a school setting to treat adolescent depression (Hendricks, Robinson, Bradley, & Davis, 1999), 19 participants were divided randomly into a music group and a control group that used cognitive-behavioural group activities instead of musical ones over a period of 8 weeks. Using the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) during the first week and last week of treatment, the researchers found that there was a positive significant difference in the post-test scores between the music and the control group. Moreover, in a follow-up 6 months after the termination of treatment, the reduction in depression continued with the music group participants, suggesting that they continued to use musical interventions to aid the reduction of depressive symptoms even after the end of the treatment

programme.

McIntyre (2007) carried out a project to investigate how adolescent males with behaviour disorder and/or emotional disorder could benefit from music therapy in a mental health unit. The participants were referred to the unit because they exhibited behaviour that is inappropriate in the mainstream classroom. All participants in the study were diagnosed with either a behaviour disorder or an emotional disorder or a combination of the two disorders. McIntyre wanted to examine how the students" behaviour, with a particular emphasis on their social interactions and behaviours in the classroom, could change through the use of music therapy. She found that since the beginning of the music therapy programme, significant changes in their behaviours, attitude, academic achievements and social interactions were found in the participants. All of these were shown in the Nordoff-Robbins Scales of Assessment (Nordoff & Robbins, 1980, cited in McIntyre, 2007), as well as the teacher evaluations and the observations made by other therapists.

A study with Korean adolescent girls revealed positive changes in interpersonal relatedness with their peers after receiving music group psychotherapy (Kim, Kverno, Lee, Park, Lee, & Kim, 2006). The authors examined the effects of music group psychotherapy within a group of teenage girls aged 11-12 years in a school setting. The study took a prevention stance rather than a curative stance and music therapy was used as a method to prevent the developmental disorders given the vulnerability of this group of

adolescents. The music intervention was delivered by a music therapist, together with registered psychiatric nurses and consisted of six 90-minute sessions. Musical experiences included music-listening, group singing, song-writing, and moving to music. Paired activities were also used to facilitate the participants exploration of peer relationships. The authors found that by the second session, participants already began to express their own emotions while responses towards each other were non-empathetic and irritable. By the fourth session, participants no longer avoid discussing significant personal issues and were more interested in group activities. All participants noted positive personal changes after receiving six sessions of music group psychotherapy, including improved peer relationships, increased self-confidence, and calmer emotions.

Using receptive music therapy activities, Reed (2002) found music listening to be an effective intervention in improving patient‟s self-esteem as well as the patient‟s respect and tolerance of other group members. She extended her research to active music-making activities by forming a choir made up of her clients. She stated that the goals of her choir were to address clients‟ socialisation skills and their ability to self-express. The choir also helped to provide a sense of accomplishment by mastering singing tasks. Reed suggested that the use of music therapy activities could facilitate psychological rehabilitation of her clients.

Covington (2001) examined the effects of the therapeutic music programme implemented in a psychiatric inpatient setting aimed specifically to use music

as a medium for psychological and emotional healing for adolescents and adults. The programme had six identified purposes including increasing patient"s self-esteem and motivation, enhancing their socialisation and communication skills, facilitating the expression of emotions, enhancing physical and emotional healing, and helping patients to identify and learn coping styles. Each patient had an individualised treatment plan, mutually agreed with his/her treatment team on admission. Before each music group, the group facilitators would assess the patients to determine whether or not the music sessions were appropriate for them. Only those who were mentally stable would be allowed to attend. Music groups had an average of 10 participants and two group facilitators. Thoughts and feelings that were elicited during the music group were briefly discussed with the facilitators but patients were encouraged to process the information in more depth during the psychotherapy group scheduled immediately after the music session. Similar to the studies mentioned above, little description was given on the ways in which the group discussion were facilitated, but researchers concluded that patients generally felt that the music acted as a source of motivation and a way to reduce anxiety and emotional turmoil.

A study by McFerran, Baker, Patton, and Sawyer (2006) examined the use of song-writing on a group of adolescents diagnosed with anorexia nervosa. Through retrospective lyrical analysis of the songs written by the 15 female participants, they concluded that song-writing enabled the clients to disclose information which had never been discussed with other professionals in the multi-disciplinary team, but it was unclear whether this disclosure of

information reflected greater engagement in song-writing than other treatment modalities provided by the facility.

Other research studies which recorded the usefulness of music therapy include Hilliard (2001) examining the effects of music therapy intervention on women suffering from eating disorders; Longhofer and Floersch (1993) who used drum ensemble to assist psychiatric patients to achieve a sense of competency; Gold, Wigram, and Berger (2001) who conducted a pilot study to examine the effects of individual music therapy with children and adolescents with psychiatric disorders on their symptoms and quality of life; and Silverman (2002) who studied the benefits of music therapy in both short and long-term mental health facilities. These studies all pointed towards the idea that music therapy is useful in supporting patients to reach their treatment goals using a variety of music therapy activities. For example, Hilliard (2001) found that by using song-writing, singing, drumming, and lyric analysis, patients seemed motivated as they engaged in their treatment and their views towards the treatment process also became more positive. Gold et al. (2001), on the other hand, found musical improvisation to be the most successful intervention in improving the patients‟ symptoms and competencies. Last but not least, Silverman (2002) found that by implementing a song-writing programme, the patient‟s was able to develop appropriate behaviour and that these behaviours were able to transfer from music therapy groups to other settings on the unit.

Apart from studies that examined the effects of music therapy on psychiatric

patients in general, some authors wrote about the use of specific music activities for patients with certain psychiatric disorders. Wooten (1992) investigated the effects of listening to heavy metal music on affect shifts in adolescent in an inpatient psychiatric facility. She concluded that the use of heavy metal music could be beneficial provided it is a music preference of the patients attending the music sessions. She also reasoned that music could be used to establish a common ground for communication with the patient and could facilitate the sharing of the emotional issues of the patients since it has the power to elicit strong feelings. Essentially music could act as a bridge to reach the patient and as a means for introducing other coping skills to the patients. Robb (1996), on the other hand, discussed techniques in song-writing and it‟s effect on adolescents who have had traumatic experiences. She reasoned that the song-writing process could harness the creative abilities of clients and facilitate their expression of their previous experiences and emotions in a different way. She concluded that song-writing could facilitate self-expression, increase client‟s self-esteem, enhance and reinforce coping strategies learnt, and encourage socialisation and communication.

Facilitation Techniques used in Music Therapy

There are a large number of research and articles on the effectiveness and benefits of music therapy on adolescents with psychiatric disorders. However, most authors focused on describing the type of music therapy activities used in their studies and the changes observed in their clients. Among the existing literature, few described *how* the music therapy activities were delivered –that

is, the therapeutic techniques, not necessarily exclusive to music therapy alone, used by the therapist to deliver the activities.

It is crucial to have a clear distinction between music therapy “procedures” and music therapy “tecniques”. Bruscia (1987) gave a very clear definition of the two terms in his book. He stated that a procedure is “a strategy or method used by the therapist to engage the client in a specific aspect of the therapeutic process, or to accomplish a specific methodological objective. The method or strategy may consist of a series of operations or interactions, and may be accomplished through the useof various techniques” (p. 16). Music therapy procedures included the range of musical activity used in a music therapy session, such as improvisations, song-writing, and lyric substitution. Music therapy techniques, on the other hand, are described by Bruscia as “an operation or interaction initiated by the therapist to elicit an immediate response from the client, or to shape his/her immediate experience… it is a single action or interaction that takes a relatively brief period, whereas a procedure is a set of operations that may take part of a session or even longer… A technique may involve action or interaction in musical, nonmusical, verbal, or non-verbal modalities” (p. 18). Such techniques can be grouped under 9 headings including techniques of empathy, elicitation techniques, redirection techniques, referential techniques and discussion techniques.

Maves and Schultz (1985) suggested that therapists who run groups in short-term settings should use therapeutic techniques that initiate, facilitate, and

encourage communication as these will enable patients to feel supported, reinforced and validated in their behaviour. Few studies have shown that music therapists in short-term settings utilised therapeutic skills that include the effective uses of questioning responses and advice giving. It is also found that non-verbal behaviour such as appropriate eye contact, postures, gestures and facial expressions, are used as part of a therapeutic regime (Hanser, 1984; Wheeler, 1983; Wolfe, O"Connell, & Epps, 1998). Wolfe (2000) suggested that effective group facilitators, regardless of profession and discipline, tend to employ brief, simple and clear supportive and reinforcing statements which are directed towards behaviours observed in groups.

In her article on practical techniques used in music therapy, Gardstrom (2001) suggested the therapist"s use of verbal processing, or asking questions specifically, is a "complementary skill" in music improvisation. She described such "probing" as helpful in the acquisition of information about other individual"s experience. Question-asking is identified as one of the ten verbal response skills in the human relations counseling model which stresses the importance of the therapist or counselor"s communication skills in making connections and in maintaining the helping relationships that ultimately would lead to treatment goals being met. Gardstrom suggested that probing does not always need to be used as a question, but can also be used to help clients to organize information in order to provide insights about his experiences and beliefs. Borczon (1997) also suggested the use of lead-in phrases to allow music therapist time to think and respond appropriately at times in which the client seems confused about his feelings. He also recommended the use of

open-ended questions rather than close-ended ones as they have a higher chance of engaging clients in discussions.

Nolan (2005) supported Gardstrom"s emphasis on the purpose of verbal processing in music therapy and stated that it can help to increase client awareness to both internal feelings and thoughts, and to external events and relationships. By speaking out their responses to music therapy, clients can also become more cognitively aware of their own emotional experiences while in another person"s company. He also agreed that therapist may use probing as statements rather than questions to model and invite client to give verbal responses.

Loewy (2000) explored the purpose of using different types of questioning in music therapy and agreed with Borczon"s recommendation that open-ended questions ensure free-flowing discussion. She also explored other types of questioning and suggested that the use of referential questions that arise from the cues presented by the client could be very useful in music therapy. These types of questions help the client in his/her organization of information and can lead him/her to express certain feelings or beliefs that may not be revealed otherwise. The specific topic can then be explored based on that point of reference. At times when direct questioning or probing is inappropriate, for example during early sessions when a strong therapeutic rapport is still lacking, the use of a referential question gives the music therapist an opportunity to gain information indirectly. On the other hand, Loewy suggested that qualifying questions help the therapist to identify the

feelings that the clients are experiencing in the moment. She suggested that this type of question should be used in an open-ended format to avoid one-word or two-word answers. This type of question differs from referential questions in that they help the therapist to gain accurate knowledge about the feeling the client is experiencing in that particular moment.

Silence is one of the most important facilitation techniques in music therapy (Loewy, 2000). She proposed that “to break the moment of silence too soon may cause the client or therapist to avoid an important process that had just occurred in the music” (p. 55). She described the period of silence as a time for both the client and therapist to “digest” the musical experiences. It is during this time the absorption and incorporation of the music takes place. Borczon (2004) suggested that the client should be responsible to fill in the silence during discussions. It is only when the silence goes too long the therapist should interfere with an open-ended question. Gardstrom (2001) pointed out that one of the most common challenges music therapy students often have to face is to develop effective verbal processing skills, especially when the musical experience is followed by a period of silence. She suggested that students may often experience temporary anxiety as they may feel fearful and intimidated by silence. Amir (1999) suggested that silence is a transition from music to words and could be seen as a type of non-verbal communication. This transition enabled a natural shift of mental states from musical into verbal communication. It also allowed time for client to give any form of expression in their own time. Amir emphasized that even though the therapist may appear not to be doing anything noticeable during this gap,

simply being in the therapist role is very important. When clients take the initiative to speak during silence, they are naturally being put in an active role rather than as the passive respondent to questions asked by the therapist. Langs (1973 – 4, cited in Amir, 1999) suggested that although most of the techniques used in therapy are verbal interventions such as questions and clarifications, interpretations, confrontations and supportive interventions, he put especially strong emphasis on the importance of silence as a constructive non-verbal communication (Langs 1973-4, in Amir 1999).

Wolfe, Audree, O"Connell, and Epps (1998) carried out naturalistic research to systematically record a music therapist"s verbalizations in a series of group sessions. The verbalizations were organized into six categories and results showed that an average of 28% of the therapist"s verbal comments across the six group sessions took the form of questions in attempts to elicit responses from group members. The next greatest percentage of verbalizations included "reinforcing statements or remarks", followed by "Mm, Mm" responses which is often combined with the use of non-verbal gestures such as nodding, to indicate that the therapist is listening, These two categories support verbal interaction and account for almost 27% of therapist verbalizations when added together. Other verbalizations included the use of "content", which is when the therapist tries to clarify or expand what client has said; "explanations", which includes instructions to music activity; "self-disclosure"; and "affective responses", which is when therapists attempts to identify client feelings.

In a similar study to Wolfe et al. (1998), Darrow, Johnson, Ghetti, and Achey (2001) explored a music therapy students" behaviours in practicum. Similar to the study by Wolfe et al., the greatest percentage of time was spent using verbal behaviours (27%) which included asking questions, giving directions, feedback and explanations. This is followed by music behaviours (25%) such as singing, playing or listening to client play and sing. Both studies seem to support the importance of the use verbalizations in facilitating group music therapy sessions.

A pragmatic study by Robb (1996) examined how song-writing could be beneficial to adolescents with traumatic experiences, the researcher provided a description of different song-writing techniques that could be used by a music therapist, such as filling in the blank techniques, changing words to familiar songs, and parodying familiar songs, as well as information on how these techniques could be introduced in music therapy sessions –from designing the script to discussing the end-product with the patients. Robb emphasised the importance of not leading the patient while facilitating the song-writing process. She suggested the use of broad statements to help the patient to brainstorm ideas when he/she requires assistance, and that after the song is completed, the music therapist should help the patient or the group to identify, express, and explore their feelings. It is important for the therapist to take on the role of an active and supportive listener, and not to rush the patient into sharing his thoughts with others.

Methodology

This research study was carried out in an acute psychiatric inpatient unit for adolescents in New Zealand.

This was an action research project involving the collection of qualitative and quantitative data. Action research has a fluid design which enables changes to take place over the period of research. This approach involves a cyclical process of investigation and analysis. Through planning, action, evaluation, and reflection, I aimed to modify my own clinical practice after each cycle in which the stages are repeated and new issues that emerged from the previous cycle addressed. According to Carr and Kemmis (1986), the purposes of action research could be divided into two categories: practical or emancipatory. The current study belong to the former which is a process in which the researcher identifies a practical problem he/she wishes to address and then works to identify action strategies for improvement in a systematic manner. The aim of this study is not to test empirical generalizations but to help the clinician explore ways to cause change.

I chose to use the action research model because it could be incorporated into my normal clinical practice with minimal changes. This is particularly important as I am the researcher as well as the clinician. This research method also increases the potential to maximize conscious learning through the research process. Kolb (1984) referred the spiral process in action research as a learning cycle.

Action research is a flexible and dynamic process. It is especially suitable for the current placement situation as the facility had a high turnover rate of patients and it was not possible to foresee the nature of future clients. It allowed the student to determine how issues could be dealt with as they arose during the research process. Potter (2007) suggested that action research was able to constantly inform and improve the music therapy student"s reflective practice.

Action research is situation-specific and thus the main purpose of this study was not to obtain findings that could be generalized to other settings, but to aid the music therapy student gain skills and knowledge in her work with this particular client population. Nonetheless, the findings of this study may benefit other music therapists or music therapy students working with adolescents in mental health settings by providing information about different facilitation techniques used and the clients" responses towards them.

Methods

Ethical approval was obtained from the Health and Disability Ethics Committee (Central Regional) with the approval number CEN/08/18/EXP.

The research took place over a period of 12 weeks and is divided into six fortnightly cycles. Each cycle consisted of six group music therapy sessions. The second session in each cycle was the research session, and research

note was written followed by a journal entry. The research notes focused on the research session. They mainly consisted of the group"s responses and behaviours in response to my actions based on the observations I made while facilitating the music therapy group. The research journal, on the other hand, consisted of my own reflections and feelings at the end of a session and had a more personal-focus. Moreover, the research session in every odd-numbered cycle was recorded using a video camera and the video clip was later analysed over the remaining period of each cycle to provide objective data.

Although not formally part of the research procedure, I had weekly supervision with my clinical liaison as an essential part of the music therapy placement. These supervision sessions dealt with the clinical issues that arose during the course of this research, including understanding and tackling my own emotional responses as a group facilitator.

Methods of Analysis

Journal

The primary data source was my research journal. This provided subjective data for the research in which the feelings and responses I had were noted. I reflected on incidents that drew my attention during the sessions. The entries also included questions that came up during the research period. After each music group session, I had a short time for an informal debriefing with staff who were present in the group. Their observations and interpretations were

noted and with their permission, included in the student‟s research journal.

Journal entries also enabled me to reflect on my intervention in relation to the plan in every cycle. It also aided the planning for the next cycle.

Analysis procedure:

1. Journal entry was read through once
2. Important statements or questions were highlighted
3. The points were then grouped into themes
4. Journal entry was read through once again to ensure the analysis was correct and all important information was included.

Research notes

Research notes were written as soon as possible after sessions since immediacy often helps preserve accuracy. These notes focused on clients‟ responses in music groups. The purpose of making such notes was to aid myself in forming associations between my own actions and my clients‟ responses as a result of my actions. This would allow me to modify my own clinical practice in future action research cycles. It is important to note that group members were not identified as the focus of these notes were the clients‟ responses to the music therapy student‟s interventions.

There were occasions when the group was engaged in deeper and meaningful discussions that were relevant to this study but because my clients were not the participants in this project, these discussions were only summarized in the research notes.

Analysis procedure:

1. Research note was read through once
2. Important instances or responses that stood out were highlighted
3. The points were then grouped into themes
4. Research note was re-read again to ensure all important information was included.

Video-recordings

Video-recordings were made in every odd-numbered cycle with the consent of group members and the recording only took place when there were no minor present in the group. Group members were informed of the video-recording during morning meeting and verbal consent was sought. Only when all group members agreed on the use of video-camera would the recording take place. The group was also told that they could request the video-camera to be turned off at any point during the session without giving a reason. These recordings were invaluable as they provided data with a high level of objectivity. The video recordings were then analysed and organised into different themes by myself. Both my verbal and non-verbal responses and techniques used in the session were noted and categorised accordingly.

Analysis procedure:

1. Each video was watched several times.
2. First time was to allow me to get an overview impression of the session and to note down any particular instances that drew my

attention.

3. A 10-minute extract was then selected which included instances that I perceived as particularly difficult to manage or handle.
4. I then watched the chosen extract minute by minute, transcribing all verbal and non-verbal interventions observed and the corresponding client responses.
5. The extract was re-watched again to ensure all information was included and correct

All the data sources enabled me to evaluate my own clinical practice and the facilitation techniques used in with my clients in this mental health facility. At the end of each cycle, data from my research journal, research notes, and the video-recording was analysed and themes drawn out. For each data, I rated each theme according to the frequency they were mentioned in the data source either directly or indirectly. The themes were then listed out and compared across the three sources of data in order for the student to work out common and unique themes that caught my attention. The plan for the next cycle would then be decided based on the themes obtained. New ideas appeared constantly over the course of research, but in order to keep my work focused, no more than three themes were addressed in any one cycle.

The purpose of having three data sources (research journal, research notes, video-recording) was to allow the triangulation of data sources. According to Altrichter, Posch, and Somekh (1996), triangulation in action research can enhance the credibility and validity of the results by providing “a more detailed

and balanced picture of the situation." (p. 117). Triangulation increases the likelihood that findings are not idiosyncratic or unreliable.

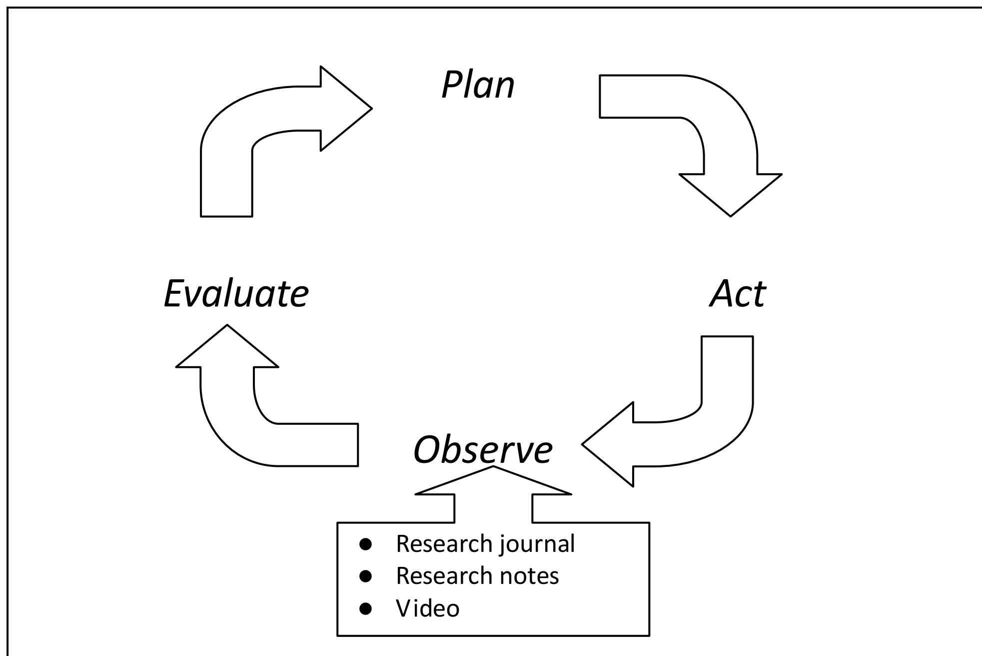
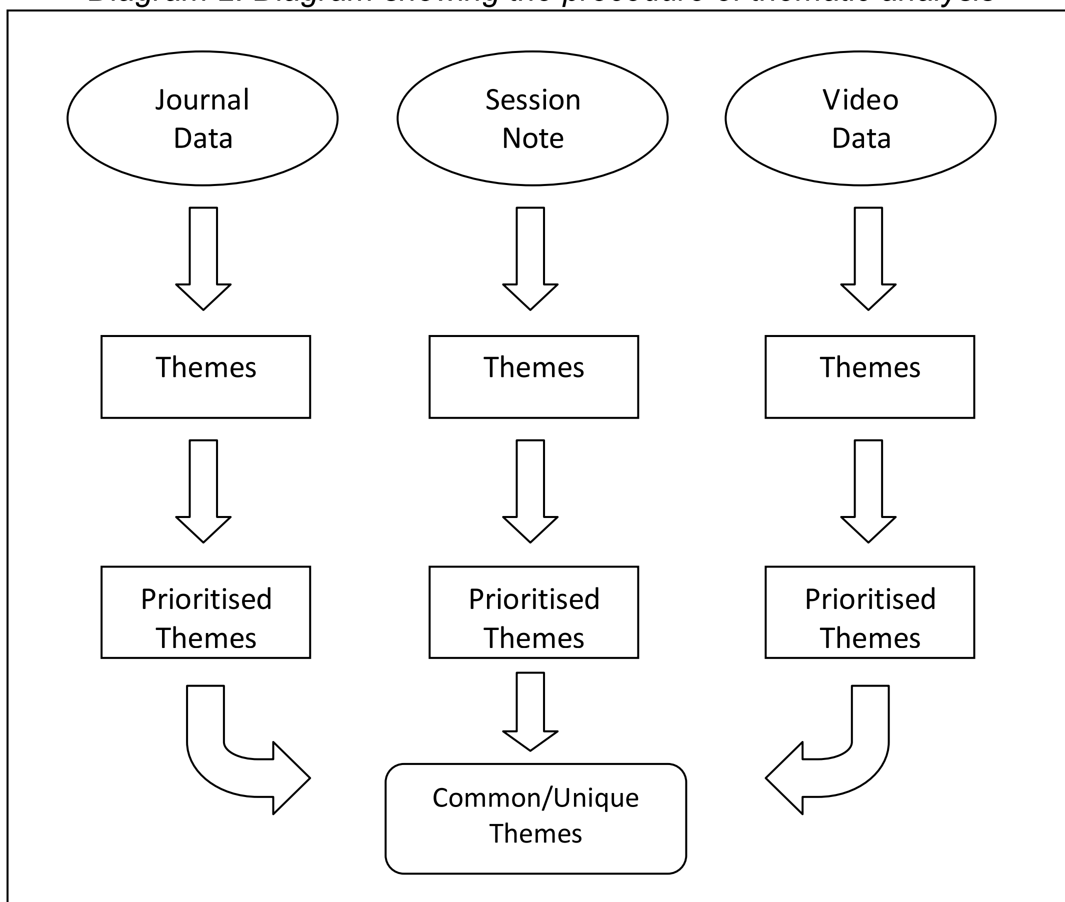


Diagram 1: Components of an action research cycle

Diagram 2: Diagram showing the procedure of thematic analysis



Results

Preliminary cycle:

Summary of existing journal entries:

A journal has been kept since the start of my placement at the adolescent facility. I have also noted inconsistencies in my levels of confidence and nervousness throughout the past few months, which tend to fluctuate from session to session. I wonder if there is any relationship between how I was feeling and how my clients have behaved in that session. I realized I have been struggling to keep my focus on my own feelings and actions rather than my clients‟.

The following journal comments focused on how I felt during earlier sessions. I seemed to worry a lot about my clients‟ reactions and responses, which in turn, would contribute to my worries and nervousness.

> *"I felt a bit anxious today on group in case they (my clients) chose not to write anything on the paper as I instructed them to? What if they refuse to share their thoughts and feelings?"* [JP-1]
>
> *"I am really relieved when one group member requested to share his favourite song with the group."* [JP-2]
>
> *Taken from journal entry 7th May, 2008.*

"I panicked at the start of today"s session when I found out there will only be one client in my group." [JP-3]

Taken from journal entry 13th June, 2008.

"I really feel an increase in my self-confidence in facilitating group activities today as they were all so responsive today!" [JP-4]

Taken from journal entry 17th June, 2008.

"I am feeling very nervous going into work today after my holiday. Will there be a lot of new faces in my group? What is a good way of breaking the ice?" [JP-5]

Taken from journal entry 22nd July, 2008.

Cycle 1:

Plan:

Examine recorded session and earlier journal entries to determine the presence of any pattern of facilitation techniques used.

Increase awareness of my own emotions when facilitating in a group.

Research notes:

This was the first session videoed for analysis. All group members, both staff

and clients had been advised about the video-recording prior to the beginning of session and consent was sought. The presence of the video camera did not seem to affect the way the group behaved. Clients were mostly engaged in musical activities throughout session despite the low energy levels in group. There was one incident where a client volunteered to start an activity. At other times the group needed verbal prompts and clear directions before they would take part. Only few group discussions took place during and in between activities. They appeared reluctant to give verbal responses. *[O1-1]*

Video-recording:

When viewing the video, I noted that I looked awkward at the very start of session as I sat down. I only gained control over the group when I made a clear announcement of the start of session, which group members seemed to have responded to. I took a very laid back approach most of the time when sitting down, leaning on the side of couch, which might have affected the degree to which other group members contributed in this session. I also initiated most, if not all, discussions, often asking direct questions which may have reduced the opportunities for group discussion as they only require a "yes" or "no" answer. *[O1-2]*

Journal reflections:

I felt anxious at the beginning as I did not know whether the presence of a video-camera would influence my clients. I realized I did not handle silence

very well, often intervening by directly asking for responses from group members. Did I ask too many direct questions?

> *"There were occasions when I would throw a question at the group and would not get a response. I felt that there was an urge for me to pick out clients specifically in order to get an answer from them. I wonder if that was the right thing to do though… Maybe I should have waited a bit longer and see if someone will take the initiative to reply?"* [J1-1]

I wonder whether the instructions I gave prior to the start of an activity were clear enough. There seem to be some confusion among group members. Maybe shorter, clearer instructions are necessary to minimize such confusions. Also, I found myself becoming increasingly nervous whenever my clients looked confused during an activity. This, in turn, seemed to have led to a further decrease in the clarity in my instructions. [J1-2]

Watching the video has made me realized how little I understand myself and my own actions.

> *"What was I trying to do when I sat down on a seat furthest away from the kids before the start of session? Why was I leaning away from the kids? Why was I looking mostly at the new member?"* [J1-3]
>
> *Taken from journal entry 30th July, 2008.*

Cycle 2:

Plan:

To adopt a more enthusiastic and active approach when sitting with the group (rather than just leaning on the arm of chair) during group activities

Increase my own awareness of my anxiety being a group facilitator and the reasons underlying it.

Allow longer periods of silence/pauses during discussions so that clients can have more time to respond.

Research notes:

Significantly more contribution from the group today when prompted, even from clients who do not usually contribute. The whole song was written by the group except for one line which I came up with as a request from a client for me to contribute to the song as well. I was still the person who initiated most of the discussions, but unlike previous interactions, the group was more responsive verbally. There was significantly more verbal interaction within the group during the song-writing process, more meaningful discussions about the original lyrics as well as the lyrics we made up along the way. When a client came up with the phrase "You can go far in life", another client suggested to use "You can succeed in life" and later on modified to "You *will* succeed in life", showing his determination and his desire to succeed in life.

The group had a discussion around this phrase and they can up with various ideas about what it means to succeed. The line “We are all the same” led to another discussion about differences and similarities between individuals, and most clients shared their ideas with the group. *[O2-1]*

Song-writing seemed to be an activity that the group enjoyed doing based on their level of participation today. The group also appeared to be more enthusiastic, and showed more interests in this activity, with some members adjusting their sitting position or moving to different spots in the circle in order to see the lyrics on the white board. *[O2-2]*

Journal reflection:

This journal entry reflected my increased awareness in my anxiety and postulations of the reasons causing such anxiety.

> *“This was my first attempt at doing song-writing. I was really nervous as I did not know what to expect, and how the group will respond to this kind of activity which required a lot of verbal input. I was surprised by the level of enthusiasm they showed though and their responses clearly helped reduce my anxiety.” [J2-1]*

I also attempted to reduce my nerves by shifting responsibility with the group, putting less focus on myself, which seemed to have worked.

"I made it very clear at the beginning of session that it was my first time song-writing too. I hoped to make the group feel that we were writing this song together as a team rather than me being the leader and expert trying to teach them how to write an song. The whole responsibility seemed to be shared equally among all group members, including myself." [J2-2]

I was more aware of my impact on the group, adopting a more enthusiastic and actively engaging posture throughout group today, which seemed to have encouraged more participation by other group members.

"I sat on the floor today with the rest of the group which made me feel closer to the rest of the group. There were clearly more dyads between myself and other group members. Although I was still the person who initiated most conversations by actively asking direct questions, they seemed more willing to give me a verbal response." [J2-3]

I consciously tried to stop myself from talking or asking questions too soon when there was a period of silence, I wonder whether it will eventually become more natural as I do this more often?

"I really tried hard to leave silent gaps after I asked a question but it made me feel awkward. I felt my impulse of breaking the silence, wanting to speak, and I really had to consciously stop myself." [J2-4]

Taken from journal entry 13th August, 2008.

Cycle 3:

Plan:

Continue to work on leaving silences/pauses

Try to use less direct questioning to encourage more group discussion.

Research notes:

This session involved a lot of input from staff, especially in the second half. Initially, all except one group member responded voluntarily to questions when they were asked as a group rather than as particular members. Some client-initiated interactions were also observed during the first half of session, both between clients and between clients and supporting staff present in group. Most of these interactions were between the only two female clients in the group who only met each other for the very first time today. Their conversation revolved mostly around the stress ball the new female client brought with her into the group. This relationship formed between the two clients clearly helped the new client settle into the unit as she was no longer seen rocking in her seat as she was before group started. The new client seemed to be distracted from her agitation because of their conversation and this helped her settle into the group activity. Although they got distracted from the song-writing activity in their conversation, they were able to be redirected

to the activity when I made eye contact with them. [O3-1]

The group seemed to have become more withdrawn in the second half of session, this was evident in the marked decrease in clients‟ verbal responses. One client turned from voluntarily giving ideas in the first half of session, to needing prompting and direct questioning before he would speak in the second half of session. Longer periods of silence were also noted. The client who had been withdrawn from group discussions from the very beginning of session (see above paragraph) got drawn to the presence of the video-camera during the second half of session. He went to look at the camera and when he returned to the group circle, he stood in front of me so that he could be caught in the video. He was prompted to return to his seat and he remained quiet until he was asked to play his electric guitar for us so that the group could sing the song to finish. He immediately brightened up at this point and played confidently as if it was a performance. He looked very pleased with himself when he was given lots of praise for his ability to play such a complex tune. He approached me at the end of group and said “I think you are the best music teacher I have ever met!” [O3-2]

Video-recording:

The frequency of my eye contact dropped markedly as the session progressed. The white board and the sheet music seem to have become a safe referential point for me to direct my gaze at times when I was feeling anxious. For example, during the 15-minute video extract taken from the

second half of session, there were only 9 instances when I made clear and direct eye contact with other group members, each lasting for no more than a few seconds. The rest of the video revealed that my gaze alternated between the sheet music in front of me and the white board next to me, even at times when I should be looking at the group. I also fidgeted a lot with the marker pen when the group did not give any response. Signs of relieve, such as sighing and smiling were observed whenever a group member responded. I filled the periods of silence with a lot of "hm"s and "em"s today, but only in second half of session. [O3-3]

Journal reflection:

My journal entry after the session focused mainly on my goals set in this cycle. Although I have noted some improvements in the frequency of direct questions, I continued to struggle with silences/pauses in my session today.

> *"I consciously tried not to pick out clients to answer my questions when no one was responding. Although I managed not to do so, I caught myself trying to fill those gaps by making a lot of "hm"s and "em"s instead. Clearly I felt very uncomfortable. During an informal discussion after the session, a support staff told me that she tried to help as she thought I was „dying out there"."* [J3-1]

I wondered about my use of direct questioning as a way to interrupt silences. I noted that I began to use direct questioning more in the second part of

session when the group became more withdrawn and unresponsive. I also tend to ask questions specifically directed at clients whom I believe are likely to respond. This again reflected my anxiety towards pauses.

> *"I felt like I was pushing the group to respond to my questions at times. There seem to be an inverse relationship between my level of anxiety at one particular moment and the time I allow the group to process the question in silence before picking out one person to respond. The more I do this, the less willing they are in responding though…"* [J3-2]

There seemed to be some counter-transference occurring during group today, especially in the second half of group. I wondered whether my marked decrease in eye contact with group is a result of these unconscious psychological processes.

> *"I was avoiding eye contact with the group today towards the end of session as I felt that they were bored and have lost interest in what we were doing. I did not feel comfortable looking at the group so I focused my attention on either the board or the sheet music in front of me most of the time. Doing that has made me feel much safer as I did not have to risk being rejected (what if clients look away when I look at them?)"* [J3-3]
> *Taken from journal entry 27th August, 2008.*

Cycle 4:

Plan:

Maintain appropriate eye contact with clients throughout session

Use other verbal processing skills more often –such as open-ended questions, statements to begin a discussion

Research notes:

A client approached me before group today and requested to write another song during music group. The group was asked at the beginning of session if they have any objections to the idea. They either shrugged or did not respond. I suggested we write lyrics to a song I had in mind, but a female client came up with a different song. She then explained to group members who had not previously heard of the artist who sang the song originally. I invited the group to sing along to the original tune once through first and the female client picked up the tune and sang along. All clients responded positively about the song and agreed to write to it. *[O4-1]*

Each group member took turns to talk about their favourite line of the song and everyone apart from the client who requested to do song-writing contributed. Some promptings were required before he would speak. However he seemed interested in the group discussions when others were talking about their favourite lines as he leaned forward and appeared to be listening the whole time. He became very anxious when it was his turn, this

could be due to his difficulty in speech. His speech was pressured and often fragmented which could have been due to his anxiety or his medication which he has been associating with his difficulty. [O4-2]

After the discussion on the original lyrics has finished, the female client who has been dominating in the discussion announced that she would not speak again for the rest of the session because she believed she has been talking too much. However, she soon turned to me and said “unless you need my help”. She was complimented for offering to help in the song-writing process and she did contribute most of the time. Another female client who has been quiet most of the time during the writing process was keen to sing, requesting if the group could sing after every 2 lines have been written. There was one occasion when she suggested to use “heart and soul” in one of the lines and the dominating female client complimented her for coming up with such “a beautiful metaphor”. The quiet female client looked pleased when her idea was being accepted. [O4-3]

In general, the group seemed more engaged and focused on task today and most clients contributed ideas to the activity. There were clearly some clients who dominated the process while others seemed more withdrawn and left out. The group did not manage to finish the song-writing process today but that does not seem to matter because the session finished on a positive note when the group all agreed to complete the song in the next session and they all took part in singing what we had written before group ended. [O4-4]

Journal reflections:

This journal entry included my thoughts about my actions today in response to the plan set.

> *"My eye contact has definitely helped engage group members today. I was more aware of where I was looking during the session and somehow I find it easier to make eye contact as the clients were more responsive." [J4-1]*

I wondered if there is any relationship between the frequency of making eye contact with clients and the reduction in verbal prompting I used in group today.

> *"I naturally used less verbal prompts today when I wanted clients to respond. Could this have been a result of an increase in my eye contact with them? Eye contact also seemed to help group members engage in the activity." [J4-2]*

I found that the group seemed more enthusiastic today than last time we did song-writing. I thought about the reasons behind this change in attitude.

> *"A client requested to do song-writing today in music, this could have been a reason why they appeared keener and more focused on the task –because they felt like they have a bigger part in it when they*

requested to do a particular activity? Or it could simply because they are generally in a better space today… Maybe I can examine the reasons behind how they behaved by asking them for some feedback at the end of a session?” [J4-3]

I still feel that I have too much verbal input today during group discussions. I wonder if I have over-contributed as a result of my fear of silence?

“I have a tendency to say something or to give some comments whenever someone gave a response… I do this because I feel like I have to as a group facilitator… Maybe this is one reason why the group does not seem to be interacting directly with each other? Maybe I have interrupted the natural flow of the discussion? [J4-4]
Taken from journal entry 10th September, 2008.

Cycle 5:

Plan:

Attempt to engage the more withdrawn clients by using more verbal prompting and redirection as well as other non-verbal prompting such as eye contact and gestures.

Research notes:

Today"s session easily took up the whole hour with very few incidents of members requesting to leave or enquiring about the time during the process. Everyone took part in group discussions, and all their feedbacks towards each other"s music was positive and supportive. All clients took initiative to share their music with others and they all seemed comfortable to do so. One male client was very supportive of the other group members, especially towards the other two male clients who seemed to be struggling to express themselves and give comments using words. He was able to give positive affirmation to those who struggled both verbally and non-verbally via nodding and smiling. *[O5-1]*

One of the two male clients who seemed to be struggling has been suffering pressurized speech, while the other has been experiencing schizophrenic symptoms including auditory phenomena. The client with pressurized speech continued to speak over music and over other people on a few occasions, but he could be redirected somewhat easier today using mostly non-verbal prompting. The schizophrenic client continued to be easily distracted by his internal phenomenon and had a few attempts of running out of group. He was able to return himself to the group each time. All responses this client gave during discussions over the songs played were brief and indifferent, such as "Yup, good music…", and "Good story line (in the song)…" There was always someone (not necessarily the same person) who was keen to share his/her feelings after songs have been played. *[O5-2]*

The song that the group reacted most strongly towards was "The Flying

Dutchman", which was brought to the group by the client with pressured speech. The reactions were all positive, and the group seemed to have really enjoyed it. This was evident from their body movements during the song and also their facial expressions observed. The group seemed especially animated while listening to this piece of music and more eye contact between group members were also noted. A few members were keen to share their comments at the end of the song and the comments were all positive and supportive. Even the female client who had been describing the taste in music that the pressured speech client has as "funny" and "unique" gave very positive comments. She told the client and the group that she would like to be able to sing like the singer of "The Flying Dutchman" in the future. Another female member told the group that the song reminded her of the Disney stories, Sleeping Beauty in particular. There were some meaningful discussions around the song "Think Twice". A client volunteered to give comment as soon as the song finished by enthusiastically raising her hand.

> *Summary of discussion:*
>
> *The client who volunteered to give comment first said that "Think Twice" was a very good song especially for this age group because it was at this age that adolescents wanted to experiment various things in life and this made them very vulnerable to meeting the "wrong crowd" and do "stupid things". She thought that the song made her think about her actions and behaviours. Another client continued to talk about the beat of the song which he really liked as well as the lyrics as it described how people have lost their lives because they did not think*

twice about their actions. The rest of the group, including staff, continued to contribute and disclose what they thought about the song. One group member struggled when it was his turn to contribute his thoughts about the song. His speech was fragmented and he appeared shy and nervous (which was evident from his hand gestures). When the group saw that he was struggling, a few clients supported him by helping him complete the sentence he was saying. The struggling member became more confident and carried on with his other thoughts about having to go through hardships in life, about how "people trying so hard to fit in with others" (which seemed to be a reflection of what he was going through at that moment), and "trying to stay on track". He told the group that the song "tried to encourage people to stick to their own values but at the same time it wanted to remind people of the consequences they need to bear from making the wrong decisions. The discussion continued and lasted for 10 minutes During this time, there were only very few occasions when I needed to prompt clients with the use of questions such as "What do you think?". My contributions were mostly affirming vocalizations such as "Yup" and "Mm, mm", accompanied by occasional nodding and smiling.[O5-3]

In terms of my own behaviour, I seemed to have taken a more relaxed stance. I sat back most of the time and took on the role of a listener. I rarely spoke during group unless it was my turn to comment on the music. I gave verbal and non-verbal affirmation when my clients seemed to be needing encouragement and affirmation. However, my attention seemed to be mostly

drawn towards group members who were already contributing. There were only a few occasions in which I made eye contact with clients who were struggling. [O5-4]

Journal reflection:

My journal entry consisted of two parts –the first part was written immediately after my session, and focused mainly on my feelings towards the session.

> *"I felt really good after today"s session. I thought I did not have to put in too much effort today in terms of verbal prompting as the whole group was quite keen to share their comments and feedback after each song. I felt very supported, not only by the staff present, but also by the clients in that they responded to my verbal and non-verbal prompts very well and there were no incidences of disruptive behaviours. I was able to take a more relaxed approach today as most group members seemed to have little problem initiating and sustaining their own discussions as they arose."* [J5-1]

The second part of my journal included my thoughts as I watched the video recording.

> *"I was so engaged with group members who were contributing that I felt like I have neglected the client who struggled to take part. It seemed like I was too busy focusing on what the group was talking about that I failed to acknowledge and support him as much as I should have done."* [J5-2]

I also managed to have a short informal interview at the end of session with the support staff and she suggested ways in which I could help the client to engage a bit more.

> *"I think the session was good in that they were all eager to share (their music and give comment)… I think it would be helpful if you can remind them, especially with him (that client who struggled to focus) halfway through the session… or whenever possible… just what we were doing and what he needed to do… yeah… just frequent redirecting would be helpful because there are so much going on in his mind and he could easily lose his focus on what he was told to do…"* [J5-3]
>
> *Taken from 24th September, 2008.*

Cycle 6:

Plan:

Give more support and encouragement to clients who have difficulty engaging in activities by using more verbal prompting and other non-verbal prompts such as nodding and smiling and other body language.

Research notes:

Today"s group was difficult to manage despite doing an activity that was requested and seemed to have been enjoyed the last time we did it. Clients appeared reluctant to share their comments and give feedback even after lots

of prompting. When a song was playing, two members were engaged in their own conversation while another member was fiddling with poker cards. Yet another member was listening to her own music on her mp3 player and ignored staff when prompted to turn off her music. Occasionally a group member would volunteer to share his/her feelings about a song with the group but often it was the staff or I who had to initiate conversations. Two male clients dominated most of the session, requesting to share their music one after another. Another male client brought his music to the group but eventually was not able to share it at all. I told the group that every member should be given an opportunity to share their music with others and invited the quiet male client to play his music. He looked very unwilling and instead of sharing his own music, he offered others the opportunity to play more of their music. *[O6-1]*

Journal reflection:

This journal entry mainly focused on my thoughts and feelings towards the session and reflected on how different I felt after today‟s session compared to the session in the previous cycle which involved doing the same activity.

> *"I was surprised by the clients" responses. I thought they would be more enthusiastic since they were the ones who requested to have do this particular activity in today‟s music group. I noticed I presented differently from previous session. Compared to the passive approach I adopted in the previous cycle, where I was able to let clients initiate and facilitate*

group discussions, I had to put in more effort in today"s session, using verbal prompts relatively more frequently. I also noticed a difference in my non-verbal presentation compared to the last cycle. I sat upright, leaning forward to the group when asking them questions. I hoped that by being more "physically" involved in group discussions, the group would be more likely to contribute." [J6-1]

"It seemed that I have become more comfortable sitting with silence over the research period. It did not take as much effort for me to hold myself back from speaking too soon. In the earlier cycles when my group was reluctant to take part in discussions, I was often the one who broke the silence by asking questions of specific clients. However, although today"s group was, again, reluctant to give verbal responses, I felt that I was more able to give my clients time to process their thoughts and let them say what they wanted to share with the group when they were ready without me interrupting too soon." [J6-2]

"I also wonder if there was some transference happening today. The group seemed to be more restless when I used to feel high levels of anxiety due to the low level of participation in earlier cycles. Today, on the other hand, my clients appeared more relaxed and comfortable even though there was not a great deal of contribution going on. I wonder if this change is related to the decrease in my anxiety levels when I facilitate in groups." [J6-3]

Taken from journal entry 15th October, 2008.

Plan for next cycle:

When my clients become engaged in their own conversation, encourage them to open up their conversation to the group so that other group members could take part, making the discussions more inclusive.

Do not use direct questioning all the time to initiate discussions, try to use affective statements instead to encourage client to contribute by setting an example for them.

Summary of Findings

This research project provided me the opportunity to systematically look at my music therapy practice in detail. It enabled me to gain a better understanding of myself and the strengths and weaknesses in my facilitation skills. The recording of sessions and the research journal provided me a clearer picture of areas that needed modification and the progress I have made over the twelve-week period.

One of the main findings was the obvious change in my anxiety levels over time and its potential relationship with the contribution by my clients in group. I have gained awareness of my own emotions during group facilitation and it seemed that my anxieties were one of the biggest barriers to effective group facilitation. I have become more able to sit with silence as my anxiety level decreased over the six cycles. I was also more able to utilize a wider range of prompting techniques when I was less anxious, this applied not only to verbal, but also non-verbal techniques such as nodding and making appropriate eye contact with clients. All these seemed to have contributed to the level of engagement by clients.

I also found that while the use of verbal prompts were very useful in initiating and engaging clients in group discussions, over-using such prompts may disrupt the natural flow of discussions, resulting in the likelihood of client withdrawals. The frequency of verbal prompting seemed to depend not only on the individual client, but also to their mental state at the time the group took

place. There were also occasions when I felt I took on the role of a music teacher rather than the role of a therapist. This made me wonder how this could have an influence on the way I deliver music therapy.

Non-verbal prompting was found to be a useful alternative to verbal prompting. It could help clients to remain engaged in the activity without disrupting the whole group process. I noticed that the approach I take on a particular day depended heavily on the degree of client contribution. When there was a high level of participation in activities and discussions, I was more laid back and relaxed, and this was most evident in my posture. On the other hand, when the group was, in general, very distracted and withdrawn, I had more input both verbally and physically.

Moreover, I discovered that shifting responsibility could be a useful way of engaging clients, especially in groups where there were clients who were in good mental space. Distracting clients who were pre-occupied with their mental disorders also seemed to help them re-engage in activities more easily.

Discussion

This section will be divided into three main sub-sections. Firstly the peculiarities and the nature of the research setting will be discussed in relation to the study. The second part will focus on discussing the development of my clinical skills over the course of the project. And lastly the presence of other important intervening factors that might be present, such as therapist variables will be addressed.

Research setting

The biggest challenges carrying out action research in this acute mental health unit for teenagers relate to the lack of continuity due to the high turn-over rate of patients most of the time, and the unpredictability of when patients would be discharged. The high turn-over rate also meant that group members were continuously changing and as a result, there were always a mixture of new and old members in a group. Unfamiliarity to the group setting and the therapist might have been a confounding variable to the degree a client contributed in a particular music group. An open group with constantly changing group members also meant that it was difficult to monitor the progress as I modified and improved my facilitation skills because clients were likely to respond differently to different facilitation techniques. Moreover, patients in this facility were often in a very unstable mental state when they were newly admitted. Thus over time, their contribution in group may change simply because their psychotic symptoms have been stabilized by medication.

Despite these issues, this research experience has enabled me to look more in-depth at a number of facilitation techniques and to develop them more fully over the research period.

Development of Facilitation Skills

One major personal development for me while doing my placement and carrying out action research this year has been an increased awareness and control of my emotional well-being (see *J2-1)*. I felt that I have achieved an increased awareness of my own anxieties and have managed to gain better control over it as the study developed (*J2-2)*. My feelings of anxiety as a group music therapy facilitator were mentioned in most of the journal entries prior to the beginning of the research process (*JP-1, 3, 5*). This was likely to be a result of unfamiliarity towards the placement setting as well as client group. Some of the entries even consisted of nothing but descriptions of how nervous I felt during music groups. It seemed that it was only after I have gained better awareness and control of my own emotions after the first few cycles that I was able to make more detailed observations of clients" behaviours and responses, and look at my own behaviours in better detail (*J1-3, J2-3, J3-3, J4-1, J4-2)*. For example, I realised that I was unable to make note of my own behaviours in cycle 2 at all without using the video camera and this was evident in the research notes which included only observations of clients" behaviours but little about myself. I also noticed that my own emotions might be linked to how the group behaved in that session (*J2-1, J2-3)*. My groups were generally less settled in the early stages of the

study but as the study developed, there were less incidence of difficult and disruptive behaviour in music groups. This change in behaviour seemed to coincide with the gradual decrease of my own anxieties over time as a group facilitator (*O5-4*).

In line with the articles by Wolfe et al. (1998) and Darrow et al. (2001), verbal prompting seemed to be the most frequently used technique in my groups, especially in the early cycles. While direct questioning dominated in the cycles, Bruscia (1987) suggested that there could be other verbalizations that could be useful to elicit responses in clients during group discussions, and that the use of questioning should be used only sparingly and sensitively because when overused, clients may feel interrogated and intruded upon. The findings of this research seemed to support Bruscia"s suggestion as I found that when such questioning was used in my groups, clients often seemed unwilling to respond and would only respond with short, one-word or two-word answers (*O1-2, J1-1)*. This suggested that when clients were not ready to contribute, the use of direct questioning might inhibit client contribution. I also wondered whether the directive approach I used while facilitating music therapy groups was a result of an ambiguity of my identity at the unit. Often I was treated as a music teacher rather than a music therapist, both by staff and by clients at the unit and this was evident in the interactions between my clients and me (O3-2, O4-3). There were occasions, especially in the early stages of this placement, when I struggled to define my role as a music therapist. The timing of the change in my approach, which went from more directive to more of a relaxed and active-listening approach, also

seemed to coincide with the time my purpose and role at the unit became more firmly established.

Over the six cycles, the amount of verbal responses from clients seemed to have increased gradually. A change in my verbal prompting techniques could be a reason for this increase. Early in the study, I used mostly direct questions whenever there was a period of silence but the frequency of direct questioning seemed to have decreased over time and more affirming vocalizations such as “Mm, mm” were used instead towards the end of the study. It seemed that such vocalisations could serve to provide affirmation to clients and encourage contribution without making one feel interrogated. One alternative technique suggested by Bruscia (1987) was the use of disclosure where the therapist reveals his/her own thoughts to the group as a way to facilitate the therapeutic process or to encourage discussion by setting an example. When I had my first attempt to facilitate song-writing in cycle 2 (J2-2), I informed the group at the very start of the session that that was my first attempt. Disclosing my novelty to this activity could have been one reason that encouraged clients to contribute to the song-writing process. Loewy (2000) also recommended the use of open-ended questions to encourage free-flowing discussion and to avoid one-word or two-word answers. Nonetheless, direct questioning seemed to be useful in redirecting clients when they lost their focus on the task. This is especially the case when a question is directed specifically to the distracted client. It seemed to help the client re-orientate back to the group activity.

Gardstrom (2001) described silence as one of the hardest to handle among newly trained music therapist. Over the entire research period, my biggest struggle was the management of silence in between musical experiences or verbal discussions (*J1-1, J2-4)*. I found myself especially anxious at such times and although the situation seemed to have improved over time, conscious effort was still and might always be required to prevent myself from speaking too soon. It is often noted that when I interrupted the silent period with statements or questions when the group was not ready, clients seemed more reluctant to share their thoughts with the group during discussions. However, when clients were given the opportunity to process the musical experience in their own time, they seemed more able to adopt an active role in the group discussion and their responses were likely to be more spontaneous (*O5-2, J5-1*). For example during music-listening in Cycle 5 in which the group was given some quiet time after each song was played, most clients took on a more active role during the following group discussions and the content of their verbal responses were relatively deeper and more personal than those in previous sessions.

Non-verbal prompts such as eye-contact, nodding, or other body gestures are also found to be very useful facilitation techniques especially when the use of verbal prompts was inappropriate (*O5-2*). When giving verbal responses, it was often observed that the client speaking to the group would look at the facilitator. I interpreted this as a need for reassurance from the group facilitator and by nodding, smiling, or even using a “thumbs-up” gesture, the client seemed to be encouraged to continue sharing with the group. Non-

verbal prompts were also useful in the redirection of clients who had lost their focus when the group was engaged in musical experiences or group discussions (*O3-1*). This allowed the therapist to engage with the distracted client without interrupting the group experience. I also found that I often combined head-nodding with a verbal "Mm, mm" or "Uh-huh" to emphasise my attempt to reinforce and encourage clients while they were giving verbal responses. According to Wolfe et al. (1998), the use of such combination would indicate to the client that the therapist is wanting the client to continue, and that the therapist is listening and understands what is being said. I also found that such verbalizations were used most frequently after I have asked the group or a specific individual a question. Wolfe et al. reasoned that the therapist"s questions were intended to invite and provide opportunities for clients to contribute verbally, thus it would be natural for the therapist to follow-up using such verbal reinforcement in order to encourage the client to continue talking and support what the client has said (Wolfe et al. 1998).

Apart from the facilitation techniques mentioned, another important skill that I have learned from working and carrying out research in an acute mental health facility is the ability to adapt to a continuously-changing group. The ability to predict the unpredictable and the ability to be aware and accommodate the accompanying emotions is crucial when working in acute units. While this study enabled the development of facilitation techniques, I have also gained an understanding of the importance of being a flexible group facilitator.

Therapist Variables

My original objective was to examine how the use of different facilitation techniques could influence the degree of client contribution in group music therapy, and to modify my own clinical practice and therapeutic skills accordingly in order to improve client contribution. However, over the course of study, it became apparent that there is one other set of variables which seemed to affect the relationship between facilitation skills and clients" responses –it is called the therapist factor. According to Beutler, Crago, and Arizmendi (1986), therapist characteristics can be divided into two categories –therapy-specific states and cross-situational traits. Therapy-specific states include those qualities that can be systematically developed through training for the purpose of enhancing therapeutic outcomes. In the present study, a therapy-specific quality may be my ability to modify and improve my clinical practice, or my ability to build therapeutic relationships with clients. On the other hand, cross-situation traits are those qualities that are more enduring and supersede the immediate therapy relationship. Traits in this category are not subject to rapid, volitional change by the therapist. Examples of cross-situational traits include the therapist"s personality and coping patterns, and his/her emotional well-being.

In terms of the importance of the therapist"s emotional well-being, from the early stages of this study, I realized that better emotional control was needed in order to make any improvements on my clinical practice. Notes on my own emotional responses dominated in my early journal entries, and I realized I

was not able to make note of what was being observed in my group sessions. According to Beutler, Machado, and Neufeldt (1994), therapist‟s emotional well-being plays an important part in determining client‟s treatment efficacy. They suggested that levels of personal distress and strength of self-confidence of the therapist served as determinants of his/her emotional well-being and studies of therapist efficacy have shown that these factors ultimately determine a therapist‟s ability to adjust and be flexible in therapeutic situations, this in turn is related to good treatment outcomes. A study concluded that while a therapist with good emotional health facilitates treatment outcome, therapists who lack emotional well-being inhibit client progress (Lambert & Bergin, 1983, as cited in Beutler et al., 1994). Studies that reviewed the effects of therapist‟s mental well-being on therapeutic progress have suggested that when a therapist is experiencing distress or anxiety while conducting therapy, his/her skills tend to become inconsistent and disrupted, which in turn, would result in compromised treatment outcomes. I felt that when I was experiencing high levels of stress and anxiety while conducting music therapy groups, a lot of my behaviours were driven by my emotions and were often inappropriate to the situation, such as avoiding eye contact with clients, asking too many direct questions just to avoid silence, and not giving enough time for clients to process information. It was only after I have made myself aware of my emotions and have gained better control of them that I became more able to look in detail ways in which my clinical techniques could be improved to suit my clients‟ needs.

My emotional well-being also seemed to have affected my ability to build good

therapeutic relationships with my clients. Therapeutic rapport is crucial in determining the level of client contributions. A positive relation between a good alliance and a successful therapy outcome is reasonably well documented across various therapies (Horvath & Luborsky, 1993, as cited in Crowe & Grenyer, 2008).

According to Paterson (1983, as cited in Beutler et al., 1994), there were certain therapist variables that have received strong evidence in their influence on the building of therapeutic rapport. These include the therapist‟s ability to show accurate empathy and genuine concern, the ability to contain, and the ability to show non-intrusive warmth to clients. These variables resembled closely to those laid down by Rogers (1957, as cited in Keijsers, Schaap, & Hoogduin, 2000) as being necessary and sufficient conditions for the achievement of patient change. In order for clients to feel that the therapist is empathetic and caring in a genuine way, the therapist must be able to provide space, thus silence, and to use appropriate verbal and non-verbal facilitation techniques that makes the client feel that they are accepted and not being judged upon. The ability to use these techniques seemed to be influenced by the therapist‟s emotional well-being. In a study which examined the differences between more and less effective psychotherapists, Lafferty, Beutler, and Crago (1989) found that one of the strongest therapist variables that differentiated between the two groups was therapist empathy. It was reported that patients of the less effective therapists felt less understood than those in the other group. One may reason that a compromised ability to empathise with clients was due to the therapist‟s lack of emotional wellness.

There is at least one other group of important factors that would affect the level of client contribution and progress in group music therapy and it is the client variables. Any form of therapy not only involves a therapist but also clients and the therapeutic relationship between the two parties. Thus client characteristics such as the client"s motivation would inevitably play a part in determining the therapeutic progress and the level of client contribution in therapy. To conclude, it seemed that the relationship between the therapist"s facilitation skills and the level of client contribution is one that is not simple, but rather a combined and complex relationship with the effects of other variables involved.

Conclusion

The present action research project has allowed me to monitor and modify my own clinical practice through constant observation and evaluation of the facilitation techniques and the corresponding responses obtained in the sessions.

In this study, I was able to look at some common facilitation techniques, both verbal and non-verbal. Verbal prompts, specifically the use of questions were found to be very useful but when used inappropriately, clients may feel that they were being intruded upon. Inappropriate use of direct questioning may also prevent free-flowing discussions from taking place as clients were likely to respond with short, closed answers. During the course of this study, I also had the opportunity to look into the use of other types of verbal prompting other than direct questioning. Action research is a continuing process and this study only represented a snapshot of the development of my clinical practice, I felt that more time is needed before my ability to use other types of verbal prompting could be developed more fully. Non-verbal prompting has been found to be a very useful alternative in helping clients maintain focus in an activity, especially when the use of verbal prompts would cause disruption to the group process. Another major outcome of this study was my ability in managing silence in music therapy sessions. As suggested, handling silence has been a challenge to newly trained therapists and could cause temporary anxiety. This study has helped me gain awareness of my responses towards silence and has allowed me to develop control over my own anxieties in the

presence of silence. I felt that while silence is a challenge to most newly trained music therapist, they should work on finding out the right balance of silent and non-silent moments because ultimately, it was the "timing" of when to remain silent and when to break it that is the most important.

Apart from my facilitation techniques and skills, there seemed to be other factors that influence the level of client contribution. These factors should not be overlooked. My emotional well-being and coping patterns, and my ability to form good therapeutic relationships all seemed to play a part in determining how much a client is going to contribute in my music therapy sessions. Regular supervision with the psychologist at the facility meant that issues about my own emotional well-being and uncertainties about client presentation were discussed and addressed, and a better understanding of clients, in turn, would enable the building of positive therapeutic rapport. It seemed that although knowledge of effective facilitation techniques is important, if the therapist is unable to understand her own emotional weakness and develop an ability to contain and show accurate empathy and non-intrusive warmth, the therapeutic outcome of my music therapy interventions would be compromised.

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Appendix One

Cycle 5 video-transcription

Point in session	***MT verbal***	***MT non-verbal***	***Client verbal***	***Client non-verbal***	***Remarks***
18:10					Group listening to N's music (Towards the end)
18:17				N raised his head to look at how other people are responding, then turned over to turn off stereo	
18:19		Raised her head, signaling she wants to share her comments first			N's choice of music has completely took me by surprise, and I really wanted to share it with the group
18:29	"Can I say something?"	Look at N with a grin	N: "Ok…"	Looked at MTS briefly, then lowered his head to look down, seemed quite nervous about what MTS is about to say	Maybe he is showing what everyone is feeling –music can be very personal and sharing it makes the clients all feel exposed

					and vulnerable to being judged. I could have been more supportive by giving them more positive praise before group ends and should have encouraged them to share more often…
18:31	"I am surprised! (pause) Eh? Coz I was thinking, 'oh, E eh? His music must be hard out, you know, just hard out rapping and all that?' But then (the music you just played to us was very calming! (pause to think)"	("His music must be hard out… raping") Hands lifted up and big movements both hands and body, suggesting how "hard out" MTS thought the music would be… Looked at N most of the time	N: (MTS: "… all that?") Yup N: (MTS: "… very calming!") Mean!	When MTS paused for the first time, he turned to look at her. When said "Yup", he nodded strongly and grinned while still looking at MTS When MTS said "… very calming!" he nodded even harder and turned to look at group, looking pleased with a bigger grin When others nodded in agreement, N nodded even	

				harder still	
18:47	"Yeah…"		N: hahahaha… (childlike, gentle)		
18:49	"I guess I have learned not to, you know, just assume other's tastes in music by the way they present themselves!"	Grinned the whole time Using hand movements while talking, quite animated			
18:57	"Good stuff!"		N: hahahaha… (echoing MTS) Never judge people until you know them!)		
19:02	"Yeah"		D: Never judge a book by its cover! N: (to D) Yeah, hard!		
19:07	"Yeah, even though I am not someone who likes reading a lot…" (Chuckles)	Nodded with animated face	Few group members laughed		
19:10			D: (to N) Can I go next (give comments)? N: Yeah, hard man	N nodded	
19:12	Occasional "Mm"s and "Ah"s	(when D said "life is about this song")	D: Ok, I like the beat and base…	N: nodded while looking at D every	

		MTS nodded strongly	N: Hard D: I am really into beat… and em… life is about this song… N: Hard out man D: Yeah, makes you want to listen to it…	time he verbally responded to D's comments. Otherwise head looked down on paper, hands fidgeting with pen	
19:25	"Yeah"		N: Mm, hard out man		
19:26			D: … because you know what the song means. It's very talented how some people can rap about their lives. Some people rap about love, girls, money, weed, alcohol… but you don't get many who take their actual life experiences and put them into rap.		
19:43	"Mm"		D: I think that's real cool… Has a lot of meaning…		
19:45	"It echoes eh…		D: (was still giving		

	with your own experiences in life?”		comments but interrupted by MTS) Em… yeah… I think he’s really talented. Coz anyone could rap about alcohol, girls, money, weed… but this (rapping about their own lives) is a talent, not anyone has it!		
20:02	“Mm, yeah…”	Nodding, then turned to look at next client (K) Nodded to signal K could start		K looked at me as if asking (non-verbally) if it’s her turn now	
20:05			K: Ya, I like the beat as well, it’s good, makes me want to slow dance to it…	As soon as K mentioned slow dancing, N started moving his body side to side while singing part of the song.	
20:18		Laid back posture, head resting on left hand while listening to comments	K: … Lyrics is real good, the song has a meaning… like talking about stuff I have been		Maybe I should have asked K to elaborate more on how the song relate to what she has

			through… I just really like it…		been through when she said it talked about things she has gone through
20:30	“Cool!”	Nodded at K, smiling		K turned to look at next group member (support staff)	
20:32			Staff: I really em… what I heard was the guitar intro and the guitar outro… Right at the beginning it’s got this really neat guitar picking or whatever and then it’s underlying in the whole song, like you can hear it throughout the song in the bass		
20:55	“Nice.” “J?”	Turned to look at J			
20:57	“Anything you wanna share?”				Maybe J would have felt more supported and encouraged to share if I took a more active

					approach in prompting?
21:01			J: It's a nice guitar… Lyrics good, good bass… (pause) instruments all got the same beat… (MTS: Yup) same time…		
21:31	"Cool… so you think the music is good."			N nodded strongly as if trying to support J	
21:35	"F? You want to say something?"				Maybe it will be useful to leave a gap here for J to see if he has got anything else he wanted to add rather than concluding on his comments and moving on to the next person so soon.
21:36-21:56				F: This song has a lot of meaning, like talk about like…lives on the street… em…	F appeared anxious when talking and he sounded like he was not very

				about like how it goes, and kind of like… talk about what it's like… talk about like… em… like ups and downs in life… I think?	certain whether or not his comments are "right" or not… More support may be useful?
21:56	(Interrupting again) "Yup, so again it echoes eh?"				
22:01				F: … But it… it… it… it's… I felt like… it's pretty kind of like… relaxing… Even though I am not into it, but I still feel kind of like… calm… coz it wasn't high (hard?) out rapping, it's kind of slow…?	F struggled with speaking clearly due to pressured speech
22:16	"Yup, like it's calm, cool, contained rap! Yeah!"	Hand movements to express "calm"			
22:21	"Good stuff!"	Turned to look at next client (R)			
22:22		Continued to look at client		R: I like… em… the intro and outro as	

				well…	
22:27	"Yup"				
22:28-22:35				During the song, I like… I thought it was a mean freestyle, just rapping about daily occurrences… Yeah, I thought it was mean!	
22:36	"So it's not about a made-up story or you know… anything dramatic eh? It's just about what happens. Cool!"	Then turned to look at N who has chosen to share that song with the group			Again, maybe I could have given a bit more time to clients before I started to speak again to give them more time to process?
22:43			N: Me? Ok… um… well… (pause) you know how it was sort of a sad song but then it kind of turned into an "up-down" song?	N moved his hands the whole time like a rapper	
	"Yup"				I responded because I thought he was wanting to know whether I

					understand what he meant by an "up-down" song
			N: Like it goes up and down and when it ends... like when it gets to the end, you think it was really sad but then it started to speed up again with raps and all that... and then it slows down...?	N looked at group when talking, using hand movements to aid his expression and explanation.	
23:08			D and N chuckled	Some eye contact observed between N and D who were sitting next to each other	
23:10	"Do you know who sang the song?"				
23:12			N: I don't know... coz... like... D: (talked about who she thought might be the singer) (Discussion continued between		

			N and D regarding who might be the singer.)		
23:22				J stood up and run towards door suddenly	
23:26		Looked at J as he ran out the door, then redirect my gaze to N			I cannot believe I just let him ran out of the room… I did not even make any attempt to ask him to stay with us…?
23:27			N: It's cool with all the music supporting the voice too eh?		
23:29	"Yup, yup, good stuff!"	Readjusting my sitting posture			
23:31			D: It's not computerized…		
23:32	"That's right eh? The…				
			D: … It's "*natural*"		
23:35	"(Laughs) Yeah… I think technology has a lot to do with the music created these days…"				
23:47	"Who wants to go	Head resting on			

	next?"	right hand, sitting casually, turning from side to side to look at group			
23:51			N: I'll play another one…	N turn to stereo again, getting ready for another song F raised hand hesitantly but quickly put it down when N said he would play another one	Maybe I should have praised N for offering to share another bit of music, AND THEN ask him if he could let others have a go first.
23:56	"Well, how about letting F have a go first?	Signaling N that F wants to share by looking at N and using finger to point at F			
23:58			N: Yup, F can have a go!		
23:59			Group started giggling (because F has a "special" taste in music	F getting up from his seat, looking a bit embarrassed and shy	
24:01			K: (to F) Is it the French horn piece? (Others continue to giggle)		

Appendix Two

Example of Thematic Analysis

Research notes:

A client approached me before group today and requested to write another song during music group. The group was asked at the beginning of session if they have any objections to the idea. They either shrugged or did not respond. I suggested we write lyrics to a song I had in mind, but a female client came up with a different song. She then explained to group members who had not previously heard of the artist who sang the song originally. I invited the group to sing along to the original tune once through first and the female client picked up the tune and sang along. All clients responded positively about the song and agreed to write to it.

Each group member took turns to talk about their favourite line of the song and everyone apart from the client who requested to do song-writing contributed. (*How could I encourage that client to join into our discussion?)* Some promptings were required before he would speak. However he seemed interested in the group discussions when others were talking about their favourite lines as he leaned forward and appeared to be listening the whole time. He became very anxious when it was his turn *(How could I make him feel more contained and supported?)*, this could be due to his difficulty in speech. His speech was pressured and often fragmented which could have been due to his anxiety or his medication which he has been associating with his difficulty.

After the discussion on the original lyrics has finished, the female client who has been dominating in the discussion *(What could I have done to invite others to join rather than letting one person dominate?)* announced that she would not speak again for the rest of the session because she believed she has been talking too much (This is a very good opportunity for giving positive reinforcement to this girl to have such an insight, but I failed to pick this up.). However, she soon turned to me and said "unless you need my help". She was complimented for offering to help in the song-writing process and she did contribute most of the time *(I did not want to interrupt when she was coming up with ideas, but how could I ask her to give others a chance to contribute? How could I reinforce her insight while encouraging the less engaged to take part at the same time? Maybe I could have said "I really like the things you have been saying, it"s a great idea for you to offer giving others more space to contribute in our discussion too!")*. Another female client who has been quiet most of the time during the writing process was keen to sing, requesting if the group could sing after every 2 lines have been written. There was one occasion when she suggested to use "heart and soul" in one of the lines and the dominating female client complimented her for coming up with such "a beautiful metaphor". The quiet female client looked pleased when her idea was being accepted.

In general, the group seemed more engaged and focused on task today and

most clients contributed ideas to the activity. There were clearly some clients who dominated in the process while others seemed more withdrawn and left out *(This comment felt important. I wonder why I did not reflect on this in my journal. It was me who felt that these clients were being left out but maybe they did not mind not actively taking part? Maybe they still felt that they are part of the process by just being with the group?)*. The group did not manage to finish the song-writing process today but that does not seem to matter because the session finished on a positive note when the group all agreed to complete the song in the next session and they all took part in singing what we have written before group ended.

Themes from session notes:

- Use of positive reinforcement
- Provide more non-verbal support to clients who appear anxious (e.g. nodding, smiling)
- Give more attention and support to clients who are quiet and withdrawn

Journal reflections:

This journal entry included my thoughts about my actions today in response to the plan set.

> *"Eye contact has definitely helped engage group members today. I was more aware of where I was looking during the session and somehow I find it easier to make eye contact as the clients are more responsive."(Eye contact does not seem to be a major issue anymore.)*

I wondered if there is any relationship between the frequency of making eye contact with clients and the reduction in verbal prompting I used in group today.

> *"I naturally used less verbal prompts today when I wanted clients to respond. Could this have been a result of an increase in my eye contact with them? Eye contact also seemed to help group members engage in the activity."* [J4-2]

I found that the group seemed more enthusiastic today than last time we did song-writing. I thought about the reasons behind this change in attitude.

> *"A client requested to do song-writing today in music, this could have been a reason why they appeared keener and more focused on the task –because they felt like they have a bigger part in it when they requested to do a particular activity? (Shifting responsibility may be a useful technique to encourage clients to contribute.) Or it could simply because they are generally in a better space today… Maybe I can examine the reasons behind how they behaved by asking them for some feedback at the end of a session? (Allow time for informal debriefing or discussion about the overall session before the end of group)"*

I still feel that I have too much verbal input today during group discussions. I wonder if I have over-contributed as a result of my fear of silence?

> *"I have a tendency to say something or to give some comments whenever someone gave a response… (I am always attending to clients who are responding, but what about clients who are more withdrawn? Maybe I should divert my attention to those who needed more encouragement…) I do this because I feel like I have to as a group facilitator… Maybe this is one reason why the group does not seem to be interacting directly with each other? Maybe I have interrupted the natural flow of the discussion?*

Themes from Journal:

- Give more attention and provide more support to clients who are not engaged
- Continue to use more non-verbal prompts when appropriate