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Music Therapists' Experience with Resistance in an Inpatient Psychiatric Setting

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Abstract

This phenomenological research study examined music therapists' experiences with resistance as it occurred with patients in the context of inpatient psychiatric care in the New York City area. While there are many definitions of resistance in the previously published literature on the subject, participants were asked to recount their experiences of resistance without reference to a specific definition: their responses are based on an individual interpretation of the phenomenon.

While there are notable studies on music therapy and resistance, there have been few studies on resistance in the context of inpatient psychiatric care. The following research questions were addressed in this study:

When music therapists encounter resistance in the inpatient psychiatric setting, what is it like for them?

How do music therapists manage and utilize resistance in an inpatient psychiatric setting (musically and otherwise)?

The method that was employed to examine the therapists' experience consisted of four in-depth interviews conducted in person by the researcher. All interviews were audio-recorded, and transcribed to text. The resulting transcriptions were then subjected to editing and cross-case analysis, in which the researcher coded the data and identified 23 emerging themes. An essential description of the phenomenon was drawn. Some examples of the findings were the therapists' descriptions of encountering resistance, the

ways that they worked with their resistant patients, and the outcomes that they attributed to their strategies.

The implications for the findings of this study may 1) provide students, music therapists, and clinicians in related fields with additional resources and insight into a process for effective music therapy practice, 2) inform students in these disciplines respective to clinical training, and 3) improve the quality of services to the clients who are served by music therapy and its related disciplines.

Music Therapists' Experience with Resistance in an Inpatient Psychiatric Setting

by

Mark E. Ackerman



A Master's Thesis Submitted to the Faculty of
Montclair State University
In Partial Fulfillment of the Requirements
For the Degree of
Master of Arts in Music: Concentration in Music Therapy
May 2018

John J. Cali School of Music

Department of Music Therapy

Thesis Committee:



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MUSIC THERAPISTS' EXPERIENCE WITH RESISTANCE in an INPATIENT
PSYCHIATRIC SETTING

A THESIS

Submitted in partial fulfillment of the requirements
For the degree of
Master of Arts in Music: Concentration in Music Therapy

by

MARK E. ACKERMAN

Montclair State University

Montclair, NJ

2018

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Introduction

Resistance in music therapy encompasses a broad set of experiences and behaviors that music therapists encounter in every context in which this practice is applied. Because resistance can appear in so many forms and in almost any context, a thorough understanding of resistance from its roots in psychoanalytic theory to its identification in music therapy is a necessary tool for the practicing music therapist-especially in the context of psychiatric health.

I first became aware of resistance in my work as a behavioral health volunteer. My interest in the study of resistance grew as I began my fieldwork as a graduate student, and found placement in the psychiatric ward of a public hospital in New York City. Having an experienced music therapist as my mentor during this placement afforded me the opportunity to get inside the thought processes of both therapist and patient, and absorb some of the wisdom that she had cultivated during her 14 years of experience.

This literature review focuses on the experience of the music therapist as he or she becomes aware of and meets resistance in group psychiatric music therapy. It is informed by classic psychoanalytic works of the early twentieth century, the music therapy practitioners of the 60s and 70s, and the application of these sources in current music therapy practice and literature.

Because the reluctance to embrace the therapeutic possibilities of music therapy is so common among patients, I am compelled to investigate the subject further by examining the personal experiences of music therapists with patient resistance. Through the interview process I anticipate building a composite picture of this phenomenon, while discovering novel manifestations and strategies encountered along the way.

Purpose of Study and Research Questions

While the sources that I draw from on this topic are illuminating, they only provide a partial picture of resistance. The field of music therapy is now reaching maturity in terms of the number of books and articles that have been published in the last 50 years. After numerous attempts to find published sources on this topic, I have come to the conclusion that resistance, in the context of music therapy, has been neglected. The existing books and journal articles do much to explore and define the topic in general, but little has been written to describe the experience of resistance from the therapist's perspective.

A global search of thesis dissertations will yield no results that appear with the words "music, therapy, and resistance" in the abstract. An example of a Master's Thesis on a related topic is the work, "Music Therapy Interns' Experiences with Client Resistance" (Van Loan, K.G., 2009). This insightful study cites many of the same sources in the literature, while focusing on intern experiences and the subject as it relates to intern supervision.

Through a phenomenological case history exploration of the music therapist's experience with resistance, I seek to understand the nature of patient resistance in psychiatric music therapy. By illuminating its form and how it is recognized, this study will seek to add to the existing body of literature, while providing insight into the many ways that resistance is experienced musically, emotionally, and sensorially, from the therapists' perspective.

- When music therapists encounter resistance in the inpatient psychiatric setting, what is it like for them?
- How do music therapists manage and utilize resistance in an inpatient psychiatric setting (musically and otherwise)?

Scope/Boundaries of the Inquiry

It is my intention to explore the perceptions and reactions of the therapist while focusing on the emotional and intuitive aspects of resistance. During the course of this phenomenological case history inquiry, I will seek to gain insight into the thought/feeling process, as well as the way each participant responds to these encounters.

The study will focus on how resistance looks, feels, and sounds in and out of the music, while bringing attention to the therapists' and patients' relationship to the group during the process. The identification and transformation of resistance from negative perception to useful therapeutic tool will be explored in the context of both transference and counter-transference.

I anticipate that the manifestation and management of the resistant stance in the inpatient adult psychiatric setting will be most accurately portrayed through the process of interviewing each participant and transcribing each account. By correlating the data and ultimately reducing it to an essential description of the experience, I hope to add meaningfully to the literature while illuminating aspects of therapy that will serve to inform practitioners and students in the field of music therapy.

Literature Review

Definition of Resistance

In the field of general psychology, resistance was first identified by Freud (1900) as a defensive function central to therapeutic analysis. Embracing the phenomenon as part and parcel of psychoanalytic practice, Greenson (1967) defined resistance as all those forces within the patient that oppose the treatment process.

In the context of insight-oriented group therapy, Yalom and Leszcz (2005) describe the resistant client as invested in maintaining a known and familiar position. They are “consciously wishing for change, while harboring a deeper commitment to avoiding change” (p. 171).

Paul Nordoff and Clive Robbins developed an early approach that encompasses a humanistic orientation to creative music therapy. While emphasizing the need of the child to assimilate the experience of intimacy evoked by a shared musical experience, they described resistance as the child's reluctance to participate in and respond to the music (Nordoff & Robbins, 1977).

In using her 3-step, free improvisation approach to relationship based analytic music therapy, Juliette Alvin identified resistance to musical instruments as a transfer of conflictual feelings to the instrument being played. By experimenting with the physical force needed to produce a sound, the client can symbolically work through their resistance to therapy, while gaining the support needed to move forward (Bruscia, 1987).

As an originator of music therapy in a psychiatric context, Mary Priestley (1976) defined resistance as “the projection of feelings of hate, fear, anger, and resentment on to the therapist” (p. 239). She also described the (lack of a) connection between emotion and thought as being an

indicator of the defended position. So resistance can be simply thought of as the avoidance of the uncomfortable, or it may be rooted in the complexities of the human psyche.

The Origins of Resistance in Psychoanalytic Theory and Practice

Sigmund Freud became aware of resistance as a result of his experience with patients in the context of individual psychotherapy. Milman and Goldman (1987), paraphrasing Freud (1926), identified resistances as originating in the id, ego, and super-ego, and attributed them respectively to impulses of the libido, repression and transference, and the tendency for feelings of guilt and the need for punishment (p. 8). While he first identified the unconscious motivation behind resistant human behavior, subsequent practitioners in the field of psychoanalysis contributed to a broader understanding of these “mechanisms of defense” in both theory and treatment (Freud, 1936, p. 6). These developments led to the belief that an understanding of resistance originating in the ego is the first step to uncovering any and all resistances.

Resistance in Group Psychotherapy Employing an Eclectic Approach to Treatment

The practice of psychotherapy in the context of the group employs an eclectic approach rooted in psychoanalytic theory, while embracing a more modern perspective of resistance as the key to change and greater self-understanding. Effective practice in this context is based on models derived from psychoeducation, problem solving, and the cognitive-behavioral approaches that have evolved through the ideas inherent in developmental, existential/humanistic, and psycho-dynamic orientations in psychology. The contribution of each informs the therapist, as they seek to create an environment that facilitates the supportive,

cohesive, and validating process that is central to effective group therapeutic work (Yalom & Leszcz, 2005).

Some Considerations on Effective Group Formation, Interaction, and Redirection

The therapy group is formed to facilitate a broad range of therapeutic factors, such as interpersonal learning, enhanced self-esteem, catharsis, etc., and is designed to help individuals by creating and maintaining a culture of acceptance and honesty that will ultimately engender trust between members and towards the therapist. Yalom (2005) states that the necessary conditions for therapy are first accomplished by establishing group norms, group cohesiveness, and the formation of a clear agenda. This atmosphere becomes personally meaningful through the individual patient's relationship with the therapist, to other members of the group, and to the "group as a whole" (Yalom & Leszcz, 2005, p. 54). Interaction between members and redirection by the therapist are facilitated by employing a here and now orientation to the group process.

Transference, Object Relations, the Group as a Re-enactment of the Family Dynamic

The idea of transference is central to an understanding of resistance in the context of group therapy. Transference occurs when the patient seeks to recreate the dynamics of a past relationship with one in the present (Bruscia, 1998). It is theorized that an individual's earliest experiences in infancy shape his or her perception of others and are central to the formation of the self. As a result, the individual forms internalized images of things and others that become "objects" in the unconscious, and are a determinant for behavior in later life (Klein, 1946). The

centered, integrated self, or a lack thereof, may be attributed to the caregiving that one receives early in life. While these images of people and events may exert a strong influence in a patient's way of relating to the therapist or others, they are not always the only source of transference, and can be either positive or negative.

Past relationships or experiences may also affect the perception of the therapist. Countertransference has been described by Yalom and Leszcz (2005) as the therapist's attempt to differentiate between the specific reactions that the therapist brings into a relationship or interaction, and a patient's interpersonal impact on the therapist and others. An awareness of this difference is central to therapeutic efficacy.

These perceptions of one's self and others take on special significance in the context of group music therapy. The therapy group can become a microcosm of the patient's family, with the therapist many times perceived as the parental figure, while other group members may assume the identity of siblings (Dvorkin, 1998). The great advantage of music therapy in this context is the act of doing or creating something within a social structure, while remaining focused on what is happening in the present. The opportunity to observe the behavior of others, the roles that patients take in the group, and the immediacy of reflective and interpretive discourse, give this form of therapy a degree of efficacy that may be unique in its ability to get to the core of patient issues.

Different Theoretical Orientations in Psychiatric Music Therapy/Intentions of the Music Therapist

Group and individual music therapy are informed by both the constructs of psychology, and by therapeutic approaches that address the issue of how humans function. In addition to its reliance on psychodynamic, humanistic, existential, behavioral, and gestalt orientations, group

music therapy draws from the fields of music education, art, speech, occupational, and physical therapies. Professional orientation and patient need determine the music therapists' approach to assessment, identification of goals, and a course of treatment. During this process, Austin & Dvorkin (1993) describe resistance as a symbolic form of expression that is a guide to the patient's inner world.

In their work with developmentally delayed children, Nordoff and Robbins (1977) developed an approach to music therapy that was based on the assumption that each person has an innate responsiveness to music, and that musical responses are a mirror of the child's psychological and emotional condition. In their piano, percussion, and vocally oriented approach, the process of self-actualization is achieved by building on the individual's potential and pre-existing strengths. Bruscia (1987), states that the Nordoff and Robbins approach embraces the child's presenting impulses and drives to validate and gratify the individual through music experiences motivated by growth and learning from within. Active participation in the music is a combination of instrumental improvisation and song themes that explore the client's inner life, while promoting self-expression as the basis for the validation of the self.

One of the first practitioners to bring psychoanalytic theory and music therapy together, Priestley (1975) developed an approach to address the needs of psychologically disturbed adults. In it, she removes obstacles that prevent the realization of personal goals and potential. Analytic music therapy is closely aligned with the Freudian psychosexual model of development and motivational constructs (i.e. repetition compulsion, pleasure principle, projective identification, etc.) while using improvisation as a tool to explore feelings, images, and memories that are identified during the therapeutic process. These referential themes are used with normal, neurotic, or borderline psychotic patients to focus on guilt, envy, gratitude, and reparation, the

mental repair of a damaged world. In keeping with the idea of object relations, Priestley (1975) relies on the Kleinian construct of splitting to help the patient integrate the positive and negative aspects of the self through music. This is accomplished by employing a duet improvisation where the therapist and client take turns depicting opposite sides of an intrapsychic conflict. She also incorporates the Jungian ideas of myth and archetypes as elementary structures from which images, symbols, and patterns of behavior arise.

Manifestations of Resistance in Music Therapy, in General and Specifically Within Psychiatric Music Therapy

A number of music therapist/authors published early accounts and case studies identifying resistance as a central theme in the context of music therapy. Music therapy pioneers such as Heimlich, (1965), Nordoff and Robbins (1977), Lehrer-Carle (1971), Alvin (1977), Bonny (1975), Priestley (1975), and Tyson (1981) contributed to the understanding of the phenomena. In order to appreciate the way these music therapists brought psychodynamic theory and practice into the field of music therapy, a look at an early case study account by Tyson is an example of an approach to working with an individual who had a unique set of personal and psychiatric needs.

Kathy was a 27 year-old woman with a background in piano. Her case is representative of the multiple diagnosis patient, whose illness included schizophrenia and borderline personality. While describing her difficult childhood, Tyson outlines her transition from an awkward, deprecating, and withdrawn young woman, to a communicative and expressive person.

Tyson (1981) uses this case study to make a connection between analytic and music therapy. The idea of the basic fault as conceived by Balint (1968) is explored as a beneficial

regression that provides an opportunity for a new beginning. In her work with Kathy, Tyson encouraged the patient to regress to a pre-oedipal level by returning to the point of childhood trauma through music.

While she recounts the therapeutic progress and periods of resistance to treatment, she also describes oral manipulation by the patient of the therapists' hands as an example of this regression (to a state of oral dependence). This new beginning takes place in the transference and provides the client with a transitional object (person). This is a necessity for the client with a weak sense of self, to return to the childhood trauma that precipitated her symptoms.

In her conclusion, the author outlines the principles of this theory and its implications for music therapy by drawing clear parallels between analytic and music therapies. She emphasizes that the two-person relationship is fundamental to progress with the borderline or schizophrenic patient, while tying this to the idea of object relations and the transitional object. This fascinating account is an example of the multitude of ways that resistance can become a central theme in music therapy, and take shape in ways that are as diverse as the people we encounter.

Since the ground-breaking work of these music therapy innovators, there have been a number of music therapist/authors who have contributed to the body of knowledge on this subject. While many published case studies have the elements of resistance, transference, or counter-transference, most refer to it as a secondary consideration, and even fewer have identified it as occurring in the context of group psychiatric music therapy.

Steele (1984), described resistance working with an emotionally disturbed child, while employing music therapy based on an approach modelled after Nordoff-Robbins. In her work with adults, Diaz de Chumaceiro (1995) examines patient songs as transferential music, and the idea of lullabies as transitional tunes, while referring to the transitional object. With the

comprehensive presentation of Case Studies in Music Therapy, Bruscia (1991) collected and published four accounts of music therapy with resistant individuals, two of them adults with mental health issues.

In the seven page article, "Resistance in Individual Music Therapy", Austin and Dvorkin (1993), draw a roadmap for future study. This article touches on the presenting musical, verbal and emotional behaviors in a number of adult case vignettes and references, while describing strategies for meeting resistant behavior. A clear picture of resistance emerges as they recount the attitudes, verbalizations, and actions that prevent awareness of a perception, idea, or memory that could contribute to the resolution of an unconscious conflict.

While studies by these authors tie the practice of music therapy to that of psychoanalytic theory, there appears to be a dearth of information examining this element in the context of the adult psychiatric inpatient population. In the field of psycho-therapeutic practice, there are innumerable accounts and case studies on the subject, while only a handful exist in current music therapy literature. As these studies begin to illuminate individual cases, references made to the experience of the music therapist in the group context are of secondary concern and only mentioned in passing.

Examples of Resistance in Psychiatric Music Therapy: The Therapists Perspective

It is likely that the psychiatric ward of a hospital in a major American city will have a number of similar features. The ward is in lock-down; patients are required to stay within the confines of that ward. They have been diagnosed with any and all designations of mental illness, drug/alcohol addiction, degenerative brain diseases, or trauma induced mental deficiency. The

institutional atmosphere may appear punitive to some patients, and their feelings about being there may range from acceptance to defiant outrage (Yalom, 1983).

It is in this context that the therapist uses the music experience to begin a genuine relationship (Rogers, 1942). The innate interest and beauty of music is a draw for many patients, and inclusion in music activities may be viewed as a privilege. As patients file in, the process starts. The choices that a patient makes in the first few minutes may be indicators of personality, diagnosis, family history or current affectual state. Where they sit, which instruments they choose, their awareness of and verbal contact with others: all these factors may be indicators of a patient's current state of being (Bruscia, 1998). The communal or intimate nature of the group music experience may be reassuring to some, while others become disengaged, and choose to leave in the first few minutes. From the first moment the therapist is, above all, an observer (Bruscia, 1987).

It may be common for patients from different cultures to view themselves or others as "outsiders" based on the makeup of the group or the songs that are suggested or played. Music, being the language of emotion, may have personal significance to an individual, helping them to remember a positive or negative life experience. The intimacy of the experience may be uncomfortable for some, while others associate participating in a music experience as a joyful opportunity for self-expression, or a reminder of a crushing personal defeat. An individual may not be convinced of the need for therapy of any kind (i.e. ego syntonicity) (Greenson, 1967), or view the exposition of thoughts and feelings as somehow being a weakness (Yalom & Leszcs, 2005). These are just a few of the ways in which a resistant stance can take hold, and while the music therapist is watching and taking mental notes, they are bound to have feelings that color their perception of what is happening and their approach to dealing with resistant individuals.

How it Looks, Feels and Sounds in and Outside of the Music

Numerous authors have referred to the cues that signal the likelihood of a resistant stance. Simkins described extreme hypo or hyperactivity during music making that can be an attempt to defend against intrusion or self-disclosure (Bruscia, 1987). A client may have limits in what he or she is willing to deal with at any given stage of the process. In his summation of the approach employed by Priestley, Bruscia (1987) states that these limits may result in the verbal avoidance of a topic, or attempts to deflect discussion to irrelevant issues. Austin and Dvorkin (1993) point out that the fear of losing control can be brought about during improvisation or vocalization, with the possibility of exposing those parts of the self that remain hidden and have never been accepted.

The intimate nature of music expression can be threatening to some, and may induce feelings of shame, guilt, or embarrassment at experiencing pleasure. Singing can be a powerful means of removing blocks to intimacy, while invoking a transference reaction to the therapist as a mother figure, resulting in a resistance to vocalization (and possible regression). Austin & Dvorkin (1993) also refer to patients that participate in the music but avoid the processing of verbal content. This is described as an avoidance of making the connections that would make the unconscious expression conscious.

During music making, a lack of affect, or contradiction between the feeling of the music and the patient's affect, can be a sign of resistance. The avoidance of being emotionally present may be manifested by extreme changes in tempo, or by the premature cessation of playing or singing. Steele (1984) states that perseverative playing, or an insistence on staying with a

musical idea or motif when opportunities for change have been introduced can be a form of symbolic expression that may signal a discrepancy between the needs of the patient and the musical experience being offered by the therapist.

Why Understanding Resistance is Useful in Clinical Work

The underlying sources of resistant verbalizations, attitudes, and behaviors are varied and unique, as each patient brings a set of experiences and attitudes to the music therapy session. The group dynamic is central to the therapeutic process in psychiatric music therapy. It benefits patients, in part, because it occurs in a social context. Group music therapy is included as part of a comprehensive approach to patient care, and is especially cost effective while complementing other forms of therapy. Simpkins stated that an increased knowledge and awareness of the subject has the potential to enable the therapist to transform an obstacle into an opportunity (as cited in Bruscia, 1987). A thorough familiarity with resistance can increase the likelihood that each patient is treated in a respectful way that honors his or her life and experience. It is common for the leaders of therapeutic groups in this context to direct their attention to compliant or easy-to-work-with patients, while ignoring or dismissing the difficult or disruptive patient (B. Abrams, personal communication, 2016).

Resistance in group music therapy is an important phenomenon because patients who are confined to the psychiatric ward bring with them a set of attitudes, identities, and life experiences that determine their reluctance or enthusiasm for participating in the therapeutic process. These qualities may be hidden or disguised, and are central to understanding individual preferences, behavior, and actions, while unlocking the assumptions (or self-perceptions) that may prevent the individual from moving forward in life (Yalom & Lesczcz, 2005).

While the literature on the topic of resistance in music therapy makes the connection between psycho-dynamic theory and its' application to music therapy, these accounts offer little in the way of insight into the experience of recognizing and meeting the resistance from a therapeutic perspective. Given that majorities of practicing music therapists have recently been identified as working in the context of psychiatric music therapy, this deficit in the literature will be addressed by an inquiry of this kind (Silverman, 2007).

Therefore, the purpose of this study will be to understand the nature of patient resistance by illuminating its form and the many ways that resistance is experienced in the musical, verbal, and affectual components of group therapy. By exploring the strategies for responding to, managing, and utilizing resistance, students and therapeutic practitioners will gain a more thorough understanding of it in order to meet the challenges of psychiatric music therapy in a group context.

Method

The design of this study consists of a phenomenological multiple case study design. I chose this design because phenomenological research seeks to gain an understanding of the qualities of a lived experience. The research lies within the human experience as told from the individual's perspective. While gathering information and perceptions through inductive, qualitative methods such as interviews and participant observation, this research can offer insight into the participant's world, motivations, actions, and experience (Polkinghorne, 1989).

Phenomenological research will be used because it can best address the experience of music therapists' experiences with patient resistance. These methods are focused on "questions, issues, and a search for patterns" in the data (Van Loan, 2009, p. 20). Live in-person interviews were conducted to gain insight and understanding of participants' experiences as music therapists.

Participants

The recruitment process

I sent letters of invitation via email (with enclosed description of study, and consent forms), to the directors of nearby psychiatric facilities that use music therapy. I also contacted colleagues through word of mouth and social media.

Potential participants were invited to participate if they meet the following criteria:

- They are licensed music therapists who are currently practicing group music therapy in the confines of a psychiatric facility for a minimum of 1 year.
- They are 18 years of age or older.
- Reside within a 50 mile radius of New York City.

- Have graduated from an accredited undergraduate or graduate program in music therapy.
- Have experienced patient resistance (e.g. refusal to participate in music therapy services or have a patient who demonstrates resistance within the therapeutic relationship or process).
- Are in sound mental and physical health to participate in an interview-based study (Van Loan, 2009).

The Interview Process

Prospective participants were asked to review the enclosed description of the study, to review the consent forms, and upon agreement to participate, to sign and return the consent forms to me. Prospective participants were asked to notify me should they not wish to participate (by returning the decline to participate card). If no response was received within 2 weeks, I assumed that they did not wish to participate and I continued the recruitment process, with no more than four active invitations outstanding at any given time, until four participants agreed to participate in the study. Prospective participants were informed that if they chose to participate in this study they agreed to:

- Participant in an audio-recorded, individual, in-depth live interview (a maximum of 45 minutes in length), in which I will invite them to answer questions about their experiences with patient resistance, and subsequently transcribe and subject to data analysis; and
- Follow up with phone interview(s) to clarify participants' statements about their experiences and to verify the accuracy of how their experiences are portrayed, following data analysis (member checking) (Van Loan, 2009).

- Upon receiving each participant's consent, I arranged a mutually convenient time to meet individually.

All interviews were audio recorded as per given consent by each participant. I sought to conduct the interview in a comfortable environment, such as the participant's home, and expected each interview to unfold uniquely, as the level of articulation, comfort, and style of communication may differ. Each interview will unfold according to the following framework: Background information on theoretical orientation, experience, patient population, and methods employed.

I began each interview by inviting participants to share the nature of their professional experience and their theoretical orientation, followed by a description of their current patient population and the methods that were employed (e.g. improvisational, receptive listening, song-writing, etc.).

Then I invited each participant to think of a time when he/she felt resistance from a client during their work, and asked them to describe the client, what he/she was like. Next, I will inquire as to anything that is important to know about their diagnosis, or any personal characteristics about the patient that stood out. Following this, I encouraged each participant to describe in detail as much as possible about the experience, any important events that followed from the experience, or anything that they found helpful in managing their feelings about the experience. My role was to gather as much information as possible while being non-judgmental, respectful, and sensitive to his/her feelings and descriptions (Van Loan, 2009). The process of gentle probing or clarification helped participants share as much detail as possible. The process was facilitated by asking, "Is there anything else that you can add to that?" or "Is there anything

that you noticed in your body at that moment” or “What was happening with your feelings in that moment?”

Participants were asked to describe their strategies for meeting the resistance, and how they felt during the process. Special attention focused on changes in the music initiated by them or the patient. They were encouraged to contextualize the experience, if applicable, to refer to previous or subsequent work with the patient (Van Loan, 2009).

While recounting their experience, participants were asked to describe the intrapersonal and interpersonal components of the experience. Each participant was encouraged to describe their observations and feelings to further describe the nature of the music and the roles that were assumed by both therapist and patient, while they described the role of the music in the therapeutic process. So doing, the participants were asked to reflect on any perceived gains or setbacks that occur as a result of the strategy employed.

At the conclusion of the interview, a follow-up interview by telephone was scheduled to confirm the accuracy of the interview, and to clarify any statements or details that appear to be unclear (Van Loan, 2009).

Upon completion of all four interviews, I listened to each recording and transcribed each interview verbatim. I listened to the audio recordings for a second time while following the transcriptions to insure accuracy. Finally, I listened to the interview a third time without following the written transcriptions to allow myself to express any thoughts, images, or feelings that I had. The purpose of this will be to refer to the journaled content to discuss what I have learned in doing this study in the discussion section (Van Loan, 2009).

Data Analysis

I employed a data analysis procedure similar to that of Muller who conducted a phenomenological study on music therapists' experiences of being present in music therapy (Muller, 2008). Muller's approach (as adapted by Van Loan, 2009), represents a good fit for the purpose of my study, and helped to provide the high level of truthfulness and trustworthiness that I was seeking. Following the interview transcriptions, I implemented the following steps in the data analysis process.

1. Edit each interview, removing statements not relevant or unrelated to the lived experience, while culling statements not relevant or pertinent to my research question.
2. Send participants the verbatim and edited interviews by mail after 2 weeks; ask them to read the transcriptions, and then follow-up by phone with a 15 minute interview to verify the accuracy of the data from their perspective.
3. Divide each interview into individual meaning units (statements about the participant's experiences with client resistance that yield a self-contained idea). This yielded a number of meaning units across all cases. I did not alter any of the participants' words, but added my own statements in brackets to clarify meaning and context.
4. I examined the meaning units (across all cases) for any common themes and/or ideas, which resulted in a number of categories, or groupings. I created a label for each meaning unit category, which captured its essence. Then I created a brief summary description for each category and cited examples from participant's experiences. The labels and summary descriptions served as codes by which I re-assembled the meaning units, based on the cross-case analysis of the participant experiences of patient resistance.

5. I ordered the themes according to a logical sequence about the experience, which answered the first question: "When music therapists encounter resistance in the inpatient psychiatric setting, what is it like for them? I concluded the final theme with the statements of how the therapists manage and utilize resistance, and with their perception of the efficacy of the strategies employed, which answered my second question.
6. Then I re-assembled each participant's experience description by grouping the coded meaning units together, according to code sequence, into the reconstructed narratives. Code markers attached to each meaning unit within the reconstructed narratives provided a reference system for the sources of each unit.
7. I then removed the code markers from each unit within the reconstructed narratives, and edited them for readability. At this point, none of the participant's original words were altered, and I will took care to minimize alterations to preserve their original meaning. (Changes were only be made for the sake of clarity, grammar, and sentence completion).
8. I formulated an "essential description" of the phenomenon, across all cases, based upon an integration of the general description of all themes, as summarized in step #4 (Van Loan, 2009).

Ethical Precautions

I sought approval after review of this study's protocol by Montclair State University's Institutional Review Board. After informing participants of the unpredictable nature of the questioning process, I explained that there was the possibility that they may experience difficult or negative emotions as a result of the process.

I took care to ensure the confidentiality of participant data by assigning numeric identities to each case, while informing them that the information as presented will not put them at risk of identification. I kept all recorded interview materials and transcriptions in a locked, secure location, off personal hard drives, shared media spaces or on-line environments. This data, with linking code keys containing participant interviews, was kept in locked storage in a separate location. Access to password codes was restricted to my advisor and me.

I informed participants that they may benefit from involvement in this study by gaining insight about patient-therapist resistance that may be applicable to present or future clinical work, and that they may gain information that is applicable to the future study and practice of music therapy.

Results

The categories that are a result of the interview process are grouped, and emerging themes are identified. These themes fall into one of the four categories shown in Table 1, and represent experiences that the music therapists had and the actions that they took in response to those experiences. The therapists then identified outcomes that they attributed to these experiences and actions, which were unforeseen at the initiation of the study. Other relevant features of the therapists' experience are included to provide context into the therapists' themes and narratives, as other categories.

Table 1 <i>Group Themes</i>			
<u>Experiences</u>	<u>Actions</u>	<u>Outcomes For Patient or Therapist</u>	<u>Other Categories</u>
Recognizing Signs of Resistance	Establishing Acceptance and Trust	Validation	Therapist's Professional Identity or Theoretical Orientation
Images of Resistance	Establishing Legitimacy	Empowerment	External Influences and Limitations
Physiological Sensations	Assessing Therapeutic Value of Resistance	Music as a Healing Experience	
Presence	Meeting the Resistance	Transformation	
Emotional Connectedness	Anticipating and Meeting Patient Needs	Self-Realization	
Feelings In Response to Encountering Resistance	Music For Establishing a Therapeutic Container or Space		
Working to Understand the Patient's Experience	Establishing or Changing Role		
Sense of Patient's Need for Safety	Self-Monitoring and Regulation		

Themes and Description with Meaning Units*

* Words in parentheses are added for context (reference to topic of discussion), or grammatical clarity.

1. Recognizing Signs of Resistance

In the course of therapy, the music therapist interprets the ways a patient is hesitant to participate or engage as an indicator of a defended position.

Participant D: *It (the assessment) turns into, okay, I'm not going to get that far with this patient now, and I'll try again the next time.*

He was dismissive or ignored the other patient's references (when reality checking). This is my hand but you're not coming any closer.

I can pick this movement with my hands, pushed out with my arm like. This is (a) very defensive kind of thing. He was pushing me away (figuratively).

Participant A: *He was very tentative at the beginning of the session (the first week). It was his non-verbal resistance, the way that he walks into the room; his head was a little down.*

His body was closed, arms crossed, legs inward. He appeared uncomfortable, (I sensed a) passive resistance. He was holding back, he paid attention to other patients when I spoke with them, just resisting me. He was scared to take the first step and afraid to open up.

He didn't give me a lot. He didn't give me a lot of words. His affect did not change, it remained flat. He responded but it was more in a short, not elaborating way. (Later), he's answering in one or two words phrases, while glancing at me briefly when I spoke to him, then looking away.

Participant B: *She didn't sit in the group; she (was) kind of sitting outside of circle. In a way she doesn't want to interrupt. She doesn't want to be disruptive.*

At that time she doesn't really want to talk about anything, I didn't know where she was coming from yet. Oh, she was also guarded. She doesn't want to share anything. Not only in the creative arts, a lot of different things.

She's observing from the outside. Patients with paranoia typically are guarded, and present as suspicious. I didn't feel any transference with her, but she does remind me of previous patients with a similar presentation. We might call it resistance, or guarded.

Participant C: *(She) had this preconception of what the space would be, that it was not going to be welcoming, this place where she was coming into, emotionally.*

She didn't seem bored or checked out. Her facial expression conveyed a sense of alertness. She was looking for something to set her off.

She was sitting upright in a very interested (position); there was something that communicated an attentive nature.

2. Images of Resistance

In the course of music therapy, the patients' guarded stance invokes a metaphor or visual image.

Participant D: *A wall, basically. I feel like, initially (it) is like a wall.*

In the groups he was one (foot in) and one foot out the door kind of thing.

Participant B: *Shadows. Yeah a shadow (her presence). (Her image reminds me of) shadows right now. I would say it's like lost. Like a lost someone. You know, from this space.*

Participant C: *Her body language, which was very telling, was that she was sort of like one foot in, one foot out. Not just checked out but testing the waters. Taking in what was going on, she was sort of half facing, and she had a response to the question. It was not what she thought would be the ideal response, but it was a response.*

3. Physiological Sensations

The therapist notices an in-body response during the therapeutic process.

Participant C: *I had a pretty wicked headache going into the room, and I didn't when I left the room. I do take something positive from it. Something probably about needing to be outside myself, or (being) totally open and available to what was going on.*

4. Presence

A heightened cognitive, sensory, and feeling state of awareness, where the therapist conveys a complete openness, receptivity, and engagement with the unfolding shared experience offered by the patient, while sensing its' pivotal significance.

Participant A: *I wanted to meet him where he was, in this low energy place, and try to bring him up a little with the music. I had to make him feel comfortable. To reduce his frustration level, to (get him to) at least accept the environment. To just accept the music process.*

Participant D: *What do I do next, what can I draw upon? I know a lot, let's do this, let's do that, it was like boom, boom, boom. I want to try it you know, kind of like spitfire. What else can I experiment with? It was a little exciting, almost.*

I fed the lyrics to them and then they sang it, I had them do it in the moment. I love it actually; (it) was beautiful to hear all of them getting into it (songwriting).

5. Emotional Connectedness

In the course of therapy, the therapist or patient develop an emotional bond or an improved interpersonal stance toward each other or the music therapy group.

Participant A: *I noticed that he remembers me, he elicited eye contact, he initiated hello, and he sat closer to me, (with his) head up.*

Participant B: *(There's an element of) socialization. They (are getting to) know each other, and they're (getting) familiar with each other at that time. So when they played music their music was more responsive to each other.*

To me somehow that's considered to be participation. There's a connection. I think a couple weeks later, at a much later time, she talked about togetherness in a group, a oneness. That's what she described.

Participant D: *They made a song about tacos, very humorous; he was sitting there and just clapping. He said, "I don't like tacos, this song is dumb." But then he participated, and there was a moment at the end where he finally cracked a smile. I smiled right back at him. Because he was smiling, joining in the group, it was like the silliest song, but it's very heartwarming, so everyone was on the same page with that.*

6. Feelings In Response to Encountering Resistance

During the course of therapy, the therapist experiences an emotional response to the patient.

Participant A: *I was pretty calm about it. (While I was) observing and evaluating, I had a sense, a feeling, (of) when to bring him in (to the group's music).*

Participant D: *Initially I experienced some self-doubt. In that moment I asked myself, why am I in this job? I was confused and uncomfortable.*

All the time (I have feelings of inadequacy as a musician). We live in New York! Then there's the big area of continuing self-growth.

At the end, I felt very sad, I was going to miss him, and I felt very connected with him. I have very fond memories of our connection. There was some regret that it took that long. I wanted to cry, it was a very loving, beautiful termination process.

Participant C: *I have a tendency to be anxious when I'm thinking of a million things, kind of a snowball effect. When my attention is focused, I'm available to that experience.*

I tend to mostly feel a sense of challenge or frustration when patients are getting in the way of other patients, when they're kind of disrespectful to one another, or really inhibiting someone else's ability to take from the space.

Participant B: *Sometimes I feel bad, though. I feel uneasy, in a way. But in a way, I feel it's necessary.*

In that particular day, right away they know each other. Although, sometimes, it can be very chaotic musically. Music wise people don't know where to go. It can be a bit frustrating.

7. Working to Understand the Patient's Experience

The therapist demonstrates the ability to consider or understand the patient's unique history or presenting conflicts.

Participant D: *(For instance), I've never been in jail or rehabbed as a forensic patient, (like he was).*

Participant C: *The attitude represented a certain persona. I knew she was comfortable being a little edgier. So she was wearing a band sweatshirt which helped me out a little bit. This band, 21 Pilots, they're an angsty rap-rock band, so (I tried to) kind of match the... attitude.*

She didn't seem bored or checked out. Her facial expression conveyed a sense of alertness. She was looking for something to set her off.

I almost wonder if that resistive persona is just a part of Laura, not the entirety of Laura, and (just) the first line of defense.

8. Sense of Patient's Need for Safety

Concerns for feelings of safety involves the therapist anticipating or responding to a patient's perceived need to be free from unwanted confrontation or harm, while respecting their comfort level with the therapeutic process.

Participant A: *I was concerned with not pushing him to do something that he wasn't comfortable doing.*

Participant D: *He probably didn't feel safe enough.*

Participant B: *I let her know that it was ok, she felt comfortable sitting outside the circle. I used my critical judgement to focus on the other patients, and didn't pay a lot of attention (to her). Of course I would take a look at her a little bit. I focused on the group process in the circle. I think she got it.*

It was important, not only physical safety, but also spiritual wise. Mentally, they feel safe. To be here and feel supported.

Participant C: *In this specific instance, I did know that Laura had a past history of physical and sexual abuse and trauma. Being able to trust in a space with a male therapist, there are all these dynamics that I needed to keep in mind. I definitely did feel the need to convey that sense of safety.*

Just (by) reflecting her ideas and rewording them back to her; (I) was acknowledging (that) your emotional expression is okay here. When she left the room, it was probably because she did not feel safe in the space.

9. Establishing Acceptance and Trust

The therapist strives to impart the understanding of a non-judgmental or non-critical stance between the resistant individual, the group members and self while establishing a genuine relationship.

Participant A: I tried to get him feeling more comfortable in the environment so he could just accept the music. To let him know that you can be with us in the music and it's ok to just listen. I felt like I had to give him space. I gave him that space at the beginning, to get comfortable, while showing that he can stay here with us, that he's accepted.

I knew he couldn't jump in with two feet that day. He wanted to see if I would respect his boundaries.

Participant D: Trusted by him? Yes, he was very clear about that in the beginning. I'm telling you my stuff because your (my) therapist (Private music therapy vs. group self-disclosure).

10. Establishing Legitimacy

The therapist seeks to establish professional, musical, or interpersonal credibility while determining the patient's orientation and willingness to engage.

Participant C: *Yeah, I think that she is probably testing my response to her putting herself out there, whether it's consciously or not. I'm needing to prove myself to her. On my part, more of a testing the waters kind of thing, proving that I can hang, so to speak.*

She probably meant to (challenge me), I have a hard time acknowledging, or checking or finding my own emotional response within that.

Participant D: *Yes. I know that (proving myself) is a myth, and may not be grounded in reality all the time. I have some Mom issues, a distorted belief in perfectionism.*

Participant A: *At this point, I never take things personally. He was testing me by withholding.*

11. Assessing the Therapeutic Value of Resistance

The current resistant stance of the patient is recognized and valued as a starting point towards engagement in the music therapy process.

Participant C: *Once we got some feedback on that, Laura (says), "I'm really agitated". "I just really don't want to be here". She's essentially politely telling me that she doesn't want anything to do with me. Then we start to talk about well, where is the emotional kind of place that we want to bring ourselves today?*

I remember her kind of turning towards and saying like, "wow". "Do you know it's going to be loud? Loud, agitation is loud"! That said to me you're in this place that you're perceiving as maybe very negative, but you're actually giving me quite a lot.

It's a multi-layered response. As a person who's not a therapist, (I'm thinking) here we go, agitated. Okay, I get it; no one wants to be here, that sort of thing. As the therapist, I'm getting something here, this is something to be worked with, and so to me, it's a little exciting. I know that therapeutically this is great.

She's one of maybe two or three people that outwardly voiced some sort of perceived negative emotion that they needed to put out into the space.

Your resistance, if we want to call it that, didn't take away from the group but provided us with a purpose for creating something or exploring something in music.

I did feel challenged in the scenario only because it was a group. Needing to sort of check in with myself at times to say this person's resistance just became the catalyst for this (group) experience. I'm doing things to meet and support them (the group) as well.

Right, that's so important because it's the acute setting. I don't always know if I'm going to see that person the next day. In this specific instance, I saw (Laura) today outside of the group and

(she) reiterated to me that she didn't need to be here at all, and that does not detract from the experience.

Participant B: For Maria, her resistance, her not wanting to participate (is) more from her illness, and that I would see differently. Okay she doesn't want to be part of this group, but it's okay. She came into the room, and for her that's a big step. Yeah, her resistance was part of the process. I (was able to) work with that.

We already achieved a goal for that week. For that week I set a goal. For that patient, she can come in, she showed up. That's something for her.

Deep inside doing that, (I got some satisfaction). (To) help her understand, or to see the possibilities. For that time.

Participant D: I was excited. Now we're getting somewhere, now we're starting to use some group dynamics and processing.

The reciprocity feeds on one another; I was inspired when he began to work with me (matching his energy and feeling competent).

Participant A: He showed a little interest, he started lifting up his head a little bit. To me that's a step. It wasn't a lot, but it was something.

I noticed that his loosened boundaries were a sign that he was taking a subtle step towards opening up and participating.

I know his diagnosis, but I'm not going to let that put me in a box or determine what I do (with him).

12. Meeting the Resistance

The therapist embraces the patient's defenses to acknowledge, reciprocate, and move the therapeutic process forward.

Participant B: The paranoia feelings are there, what to expect, what's going to happen and all that. So that particular group session she didn't want to participate and she left prematurely. It was ok; I didn't expect her to stay through the whole session. She still had the paranoia. She was coming from a resistant place; I kept my focus on the group.

She accomplished something (when) I convinced her to come in.

I was inviting her, the purpose (was) to improve. (By) inviting her into the group I (was) trying to help her socialize with other people. To leave that isolation, and give her the opportunity to see a different perspective of life. Or the possibilities of this cohesiveness, (The) togetherness with other people.

Participant C: *It mirrors the verbal interaction in the sense that I want to create that space that she can voice those opinions and then, be flexible enough that I can show (that) we can go there, we can be in that agitation.*

In this instance, being more accepting of and responsive to it, and willing to see where that takes us.

I responded, "alright, okay, it's gonna be loud". To acknowledge verbally that we were going into her music, reciprocating what she was saying.

Not just play to where we we're at, where the individuals are at, but to where they were trying to bring it. There was an agreement on this idea of calm something, just a calmer state.

Participant D: *The rhythm is so important. But the themes come from them; the words come from them, the choice of the tempo. Do you want to sing it; do you want to rap it? (On creating choices)*

I realized that I was working way harder than he was in our individual sessions. Sessions flowed a lot easier when I (would) just sit there and do nothing.

13. Anticipating and Meeting Patient Needs

The therapist predicts or takes notice of an individual's unspoken requirements for inclusion in the therapeutic process while providing the means to do so.

Participant B: *I didn't really want to try to show her, but in a way yes. To let her know that we had something going on that day. To have the opportunity to connect with the other people in the group.*

Maria, at that moment was a kind of an outsider. She didn't even come out of her room; she didn't socialize with anyone at all. They kind of knew each other for a short period of time (the group), and from my perspective, Maria is probably (feeling) left out in that particular moment.

Participant C: *(She) had this preconception of what the space would be, that it was not going to be welcoming, this place where she was coming into, emotionally.*

Participant D: *It was mixed throughout his course of stay (lack of engagement). Then I first noticed that this is an area where we can reach him. That was the work, for him to foster positive relationships.*

I was trying to help him work on these social skills and letting go of this resentment. That's not what he needed. He needed me to just accept him for where he was at, and be with him in the music. The outcome from our individual work together was that he was learning how to be in a relationship with me.

14. Music for Establishing a Therapeutic Container or Space

During the course of the music therapy intervention, the therapist creates a complimentary opening in the music for a patient's personal expression or uses music to affirm or prolong that expression.

Participant B: *Yeah, (I'm looking for a way to bring her in and another way looking to give her the space she needs to take her own time).*

That's the way I see this particular technique. Containment, and for them, that's to get into a structure.

Participant D: *I would be angry because I put in so much work; he was just like saying "f" it. When I kind of just let go and met him where (he was), I was more able to be a container musically for him.*

That's a huge part of my orientation. I use the room, body rhythms, or even silence for whatever they bring.

I held the space to create optimum conditions for healing; I was bearing witness.

Participant C: *(With) that steady rhythm that she can, for lack of a better word, project herself onto (it), put that into the music there, and know that that's her place in the music.*

15. Establishing or Changing Role

The therapist describes a function or posture that they assume in the course of music therapy activities.

Participant C: *Working with adolescents, I have to check my realness, or at times assume a more authoritative stance. I go in and out of it.*

It definitely became a transition from leader to facilitator, to sort of blue sky sort of thing. Then, at the very end, I need to come back to provide that closure, acknowledgement that we did something.

Participant D: *Facilitator is a good word; I'm a co-creator with everyone else. I'm going to be that para-dynamic anyway because I'm a staff member and I'm a therapist.*

16. Self-monitoring or Regulation

Therapists report tendencies or actions that do not further the therapeutic process or relationship.

Participant D: *I brought in congas; I was trying to help him, my wanting to fix his anger against these people who assaulted him, to help him express his anger on percussion.*

I caught that my stuff was getting (in the way).

It was very frustrating for me; (I) was coming from a place of fixing. When I was more grounded, and when I was able to catch, you know this tendency to want to prove something, I just saw it as part of him. I was more accepting of where he was at.

17. Validation

The effectiveness of a prior course of action affirms the patient's feelings of self or the therapist's approach.

Participant B: In the helping professions, there are moments that I feel very in a similar way (validated). In that day, I was happy for her. (It was) just a small step, just coming to a group. It's so easy for some people. But for her she made an effort. And, all the time I talk to her about coming in, and finally she made it. And she saw the possibilities in the moment. She got an opportunity to just be there.

They can get some acknowledgement from other people, some validation.

In the end, she really came a long way. Not only coming to all the groups, but also going through a group process. She helped us to achieve that cohesiveness and togetherness and she understood that there is a process to help, giving a steady beat. Then she feels accomplishment.

Participant C: (To) just acknowledge that on her part (that) she's been sitting there this whole time and fuming, needing to leave the room, coming back in, turning away from people. Not

saying "alright then you can go", but saying "all right, that is absolutely an understandable way to feel".

Being able to share that undesirable reaction. Just validating it and hearing it. In this instance, being more accepting of and responsive to it, and willing to see where that takes us.

I do find that (validating the patient's experience) to be a primary concern. Specifically in this case, I think that trying to explain to Laura the benefit of her being here in this facility, even if I was well intended, would be not hearing her agitation. In validating it, it's allowing for that to begin to move somewhere a little bit.

So the potential is for her own self-expression.

Participant A: He feels validated emotionally, and that is what relaxes him. And that's where (in) the resistance, you see a reduction.

18. Empowerment

As a result of music therapy, the therapist or patient imparts or gains a sense of confidence or control over their ability to solve problems or act as an agent of change.

Participant D: What actually resonates with me are my therapist mindsets of beginner's mind, or (that) the client is my teacher, that I'm here as a guide. I'm not here doing the therapy to them, or prescribing something.

Participant A: *How would I play the theme of strength and connection (she asked him)? So I'm giving him the strength, and the connection, and the control.*

Participant B: *Okay if you want to come in I can give you more. I actually gave her options.*

Sometimes they don't know what to do, and they expect that something will happen. They want to make something out of it, or to take something away from the group. That day I provided a way (forward). To provide coping skills to deal with their issues. They were focused and enthusiastic.

Participant C: *My emotional reaction (was), yes! This is good! I'm not trying to hand stuff to people; I'm trying to allow people to get their own something, whatever it is.*

19. Music as a Healing Experience

The therapist reports a health-giving or harmonious outcome as a result of resolving an interpersonal or intrapersonal conflict, or gaining a greater sense of well-being through the act of making music in a group.

Participant C: *Making music is in itself a therapeutic experience- being able to channel anxious energy into a more focused place.*

Participant D: *I (thought I) needed to get him better and get him out, and that's where the resistance was the most. When I let go of that, we were able to just be with each other in the music.*

I personally believe that sometimes it's really only the music that is a solace for these clients.

20. Transformation

The therapist describes a transition or change in stance, perception, or identity.

Participant D: *Our individual treatment (progressed) in three stages. (In the) beginning, I was excited. (In the) middle, when the highest resistance and conflict came, (it was) me running around him. (In the) end, when there was the least amount of resistance, the conclusion (was) resolution and harmony.*

There was a change in my perspective. I was struggling and felt stuck, but through supervision and therapy I got an objective view. I played our improvisation. There was a real connection in there, and we had some really beautiful, tender moments.

Participant B: *The process is containment, holding to interaction, and self-expression; they feel safe this way. The check-in was also containment for them. They check in, they feel safe. It's a structure. They want to share a little bit before they go into the music, or use the voice. They talked about what's going on, what the doctor told them, when they can be discharged.*

Participant C: *That they're in a place right now, moving towards a place where there's more ego strength there, there's more of a sort of footing, (and) that they feel comfortable doing it.*

She had now body wise turned towards the group, she had this look, I'm thinking on her face, she's taking in something here, actively listening. She was holding the egg shaker still, and just kind of tapping it with two of her fingers; showing some willingness to step outside of herself a little bit to meet the group's now more coherent music.

Yes, she came in really pretty strong at the beginning, playing on sort of bursts of egg shaker, then as the group got a little more into it, she actually backed away a little bit, and you could see her sitting back and not playing, but watching and listening to the music that was happening.

She was realizing the potential for using music in a in a manner that perhaps was not what she thought it was going to be, to really be a player in that.

Participant A: *I said "why are you feeling better today"? And then he said "I'm here. Because I'm here". You could take (that) as, I'm here, I'm in the hospital getting help.*

21. Self-Realization

The patient has an awakening to the possibilities of one's potential, individually or in the group.

Participant C: *This idea of how open can the structure still be, while being on task and meeting the needs of the people who are there. As a group they are collectively working to self-actualize.*

I was acknowledging that we just had a genuine musical experience here, proving to myself that there was this (musical experience and) now you all know what we can do here. There was (a) sort of unspoken acknowledgement.

22. Professional identity /theoretical orientation

How the therapist perceives their professional approach as informed by education and professional experience.

Participant A: *You change through the years, because of your experiences. My philosophy working with the population is: it's important to observe and to be in the moment. You have to meet the present needs.*

Participant B: *I use voice a lot. And kind of toning and holding because I did the training with Diane Austin.*

In this day with Maria, she didn't know what was (going to happen). To give them the structure. It feels like the steady thing I do, (to be) helpful.

They saw me as a leader, in that particular group. The patients wanted to know what it is today, and the patient's look at me as a leader, like giving them into things. What are we going to do today? And can we do this, yes they ask me, if we can try this. I am the one to make decisions.

(I gained) a sense of accomplishment and the satisfaction of being a facilitator. To let the patient know that we care.

Participant C: *There's a concept in Nordoff- Robbins that really talks about the idea of interpreting resistance or resistive-ness as just another interactive way of being, essentially, so rather than it being a closed door, it's still a response that can be invited.*

This experience absolutely (affirmed my competence). Going from figuring out what I'm doing to hopefully knowing what I'm doing, you know!

23. External Influences and Limitations

The inherent forces in the inpatient psychiatric environment, or patient's background, that challenges the efficacy of the therapist.

Participant C: *It's funny, I guess, we're going to be talking about resistance to a certain extent, one of the main challenges that I've experienced is having the patients pulled out by the medical staff when we're having a therapy session. You know, can you respect? We are doing a meditation based experience for the next 10 minutes; can we have at least 10 minutes?*

Participant D: *The broken system (is) enabling him to be institutionalized. I'm reacting (feeling angry) to the stigma, which was even exacerbated by his help rejecting (stance).*

I felt really connected with him in the music. All the other times, I was doing psychodrama, all these different interventions, and I wanted to show the psychiatrist that I can fix him and I'm a valid part of the team. I didn't know if they understood the difference between a creative arts therapy and recreation.

I have a lot of anger about how broken our system is here. The narrow focus of the medical system.

Participant B: *That no one is going to come after them, no one's going to try to (hurt) them, because unfortunately that's the way the world (is). Yeah, that's what they are facing in city life, being attacked, being devalued.*

Narrative A

There was a gentleman in his 60s, he is in for depression. There (are) behavioral issues attached to his physical issues, where he has had a stroke but he's very high functioning. There's some impulse (issues), but it's mainly depression. Last week when I first met him, head down, sitting, I set up the group the same way, he was sitting a little farther, a little more on the outskirts. So he was, a little bit, kind of, staying back. Not wanting to be right in the circle where everybody else was, and where I was. He gets frustrated and he gets angry, and he takes it out on himself and others, and that makes him more depressed.

He was very tentative at the beginning of the session (the first week). It was his non-verbal resistance, the way that he walks into the room; his head was a little down. His body was closed, arms crossed, legs inward. He appeared uncomfortable, (I sensed a) passive resistance. He was holding back, he paid attention to other patients when I spoke with them, just resisting me. He was scared to take the first step and afraid to open up.

He didn't give me a lot. He didn't give me a lot of words. His affect did not change, it remained flat. He responded but it was more in a short, not elaborating way. (Later), he's answering in one or two words phrases, while glancing at me briefly when I spoke to him, then looking away. I wanted to meet him where he was, in this low energy place, and try to bring him up a little with the music. I had to make him feel comfortable. To reduce his frustration level, to (get him to) at least accept the environment. To just accept the music process. (On second meeting) I noticed that he remembers me, he elicited eye contact, he initiated hello, and he sat closer to me, (with his) head up. So, you know, that's a win win win in my book. I was pretty calm about it. (While I was) observing and evaluating, I had a sense, a feeling, (of) when to

bring him in (to the group's music). I was concerned with not pushing him to do something that he wasn't comfortable doing.

I tried to get him feeling more comfortable in the environment so he could just accept the music. To let him know that you can be with us in the music and it's ok to just listen. I felt like I had to give him space. I gave him that space at the beginning, to get comfortable, while showing that he can stay here with us, that he's accepted. I knew he couldn't jump in with two feet that day. He wanted to see if I would respect his boundaries.

At this point, I never take things personally. He was testing me by withholding. He showed a little interest, he started lifting up his head a little bit. To me that's a step. It wasn't a lot, but it was something. I noticed that his loosened boundaries were a sign that he was taking a subtle step towards opening up and participating. I know his diagnosis, but I'm not going to let that put me in a box or determine what I do (with him).

He feels validated emotionally, and that is what relaxes him. And that's where (in) the resistance, you see a reduction. How would I play the theme of strength and connection (she asked him)? So I'm giving him the strength, and the connection, and the control. I said "why are you feeling better today"? And then he said "I'm here. Because I'm here". You could take (that) as, I'm here, I'm in the hospital getting help.

You change through the years, because of your experiences. My philosophy working with the population is: it's important to observe and to be in the moment. You have to meet the present needs.

Narrative B

Maria came in 2 months ago with a lot of psychoses, like hearing voices. She also had a lot of paranoia. She didn't want to talk about her family background and all that. She has a son who doesn't reach out to her so.... she was estranged from her family and her brother doesn't want to take her in. In the beginning she didn't want to get into the rec room or activities. She didn't even want to place herself up in the public area (or) in the lounge. She's guarded, she doesn't want to show a lot of herself. She didn't want to share anything. (She was) worried that people (might) find some way to get in here to hurt her. So she doesn't want to do anything. Once her psychosis decreased she tried to come to one of my music therapy sessions. (It) was her first time (that she) joined this type of group. I think it kind of spooked her a little bit.

She didn't sit in the group, she (was) kind of sitting outside of circle. In a way she doesn't want to interrupt. She doesn't want to be disruptive. At that time she doesn't really want to talk about anything, I didn't know where she was coming from yet. Oh, she was also guarded. She doesn't want to share anything. Not only in the creative arts, a lot of different things. She's observing from the outside. Patients with paranoia typically are guarded, and present as suspicious. I didn't feel any transference with her, but she does remind me of previous patients with a similar presentation. We might call it resistance, or guarded.

Shadows. Yeah, a shadow (her presence). (Her image reminds me of) shadows right now. I would say it's like lost. Like a lost someone. You know, from this space.

(There's an element of) socialization. They (are getting to) know each other, and they're (getting) familiar with each other at that time. So when they played music their music was more responsive to each other. Sometimes I feel bad, though. I feel uneasy, in a way. But in a way, I feel it's necessary. In that particular day, right away they know each other. Although, sometimes,

it can be very chaotic musically. Music wise people don't know where to go. It can be a bit frustrating.

I let her know that it was ok, she felt comfortable sitting outside the circle. I used my critical judgement to focus on the other patients, and didn't pay a lot of attention (to her). Of course I would take a look at her a little bit. I focused on the group process in the circle. I think she got it. It was important, not only physical safety, but also spiritual wise. Mentally, they feel safe. To be here and feel supported. For Maria, her resistance, her not wanting to participate (is) more from her illness, and that I would see differently. Okay she doesn't want to be part of this group, but it's okay. She came into the room, and for her that's a big step. Yeah, her resistance was part of the process. I (was able to) work with that.

We already achieved a goal for that week. For that patient, she can come in, she showed up. That's something for her. Deep inside doing that, (I got some satisfaction). (To) help her understand, or to see the possibilities. For that time.

The paranoia feelings are there, what to expect, what's going to happen and all that. So that particular group session she didn't want to participate and she left prematurely. It was ok; I didn't expect her to stay through the whole session. She still had the paranoia. She was coming from a resistant place; I kept my focus on the group.

She accomplished something (when) I convinced her to come in. I was inviting her, the purpose (was) to improve. (By) inviting her into the group I (was) trying to help her socialize with other people. To leave that isolation, and give her the opportunity to see a different perspective of life. Or the possibilities of this cohesiveness, (The) togetherness with other people. I didn't really want to try to show her, but in a way yes. To let her know that we had something going on that day. To have the opportunity to connect with the other people in the group. Maria,

at that moment was a kind of an outsider. She didn't even come out of her room; she didn't socialize with anyone at all. They kind of knew each other for a short period of time (the group), and from my perspective, Maria is probably (feeling) left out in that particular moment.

Yeah, (I'm looking for a way to bring her in and another way looking to give her the space she needs to take her own time). That's the way I see this particular technique. Containment, and for them, that's to get into a structure. In the helping professions, there are moments that I feel very in a similar way (validated). In that day, I was happy for her. (It was just a small step, just coming to a group. It's so easy for some people. But for her she made an effort. And, all the time I talk to her about coming in, and finally she made it. And she saw the possibilities in the moment. She got an opportunity to just be there.

They can get some acknowledgement from other people, some validation. In the end, she really came a long way. Not only coming to all the groups, but also going through a group process. She helped us to achieve that cohesiveness and togetherness and she understood that there is a process to help, giving a steady beat. Then she feels accomplishment.

Okay if you want to come in I can give you more. I actually gave her options. Sometimes they don't know what to do, and they expect that something will happen. They want to make something out of it, or to take something away from the group. That day I provided a way (forward). To provide coping skills to deal with their issues. They were focused and enthusiastic. The process is containment, holding to interaction, and self-expression; they feel safe this way. The check-in was also containment for them. They check in, they feel safe. It's a structure. They want to share a little bit before they go into the music, or use the voice. They talked about what's going on, what the doctor told them, when they can be discharged. In this day with Maria, she

didn't know what was (going to happen). To give them the structure. It feels like the steady thing I do, (to be) helpful.

They saw me as a leader, in that particular group. The patients wanted to know what it is today, and the patient's look at me as a leader, like giving them into things. What are we going to do today? And can we do this, yes they ask me, if we can try this. I am the one to make decisions. (I gained) a sense of accomplishment and the satisfaction of being a facilitator. To let the patient know that we care.

Narrative C

(There) was one female sitting, facing the table on the side. (Her) chair was turned away from the rest of the group. (Laura was) a 17 year old female. (She had) a lot of impulsivity, some Identity issues as well, which I possibly related to the trauma. She left the room in this particular instance, didn't give me a reason, I believe that this was her first day on the unit.

(She) had this preconception of what the space would be, that it was not going to be welcoming, this place where she was coming into, emotionally. She didn't seem bored or checked out. Her facial expression conveyed a sense of alertness. She was looking for something to set her off. She was sitting upright in a very interested (position); there was something that communicated an attentive nature. Her body language, which was very telling, was that she was sort of like one foot in, one foot out. Not just checked out but testing the waters. Taking in what was going on, she was sort of half facing, and she had a response to the question. It was not what she thought would be the ideal response, but it was a response.

I had a pretty wicked headache going into the room, and I didn't when I left the room. I do take something positive from it. Something probably about needing to be outside myself, or

(being) totally open and available to what was going on. I have a tendency to be anxious when I'm thinking of a million things, kind of a snowball effect. When my attention is focused, I'm available to that experience. I tend to mostly feel a sense of challenge or frustration when patients are getting in the way of other patients, when they're kind of disrespectful to one another, or really inhibiting someone else's ability to take from the space.

The (Laura's) attitude represented a certain persona. I knew she was comfortable being a little edgier. So she was wearing a band sweatshirt which helped me out a little bit. This band, 21 Pilots, they're an angsty rap-rock band, so (I tried to) kind of match the... attitude. She didn't seem bored or checked out. Her facial expression conveyed a sense of alertness. She was looking for something to set her off. I almost wonder if that resistive persona is just a part of Laura, not the entirety of Laura, and (just) the first line of defense.

In this specific instance, I did know that Laura had a past history of physical and sexual abuse and trauma. Being able to trust in a space with a male therapist, there are all these dynamics that I needed to keep in mind. I definitely did feel the need to convey that sense of safety. Just (by) reflecting her ideas and rewording them back to her; (I) was acknowledging (that) your emotional expression is okay here. When she left the room, it was probably because she did not feel safe in the space.

Yeah, I think that she is probably testing my response to her putting herself out there, whether it's consciously or not. I'm needing to prove myself to her. On my part, more of a testing the waters kind of thing. Proving that I can hang, so to speak. She probably meant to (challenge me), I have a hard time acknowledging, or finding my own emotional response within that. Once we got some feedback on that, Laura (says), "I'm really agitated". "I just really don't want to be here". She's essentially politely telling me that she doesn't want anything to do with me. Then

we start to talk about well, where is the emotional kind of place that we want to bring ourselves today? I remember her kind of turning towards and saying like, "wow". "Do you know it's going to be loud? Loud, agitation is loud"! That said to me you're in this place that you're perceiving as maybe very negative, but you're actually giving me quite a lot.

It's a multi-layered response. As a person who's not a therapist, (I'm thinking) here we go, agitated. Okay, I get it; no one wants to be here, that sort of thing. As the therapist, I'm getting something here, this is something to be worked with, and so to me, it's a little exciting. I know that therapeutically this is great. She's one of maybe two or three people that outwardly voiced some sort of perceived negative emotion that they needed to put out into the space. Your resistance, if we want to call it that, didn't take away from the group but provided us with a purpose for creating something or exploring something in music.

I did feel challenged in the scenario only because it was a group. Needing to sort of check in with myself at times to say this person's resistance just became the catalyst for this (group) experience. I'm doing things to meet and support them (the group) as well. Right, that's so important because it's the acute setting. I don't always know if I'm going to see that person the next day. In this specific instance, I saw (Laura) today outside of the group and (she) reiterated to me that she didn't need to be here at all, and that does not detract from the experience. It mirrors the verbal interaction in the sense that I want to create that space that she can voice those opinions and then, be flexible enough that I can show (that) we can go there, we can be in that agitation. In this instance, being more accepting of and responsive to it, and willing to see where that takes us. I responded, "alright, okay, it's gonna be loud". To acknowledge verbally that we were going into her music, reciprocating what she was saying. Not just play to where

we're at, where the individuals are at, but to where they were trying to bring it. There was an agreement on this idea of calm something, just a calmer state.

(She) had this preconception of what the space would be, that it was not going to be welcoming, this place where she was coming into, emotionally. (With) that steady rhythm that she can, for lack of a better word, project herself onto (it), put that into the music there, and know that that's her place in the music. Working with adolescents, I have to check my realness, or at times assume a more authoritative stance. I go in and out of it.

It definitely became a transition from leader to facilitator, to sort of blue sky sort of thing. Then, at the very end, I need to come back to provide that closure, acknowledgement that we did something. (To) just acknowledge that on her part (that) she's been sitting there this whole time and fuming, needing to leave the room, coming back in, turning away from people. Not saying alright then you can go, but saying "all right, that is absolutely an understandable way to feel". Being able to share that undesirable reaction. Just validating it and hearing it. In this instance, being more accepting of and responsive to it, and willing to see where that takes us.

I do find that (validating the patient's experience) to be a primary concern. Specifically in this case, I think that trying to explain to Laura the benefit of her being here in this facility, even if I was well intended, would be not hearing her agitation. In validating it, it's allowing for that to begin to move somewhere a little bit. So the potential is for her own self-expression.

My emotional reaction (was), yes! This is good! I'm not trying to hand stuff to people; I'm trying to allow people to get their own something, whatever it is. Making music is in itself a therapeutic experience- being able to channel anxious energy into a more focused place.

Yes, she came in really pretty strong at the beginning, playing on sort of bursts of egg shaker, then as the group got a little more into it, she actually backed away a little bit, and you

could see her sitting back and not playing, but watching and listening to the music that was happening. That they're in a place right now, moving towards a place where there's more ego strength there, there's more of a sort of footing, (and) that they feel comfortable doing it.

She had now body-wise turned towards the group, she had this look, I'm thinking on her face, she's taking in something here, actively listening. She was holding the egg shaker still, and just kind of tapping it with two of her fingers; showing some willingness to step outside of herself a little bit to meet the group's now more coherent music. She was realizing the potential for using music in a in a manner that perhaps was not what she thought it was going to be, to really be a player in that. This idea of how open can the structure still be, while being on task and meeting the needs of the people who are there. As a group they are collectively working to self-actualize.

I was acknowledging that we just had a genuine musical experience here, proving to myself that there was this (musical experience and) now you all know what we can do here. There was (a) sort of unspoken acknowledgement. There's a concept in Nordoff- Robbins that talks about the idea of interpreting resistance or resistive-ness as just another interactive way of being, essentially, so rather than it being a closed door, it's still a response that can be invited. This experience absolutely (affirmed my competence). Going from figuring out what I'm doing to hopefully knowing what I'm doing, you know! It's funny, I guess, we're talking about resistance to a certain extent, one of the main challenges that I've experienced is having the patients pulled out by the medical staff when we're having a therapy session. You know, can you respect? We are doing a meditation based experience for the next 10 minutes; can we have at least 10 minutes?

Narrative D

Larry was a forensic client, so a little background on him- bipolar disorder, came in presenting with severe depression and polysubstance abuse. He came in intoxicated, I believe his main substances of abuse were alcohol and cocaine, but (it) was alcohol that brought him in. Larry had a really crappy upbringing and was on the street. I think his highest level of education was 8th grade, or he dropped out early in the first year of high school and then was part of gangs, and then he got caught up in drugs, and basically since 2005 he has been institutionalized in some form. He really needed assistance socially, he was isolative, (he had this) blunted affect and this inability to really connect. He wasn't very high-functioning and higher abstract concepts were really, really difficult for him. One of the largest areas of resistance that I first encountered was (that) he was not willing to participate. He needed a lot of prompting- so in the groups especially early on, he wouldn't really join, he was isolative. His defenses were just really, really high, and that's where the beauty of music therapy, the creative arts therapies (come in), as you can bypass that. One item, coloring material and drawing, he was very artistic.

It (the assessment) turns into, okay; I'm not going to get that far with this patient now, and I'll try again the next time. He was dismissive or ignored the other patient's references (when reality checking). This is my hand but you're not coming any closer. I can pick this movement with my hands, pushed out with my arm like. This is (a) very defensive kind of thing. He was pushing me away (figuratively). A wall, basically. I feel like, initially (he) was like a wall. In the groups he was one (foot in) and one foot out the door, kind of thing.

What do I do next, what can I draw upon? I know a lot, let's do this, let's do that, it was like boom, boom, boom. I want to try it you know, kind of like spitfire. What else can I experiment with? It was a little exciting, almost. I fed the lyrics to them and then they sang it, I

had them do it in the moment. I love it actually; (it) was beautiful to hear all of them getting into it (songwriting). I was excited. Now we're getting somewhere, now we're starting to use some group dynamics and processing.

They made a song about tacos, very humorous; he was sitting there and just clapping. He said, "I don't like tacos, this song is dumb." But then he participated, and there was a moment at the end where he finally cracked a smile. I smiled right back at him. Because he was smiling, joining in the group, it was like the silliest song, but it's very heartwarming, so everyone was on the same page with that.

Initially I experienced some self-doubt. In that moment I asked myself, why am I in this job? I was confused and uncomfortable. All the time (I have feelings of inadequacy as a musician). We live in New York! Then there's the big area of continuing self-growth.

I felt very sad, I was going to miss him, and I felt very connected with him. I have very fond memories of our connection. There was some regret that it took that long. I wanted to cry, it was a very loving, beautiful termination process.

He probably didn't feel safe enough. Trusted by him? Yes, he was very clear about that in the beginning. I'm telling you my stuff because your (my) therapist (Private music therapy vs. group self-disclosure).

Yes. I know that (proving myself) is a myth, and may not be grounded in reality all the time. I have some Mom issues, a distorted belief in perfectionism.

I was excited. Now we're getting somewhere, now we're starting to use some group dynamics and processing. The reciprocity feeds on one another; I was inspired when he began to work with me (matching his energy, feeling competent). The rhythm is so important. But the

themes come from them; the words come from them, the choice of the tempo. Do you want to sing it; do you want to rap it? (On creating choices)

I realized that I was working way harder than he was in our individual sessions. Sessions flowed a lot easier when I (would) just sit there and do nothing. It was mixed throughout his course of stay (lack of engagement). Then I first noticed that this is an area where we can reach him. That was the work, for him to foster positive relationships. I was trying to help him work on these social skills and letting go of this resentment. That's not what he needed. He needed me to just accept him for where he was at, and be with him in the music. The outcome from our individual work together was that he was learning how to be in a relationship with me.

I would be angry because I put in so much work; he was just like saying "f" it. When I kind of just let go and met him where (he was), I was more able to be a container musically for him. That's a huge part of my orientation. I use the room, body rhythms, or even silence for whatever they bring. I held the space to create optimum conditions for healing; I was bearing witness. Facilitator is a good word; I'm a co-creator with everyone else. I'm going to be that para-dynamic anyway because I'm a staff member and I'm a therapist.

I brought in congas; I was trying to help him, my wanting to fix his anger against these people who assaulted him, to help him express his anger on percussion. I caught that my stuff was getting (in the way). It was very frustrating for me; (I) was coming from a place of fixing. When I was more grounded, and when I was able to catch, you know this tendency to want to prove something, I just saw it as part of him. I was more accepting of where he was at. What actually resonates with me are my therapist mindsets of beginner's mind, or like the client is my teacher, that I'm here as a guide. I'm not here doing the therapy to them, or prescribing something.

I (thought I) needed to get him better and get him out, and that's where the resistance was the most. When I let go of that, we were able to just be with each other in the music. I personally believe that sometimes it's really only the music that is a solace for these clients. Our individual treatment (progressed) in three stages. (In the) beginning, I was excited. (In the) middle, when the highest resistance and conflict came, (it was) me running around him. (In the) end, when there was the least amount of resistance, the conclusion (was) resolution and harmony.

There was a change in my perspective. I was struggling and felt stuck, but through supervision and therapy I got an objective view. I played our improvisation. There was a real connection in there, and we had some really beautiful, tender moments. The broken system (is) enabling him to be institutionalized. I'm reacting (feeling angry) to the stigma, which was even exacerbated by his help rejecting (stance). I felt really connected with him in the music. All the other times, I was doing psychodrama, all these different interventions, and I wanted to show the psychiatrist that I can fix him and I'm a valid part of the team. I didn't know if they understood the difference between a creative arts therapy and recreation.

Discussion

This qualitative research study was conceived as a way to gain insight and knowledge about music therapists' experience with patient resistance by examining the following research questions:

- When music therapists encounter resistance in the inpatient psychiatric setting, what is it like for them?
- How do music therapists manage and utilize resistance in an inpatient psychiatric setting (musically and otherwise)?

Summary of Results

The music therapists interviewed for this study revealed observations, thoughts, reactions and strategies as the resistant experience unfolded in both group and individual music therapy sessions. These music therapists sought to create an atmosphere of safety and acceptance, while moving each patient toward goals related to self-acceptance and socialization. As a result of this process, the patients were reported to have gained a sense of self-worth, an increase in self-esteem, feelings of belonging, and the possibility of hope. These therapists provided insight into the music making and therapeutic processes, while illuminating the considerations that are central to recognizing, meeting, and using the resistance as a tool to move forward therapeutically. As a result, they reported experiencing a wide range of feelings; anger, concern, frustration, confusion, empathy, warmth, satisfaction, and competence. Through the process of recounting their experiences, a deeper understanding of the nature of resistance in music therapy is portrayed.

After reviewing the literature on the subject and discussing it with practitioners, students, and educators in the field of music therapy, I came to the conclusion that the phenomenological research method was best-suited to investigate this subject. At this point in time, there are no phenomenological studies that focus exclusively on the experiences that music therapists have had with resistance in the inpatient psychiatric environment.

In response to my first question, I found that each participant had a unique experience and orientation when describing the phenomenon, resulting in eight distinct themes across all four cases. Each code represents a categorical theme that describes an aspect of the experience, thus creating a single holistic representation of the phenomenon based on the 23 cross-case themes. Many of these themes have been addressed in the existing literature on therapeutic resistance, but are framed, in varying degrees, from a more observational or procedural than experiential perspective. There are eight themes across all four cases that describe valid findings that are representative of the resistant experience in music therapy for the therapist, including;

Recognizing Signs of Resistance; Images of Resistance; Physiological Sensations; Presence; Emotional Connectedness; Feelings in Response to Encountering Resistance; Working to Understand the Patient's Experience; and Sense of Patient's Need for Safety.

In response to my second question, I found that the four music therapists conveyed both similarities and differences in their work with individuals who presented with different needs. While the responses to this question varied considerably, they accurately portray the resistant experience in a comprehensive fashion, with an additional eight themes falling into a progression that describes their process in an acute inpatient environment. Common themes of establishing

acceptance, building trust, and responsiveness to the individual patient's presenting condition, were contrasted by the challenges of leading music therapy groups while remaining flexible in working with their respective clients, including;

Establishing Acceptance and Trust; Establishing Legitimacy; Assessing Therapeutic Value of Resistance; Meeting the Resistance; Anticipating and Meeting Patient Needs; Music For Establishing a Therapeutic Container or Space; Establishing or Changing Role; and Self-Monitoring and Regulation.

As a result of the study findings, 5 additional unexpected outcomes were identified as a result of the music therapy process, and are consistent (to varying degrees) with previously published literature, including; *Validation; Empowerment, Music as a Healing Experience, Transformation, and Self-Realization.*

The remaining two themes provide insight into each therapists' unique approach and influencing factors, including; *Therapist's Professional Identity or Theoretical Orientation, and External Influences and Limitations.*

My initial interest in the subject began as a result of fieldwork in the adult psychiatric ward of a hospital in New York City. Occasionally, a patient(s) would leave after being in the music room for a few minutes. I found myself asking, "Why would he come in, and just walk out as the session was just getting started?" I went on to recognize resistance when a patient did or said something that left me with the question, "what was that?" I found that I was, at times,

perplexed by a patient's actions or musical choices, and decided to investigate the underlying cause of what forces were at play.

Recognition of this phenomenon was recounted as the therapists described their initial impressions. Participant A stated, "*Patients with paranoia typically are guarded, and present as suspicious. She doesn't want to share anything*". Participant D, "*He was not willing to participate. He needed a lot of prompting- so in the groups especially early on, he wouldn't really join, he was isolative. (He had this) blunted affect, this inability to really connect*". These perceptions were amplified, as the therapists spoke of the imagery that they associated with these patients. Participant B, remembering his patient, described her persona. "*Shadows.... Yeah, a shadow. (Her image reminds me of) shadows right now. I would say it's like lost. Like a lost someone. You know, from this space*". Participant D looked away, and remembered: "*A wall, basically. I feel like, initially (he) was like a wall. In the groups he was one (foot in) and one foot out the door, kind of thing*".

Another aspect of the resistant patient is that they are always motivated by the need to protect the self against feelings of vulnerability (Benedikte Scheiby, 2018, personal communication). This need for self-protection is illustrated by Participant B's description: "*She's guarded, she doesn't want to show a lot of herself. She didn't want to share anything. (She was) worried that people (might) find some way to get in here to hurt her*". Participant C described Laura's defended stance: "*In this specific instance, I did know that Laura had a past history of physical and sexual abuse and trauma. Being able to trust in a space with a male therapist, there are all these dynamics that I needed to keep in mind. I almost wonder if that resistive persona is just a part of Laura, not the entirety of Laura, and (just) the first line of defense*". These findings point to elements of resistance that are supported in the previously published literature on the

subject, but also provide insight into the unique experiences of the therapists that are portrayed here.

The themes of providing a sense of safety and acceptance, while creating a group atmosphere of cohesion and support are considerations that are reflected in the literature (Bruscia, 1987; Yalom, 1983, 2005) and set the stage for work with defended patients.

Participant A stated, *“I gave him that space at the beginning, to get comfortable, while showing that he can stay here with us, that he’s accepted”*. Participant B said, *“Mentally, they feel safe. To be here and feel supported”*. Participant A stated, *“I was concerned with not pushing him to do something that he wasn’t comfortable doing. I knew he couldn’t jump in with two feet that day. He wanted to see if I would respect his boundaries”*. Another related consideration in the patient-therapist relationship was expressed by Participant C regarding his non-judgmental and unconditionally accepting approach. *“Working with adolescents, I have to check my realness, or at times assume a more authoritative stance. I go in and out of it. Proving that I can hang, so to speak”*. This consideration is reflected by Alvin (as cited in Bruscia, 1987, pg. 89) when she described a “non-directive and non-authoritarian style which creates an equality in the musical partnership”.

Finding common ground for meeting the resistive stance was described by Participant A. *“I wanted to meet him where he was, in this low energy place, and try to bring him up a little with the music. I had to make him feel comfortable. To reduce his frustration level, to (get him to) at least accept the music process”*. This procedure was echoed by Simkins (in Bruscia, 1987, pg. 370). *“The basic approach is to match the music to the client’s energy level, and then using small increments, introduce the opposite energy level until modulation or balance is achieved”*. Participant C: *“That said to me you’re in this place that you’re perceiving as maybe very*

negative, but you're actually giving me quite a lot. Your resistance, if we want to call it that, didn't take away from the group but provided us with a purpose for creating something or exploring something in music”.

Insight into the therapists way of working is expressed in the following statements; Participant D:” *I'm not here doing the therapy to them, or prescribing something. I use the room, body rhythms, or even silence for whatever they bring”.* Participant C: *My emotional reaction (was), yes! This is good! I'm not trying to hand stuff to people; I'm trying to allow people to get their own something, whatever it is”.* These perspectives reflect a broader approach that leaves room while conveying an expectation of response to keep the verbal or musical conversation open.

Taking the patient's presenting persona and finding a way to use it to engage and ultimately to make music is an element that is central to the process with these patients, and is illustrated by the following statements; Participant B: *“Okay she doesn't want to be part of this group, but it's okay. She came into the room, and for her that's a big step”.* Participant A: *He feels validated emotionally, and that is what relaxes him. And that's where (in) the resistance, you see a reduction.* Participant C: *“Being able to share that undesirable reaction. Just validating it and hearing it. In this instance, being more accepting of and responsive to it, it's allowing for that to begin to move somewhere a little bit”.*

As these therapists described their process in working with each patient, a tendency to frame the evolution of their work in terms of stages emerged. Participant B on providing structure and purpose said, *“The process is containment, holding to interaction, and self-expression; they feel safe this way”.* Participant D summarized it as follows: *“Our individual treatment (progressed) in three stages. (In the) beginning, I was excited. (In the) middle, when*

the highest resistance and conflict came, (it was) me running around him. (In the) end, when there was the least amount of resistance, the conclusion (was) resolution and harmony”.

Another novel outcome of these interviews was the insight into her process as described by Participant D as she recounted her struggle in working with Larry, and the subsequent identification of an approach that was hindered by the countertransference that she carried into her work with him. *“I know that (proving myself) is a myth, and may not be grounded in reality all the time. I have some Mom issues, a distorted belief in perfectionism. I realized that I was working way harder than he was in our individual sessions. I was trying to help him work on these social skills and letting go of this resentment. That's not what he needed. He needed me to just accept him for where he was at, and be with him in the music. I caught that my stuff was getting (in the way). All the other times, I was doing psychodrama, all these different interventions, and I wanted to show the psychiatrist that I can fix him and I'm a valid part of the team”.* These statements reflect the gradual uncovering of her tendency to bring dynamics from past relationships into her work with the patient. The process of bringing the unconscious into the conscious is a form of (negative) countertransference that can be explained as “music that seems out of context with the client’s expression at that moment”, or “music that does not seem to be appropriate from the therapist’s perspective”. This unconscious proclivity is also described as, “musical expressions that the therapist feels pushed into producing” (Scheiby, B. 1998. Pg. 216)

One aspect of the process that became apparent was the necessity to put aside one’s preconceived plans or personal feelings in order to be able to better meet the needs of a patient. In reflecting on her process, Participant A stated: *How would I play the theme of strength and connection (she asked him)? So I’m giving him the strength, and the connection,*

and the control. Participant C, in adjusting his stance, said: "The (Laura's) attitude represented a certain persona. I knew she was comfortable being a little edgier. So (I tried to) kind of match the... attitude". Participant D recounted a change in her approach: "I realized that I was working way harder than he was in our individual sessions. Sessions flowed a lot easier when I (would) just sit there and do nothing. I (thought I) needed to get him better and get him out, and that's where the resistance was the most. When I let go of that, we were able to just be with each other in the music".

There were five themes that related to patient and therapist outcomes that were unexpected at this study's inception, and emerged as the cross-case analysis developed. The power of music to heal surfaced as the therapists summed up their experiences. Participant D said, in a moment of reflection, *"I personally believe that sometimes it's really only the music that is a solace for these clients"*. Participant C: *Making music is in itself a therapeutic experience- being able to channel anxious energy into a more focused place"*. Having witnessed her patient's progress from being a reluctant observer to an integrated member of the group, Participant A said: *"He feels validated emotionally, and that is what relaxes him. And that's where (in) the resistance, you see a reduction"*. After bringing his schizophrenic patient into the process, Participant B alluded to the theme of empowerment: *"She helped us to achieve that cohesiveness and togetherness and she understood that there is a process to help, giving a steady beat. Then she feels accomplishment"*. The observation that there was a transformation in his client's self-perception was echoed when Participant C said: *"She was realizing the potential for using music in a in a manner that perhaps was not what she thought it was going to be, to really be a player in that"*. In reflecting on the progress that the group was making, Participant C also realized that his sense of purpose and accomplishment were both recognized and self-realized:

“We just had a genuine musical experience here, proving to myself that there was this (musical experience and) now you all know what we can do here. There was (a) sort of unspoken acknowledgement”.

Clinical Implications of Findings

For the student of music therapy, or for the less experienced practitioner, the findings in this study may serve to increase an awareness of the phenomenon of resistance as an inevitable element in the music therapy process. The identification of resistance as a “necessary dynamic in effective therapy” (McFerran & Finlay, 2018 pg. 3), and as an element that correlates with more successful outcomes, will provide insight into avenues of approach that use the resistance as a tool to engage the patient in an incremental way. An understanding of these patient-therapist experiences may also serve to inform the therapeutic process for other creative arts therapists, or for any professional in the arts or counseling therapies who is seeking a deeper understanding of working in the field of psychopathology.

This nature of this interaction between client and therapist may serve to inform the clinical relationship in a broader sense, going beyond the initial identification of resistance and the strategies contained herein. By creating a “safe-enough space where an optimal level of challenge at the contact relational boundary” is facilitated, the therapist can “contain expressions of the subjective life of the client, while allowing these expressions to emerge more freely (Atwood and Stolorow, 2014). Through a greater understanding of these dynamics, the music therapist will be better equipped to assess a patient’s current state, and to create a compassionate environment where the relief of distress and dysfunction through the group music experience opens the door for personal well-being and development. This deeper understanding of resistance

enables the therapist to engage at this contact boundary as a better informed and equipped clinician.

It is my expectation that professionals working in the field of music therapy will gain a greater comprehension of the subject through the experiences that are illustrated here, while reaffirming their commitment to an approach that is informed by “a spirit of not knowing” (Benedikte Scheiby, 2018, personal communication). Having sufficient confidence in their own experience and instincts, the most effective therapists put all their knowledge aside, and enter the therapeutic arena with an open mind unhindered by preconception. Being able to approach each therapeutic opportunity as if it is their first, without imposing a preconceived agenda, or feeling the need to prove oneself, are related to therapeutic presence and the not knowing, and are illuminated and contrasted by the accounts of the therapists contained here.

This fascination with the workings of the human mind and spirit are a source of endless complexity and infinite variety; through the examination of this phenomenon, this study may serve to inform and inspire music psychotherapeutic informed music therapists.

Reflection upon Research Process

As a result of this study, I came away with some unexpected outcomes that were beneficial, but at the same time, I was challenged in ways that I hadn't anticipated. The interview process varied considerably from one participant to the next, and followed two different trajectories. The first two interviews were like trying to pry the lid off a container, then peeling away the layers of an onion to get to the sweet spot in the middle. The last two could be described as following the path that was these therapists stream of thought, while pausing briefly along the way: to probe, investigate, and to elicit vivid detail during their recollection of

thoughts, considerations and sensations. While I initially planned for a 15 minute follow-up phone call to clarify previous statements, I found that it was necessary to continue probing and questioning for up to an hour to complete some of the interviews. For the participants who were (initially) more forthcoming, the follow-up was about solidifying ideas and statements that emerged in a somewhat haphazard order, trying to tie related ideas together. For all of the music therapists continued probing resulted in a deeper look into their internal process.

Putting all these ideas and experiences into words was an undertaking that has broadened my ability to articulate what I am experiencing and ultimately has increased my capacity as a listener, an interviewer, and one who hopes to communicate. The process of grouping and ordering these themes with my faculty sponsor enabled me to structure the experiences in a logical order to tell the story that is resistance in music therapy, and provided me with a greater understanding of how to organize information while grouping related ideas in a logical order.

I tend to reflect on the different articulation styles of participants in terms of each person's readiness to share their internal experience. This varied considerably, with two of the participants appearing quite resistant to admitting difficulty, conflicting feelings, or any self-doubt as they sought to steer the conversation away from what was going on with them, and by constantly referring to that which was outside the self. In the process leading up to the interviews, I had the good fortune to make contact with some of New York City's veteran music therapists, as I sought to identify possible participants for the interviews that I had planned. It was during a conversation with one long time supervisor of music therapists in training, that I was told, "a significant aspect of resistance in music therapy is the resistance offered by music therapists themselves" (Anthony Scarpa, 2017, personal communication). This prophecy became a reality, and points towards references to therapist resistance that have been described as "a

narcissistic need for recognition and validation that has not been worked through” (Austin, 1993, p. 428).

Due to the time-limited and transient nature of acute psychiatric care in New York City public institutions, one limitation of this study is that there are only passing references to efficacy of treatment. As a tool of advocacy, the nature of the phenomenological process is effective in providing insight into patient care while uncovering the value of what lies in the telling of each person's experience. These perceptions may inform therapeutic practice in a broader sense, or provide the means to engage the defended person in an individual sense.

Future implications for study in this field of inquiry may include a focus on the group dynamic. In the telling of the stories here, only a few passing references to the other members of the music therapy group were made. Resistance in group therapy is well documented in the context of talk therapy techniques, and it has been my experience that many of the most interesting dynamics that occur in verbally based groups also occur in music therapy. The avoidance of intimacy or the unfamiliar, subgroups that form within the group that shift the balance of power, and the circumvention of the “here and now orientation” could best be addressed by a future study.

Conclusion

I offer this study with the hope that through this examination of resistance in the psychiatric music therapy setting, music therapists and clinicians will find useful insights and inspiration to inform their work with patients. Ultimately, the value of this study may serve as bridge between our individual experience and the collective unconscious: that we draw from the waters of the river of knowledge in the spirit of discovery.

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Appendix A

Link to Raw Interview Transcription with Code Markers

The following link is a google doc that is comprised of the long-form transcription of interviews A through D. It is accessible from any Montclair.edu account.

https://docs.google.com/document/d/1qNFphIylCX2RHySsRDnzVfj_p_qF7lZVPMF4pN2JDH8/edit?usp=sharing

Key to code markers:

A – Participant A

R – Researcher

A1 – Code unit

A01 – Background information

Appendix B

Link to Culled Interview Statements with Code Units

The following link is a google doc that is comprised of the culled statements used as code units from interviews A through D.

https://docs.google.com/document/d/1S3vj5W5kRFLaJKiPR_FKss__daw3f8vvsrV7E0_YnuU/edit?usp=sharing

A – Participant A

A1 – Code unit

A01 – Background information

AP1 – Statement from telephone follow-up