MUSIC THERAPY: AN ETHNOGRAPHIC APPROACH TO
UNDERSTANDING HOW MUSIC THERAPISTS AND ADOLESCENT
PATIENTS COMMUNICATE AND PERFORM COMMUNITY

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DEDICATION

This thesis is dedicated to my lovely grandmother, Katherine Buchaca, who left this world to be in peace while this thesis was being produced. Her kindness toward others, her optimistic nature, and her genuine heart will never be forgotten, and her love for music lives on through me.
ABSTRACT OF THE THESIS

Music Therapy: An Ethnographic Approach to Understanding how
Music Therapists and Adolescent Patients Communicate and
Perform Community
by
Melanie Katherine Frontz
Master of Arts in Communication
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Adolescents with developmental disabilities, neurological limitations, emotional
issues, and behavioral issues are particularly stigmatized in today’s society. Feeling
pressured to fit into society’s mold of “perfect” causes these individuals to further alienate
themselves when what they really need is to experience a sense of community, which can
only occur through communication. Various complementary and alternative medicine
practices (CAMs) are being used with these populations to improve their quality of life and
their well being. One CAM that is particularly successful with adolescents is music therapy
(MT). This research was designed to investigate how communication within the context of
MT encourages community construction for adolescents. Through ethnographic qualitative
methods, I have found four patterns that lend to community construction: the communication
of (1) connections, (2) togetherness, (3) autonomy, and (4) identity/expression. By using
specific communication strategies, music therapists enable these four patterns to surface, and
thus, encourage community construction both on a micro level, being the group within the
music therapy session, and on a macro level, being the community at large. The micro
community building motivates and encourages individuals to integrate into the larger
community, ultimately affecting society as a whole.
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CHAPTER 1

INTRODUCTION

As I peered down the staircase of our memory-laden home, an uncanny sensation made its presence known. Everyone was quiet; no one spoke a word. Instead, we walked outside and quietly approached the car. The same mesh lavender dress that I wore on Easter that year was gently gliding with each wisp of the wind. My mother said softly, “Get in the car, hunny,” her hair glistening in the sun. But this day there would be no Easter egg hunt, no candy-filled baskets, and no smiles. I remember the emptiness on their faces, and thinking they must be hot wearing all that black. And I remember not remembering him, except from one vague reminiscence two years back: the first day I saw my father, my hero, shed a tear. In that moment, very confused, I glanced at my father, and asked, “Who’s that, daddy?” He was staring at an unshaven man with worn out clothes clumsily making his way down the sidewalk. “Mel, that’s your uncle.”

The rest of the memories of my father’s brother come from narratives passed down by the family and from dreams that I have only recently come to separate from reality. Just one memory, just one artifact: his tarnished classical guitar. The mellow sounds that came from that six-stringed instrument were warm and rich and the nylon strings felt like silk on my fingers. The few blemishes in the orange wood, and the beautifully decorated rosette around the sound hole made this guitar all the more unique. I don’t know if my uncle was attached to that guitar, if he carried it around with him on the streets, or if it just sat untouched in Grandma and Grandpa’s home. All I know is that the moment I picked it up and started to sing, something inside of me woke up. I felt a whirlwind of emotions: happiness, sadness, peace, and depth; but most importantly, I felt I had escaped, before I could even comprehend the meaning of that word. This was the beginning of my realization that music could speak meaning into my life. It could help me communicate my identity when I felt lost. Not only did music communicate to me, it gave me an avenue through which I could communicate with others. This was the start of my discovery of music’s ability to heal. Little did I know,
the realization that music could have such power would be an important component of my mental and emotional health throughout my adolescence and beyond.

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Many of today’s adolescents are subconsciously searching for some kind of escape just as I was. They may be looking for a way to be free from difficult times in their lives, or maybe they are searching to feel unbound from labels and stigmas. Some of these teens will find healthy avenues to achieve this, others will not. But what many of these teens will do is detract themselves from other people in search of escape, when what they are really lacking in their lives is a sense of community in a place where they can be free from pressures to fit society’s mold of “perfect.” This sense of community can only be fostered through communication. At a young age, I found music to be a great vehicle of expression and a way to communicate my feelings and thoughts to others. Being drawn to music is not uncommon for adolescent populations as music is a large part of their daily lives already (McFerran, 2010). Literature in the area of the therapeutic use of music with adolescents is scarce in comparison with the need that is growing to better understand this phenomenon. Therefore, this thesis is focused on the communication that occurs in the music therapy context with adolescents, specifically those with developmental disabilities, those with emotional/behavioral problems, and those who are otherwise at-risk, and how that communication lends to community construction in this setting.

In this chapter, I give an overview of complementary and alternative medicine practices and therapies that are being used on a daily basis worldwide to help patients with illnesses. Complementary and alternative medicine practices and therapies will be referred to as CAMs throughout the remainder of this paper. After the brief overview of CAMs, I discuss the interconnectedness of music and communication and how this link makes music therapy a particularly effective CAM strategy with certain populations. Music therapy will be referred to as MT throughout this thesis, and music therapists will be referred to as MTs. Following the section on the interrelatedness of music and communication, I describe how MT developed as an official field because of music’s effects on cognition and motor skills. Finally, I illustrate how community is performed and constructed in MT settings.
COMPLEMENTARY AND ALTERNATIVE MEDICINE

As I sat in the waiting room at the MT center, I tried to understand where Libby was coming from. Last week all she wanted to do was give me hugs, and today she didn’t even want me to come into the clinic to play music with her and the therapist. Her father explained apologetically:

Sorry, Melanie. She has been having difficulties this week; she has been really tired and not able to pay attention at school. We put her on a new medication, to help minimize the seizures. It seems to just be wearing her out. She is still getting them, the seizures, four to five times a day. But we are going to give this medication another couple of weeks and see if it works. If Libby could just talk, our lives would be really different. When she was born, the doctors told us we could put her in a facility and go on our way. We didn’t opt for that, obviously. We won’t give up. No stone goes unturned. (Field Notes, 10/06/2012)

During this unexpected conversation with Libby’s father, I learned about her diagnosis of hemiplegia, a very uncommon disorder characterized by a weakness of half of the body and consistent seizures. He told me about the struggles they had had experimenting with a variety of medications attempting to minimize her pain and optimize her normality. I learned of the constant hospital visits where the doctors kept their distance from Libby and the family was told there was nothing they could do. And I learned of the love this family has for their child that they would go above and beyond the expected efforts to make sure their daughter is at peace, to make sure that “no stone goes unturned.” Day in and day out, Libby’s parents must watch their child grow up with a disorder that has no cure. Libby’s father watches children speak to their parents using simple phrases like, “I need to go potty” or “I’m hungry,” and wonders what it would be like if Libby could do the same. They have been forced to find alternative ways to communicate with Libby with signs and gestures, which is still difficult because only one of her hands is functional. They have learned to express their love and care for Libby in a way that goes beyond just verbal words. Many families and individuals suffer with similar struggles.

***

When conventional medicine has no cure for an individual’s particular case, some families decide to turn to CAMs, such as Libby’s father. Health communication discourse on CAMs is expanding as more research is growing in support of such therapies and their positive effects on the well being of patients with varying limitations and illnesses. Despite
the growth of commutation about CAMs, they are not as widely used as they could be. Part of the reason this is the case is because of some barriers that limit physicians’ inclinations to promote CAMs (Tasaki, Maskarinec, Shumay, Tatsamura, & Kakai, 2002). In a study of cancer patients and their use of CAMs, Tasaki et al. (2002) found that patients perceived that physicians would oppose or be indifferent to their use of CAMs. They also found that patients expected physicians to respond negatively when presented with the possibility of seeking out a CAM practice. It is precisely these types of barriers that limit discourse on CAMs as effective practices. Because the use of CAM is growing, it is important that we continue researching the efficacy of such practices with various populations (Brown & Patel, 2005). This thesis will add to this growing area of health communication literature. It will contribute to the discourse about CAMs by presenting ways in which MT as a CAM is particularly effective with adolescents with developmental disabilities, neurological limitations, and emotional/behavioral issues.

The very nature of the words “complementary” and “alternative” illustrates the way many people view CAM practices, though this has the potential to change. The National Center for Complementary and Alternative Medicine (NCCAM), part of the National Institutes of Health (NIH), is an agency that focuses its efforts on investigating the utility of complementary and alternative medicines within the healthcare setting (NCCAM, 2008). NCCAM (2008) “defines CAM as a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine” (p.1). Conventional medicine, in this context, refers to medicine practiced by medical doctors (M.D.’s) and other doctors of osteopathic medicine (D.O.’s). These include psychologists, nurses, and physical therapists (NCCAM, 2008). On their website, the NCCAM (2008) explains that CAMs could potentially develop into practices that are more commonly accepted and utilized.

There are a variety of types of CAMs being used to advance the health of patients with a range of diagnoses and illnesses. The three categories of CAMs presented by the NCCAM (2008) are the following: (1) natural products, (2) mind and body medicine, and (3) manipulative and body based practices. Natural products utilized in the first category are supplements such as vitamins and herbs. Some of the mind and body medicine practices include (but are not limited to) meditation, yoga, and acupuncture. Finally, some practices
that fall under the third dimension of CAMs are spinal manipulation and massage therapy. Although a few examples of each category have been presented here, there are multiple other CAMs not mentioned above that are used on a daily basis nationwide to promote health. Although these three dimensions have been presented as distinct categories, the NCCAM (2008) points out that oftentimes certain practices fall into more than one of the aforementioned categories, making the boundaries imprecise.

Research has confirmed the overlapping nature of the dimensions of CAMs. Many different types of CAMs are being used to treat a variety of symptoms and problems. Often, patients attempt multiple complementary and alternative therapies for the same problem until they are healed or their well being improves. In a survey of 1,035 randomly selected individuals, Astin (1998) investigated the most common types of CAMs being utilized for a multitude of health issues in an attempt to discover the reasons patients decided to use complementary and alternative medicines. He found that in the past year, 40% of the participants involved in the study used some type of alternative medicine. Respondents reported being treated for many different health issues by a CAM including chronic pain, anxiety, sprains, muscle strains, chronic fatigue syndrome, addiction, headaches, and arthritis. Across each health problem, different forms of CAMs were utilized, the most common being lifestyle diet, chiropractics, relaxation, and exercise/movement.

CAMs are not only used to cure/alleviate seemingly common health problems such as headaches and anxiety. They are also being used in more serious cases. For example, patients with cancer often engage in CAMs to reduce their symptoms (Daykin, McClean, & Bunt, 2007). In addition, individuals with developmental disabilities like autism spectrum disorders (ASDs), cerebral palsy, attention-deficit hyperactivity disorder (ADHD), mental retardation, Down’s syndrome, learning disabilities, and visual impairment are using CAMs for their symptoms (Brown & Patel, 2005). The fact that these practices are effective in reducing, and at times, eliminating symptoms for particular impairments and limitations is one that should be more widely known throughout society. As is apparent, the umbrella that is “complementary and alternative medicine practices and therapies” encompasses a variety of applications, including those that incorporate the arts.
THE INTEGRATION OF ARTS THERAPIES

As previously mentioned, the use of CAMs with individuals with developmental disabilities is increasing (Brown & Patel, 2005). It is possible that the increasing use of these practices is related to the chronic and incurable nature of such diagnoses. Although there is no “cure” for cerebral palsy, for example, there are practices and therapies outside of conventional medicine that can improve the quality of life of individuals with such a diagnosis. Simply because an individual has an incurable diagnosis does not mean that they lack typical desires such as building relationships and having hobbies. Unfortunately, in many cases because of their diagnosis, it is hard for them to find places where they can meet these desires especially once they get older and out of the school system. This is partly because individuals with developmental disabilities, either physical, neurological, or both, carry a stigma around with them that they are outside of the “norm.” However, organizations that provide arts therapies can be a space where these individuals do not experience this stigma and they can begin to belong.

Individuals with physical disabilities, sometimes referred to as PWDs (people with disabilities), are just one group of people who are stigmatized from society. Harter, Scott, Novak, Leeman, and Morris (2006) argue that “the identity construction of PWDs occurs amid a number of socio-historical narratives that compete to reify hegemonic norms” (p. 6). PWDs are constantly at odds with the idea of normality versus abnormality because they are in a hegemonic society that prefers normality. However, some organizations have offered CAMs to help PWDs find a place where they can belong in society.

The various organizations that have used art-related CAMs to help individuals with disabilities have made a great impact on many lives. One organization that has accomplished this is Passion Works (Harter et al., 2006). Passion Works is an art studio that works with clients that have a variety of developmental disabilities, mostly mental retardation and cerebral palsy. The majority of the clients depend on a wheelchair for movement. The level of illness varies from client to client. The staff artists act as caregivers and also help the clients in their artistic creations. Through these artistic creations, the clients are able to express themselves. Harter et al. (2006) conducted an ethnographic research of this organization and discovered that clients were able to challenge their “cultural alienation” by entering into conventional hobbies. Through this they could “explore, clarify, and critique the
dialectic of selfhood and social participation” (p. 19). This organization enables PWDs to express their rights and identities through artistic representation (Harter et al., 2006).

Harter (2009) mentions other organizations that have also used art as a therapeutic tool with other types of populations. For example, MD Anderson Cancer Center Children’s Art project enables children who suffer from cancer to express their experiences through art. In addition, Victoria Marks, a UCLA professor and choreographer, facilitates classes and workshops in which US soldiers who suffer from posttraumatic stress disorder (PTSD) (Joseph, 2008). These soldiers are able to share their experiences through dance (Joseph, 2008). Finally, Quinlan and Harter (2010) describe an organization called Dancing Wheels, which incorporates dancers in wheelchairs in their performances. All of these organizations are using art as a complementary therapeutic method to reach certain goals that involve their patients and their audiences.

Dance, painting, and drawing are not the only types of arts therapies being utilized as complementary and alternative medicine therapies. Music as therapy is also used with many individuals in the context of education and health care. Music is used as a CAM therapy to treat those with attention-deficit hyperactivity disorder (Chan, Rappaport, & Kemper, 2003), autism spectrum disorders, cerebral palsy, mental retardation, Down’s syndrome, and visual impairment (Brown & Patel, 2005). In addition, music is used to help treat anxiety (Astin, 1998). A more comprehensive explanation of circumstances in which music is being used as a CAM therapy will be presented in future sections. First, I will provide the relationship between music and communication, which will help further establish the reasons for the growing use of MT as a CAM practice.

**Musical Communication**

Part of the reason why music is such a popular form of complementary and alternative medicine has to do with music’s communicative properties. Music and communication are interconnected and readily apparent in human interaction. Consuming music is part of people’s daily lives (Larsen, Lawson, & Todd, 2010), as is communication. Throughout daily interactions, many times we are communicating with, through, and about music, sometimes without even realizing it. Because of these connections, research is growing on the use of music as a CAM practice.
Humans are always sending and receiving messages whether intentionally or unintentionally. Listening to, performing, and composing music are all ways of sending messages to ourselves intrapersonally, and to others interpersonally. Many times, humans are prompted to listen to music in order to relieve stress, change their current emotional state, emphasize their current emotional state, or feel enjoyment (Juslin & Sloboda, 2010). In this sense, by choosing to listen to a certain type of music, we are sending ourselves messages regarding our emotional state. These messages may be in support of how we currently feel, or they may be attempts to transform our wellbeing. Larsen et al. (2010) discovered that the consumption of music is a building block in the construction of peoples’ identities as it communicates meaning and safety to its listeners. The type of music we decide to listen to and associate ourselves with is a way of communicating our own identities to ourselves and to others (Larsen et al., 2010). For example, by saying we listen to classical music, we may be trying to convey an identity of someone who is sophisticated or elegant. Or, if we say that our favorite genre of music is heavy metal, we may be communicating an identity of rebellion or deviance. All of these examples of consciously choosing what type of music to listen to and what genres to associate ourselves with are illustrations of how musical decisions are communicative in nature.

In addition to listening to music, performing music is an act of communication. When playing music for others, the musical choices made are strategic. Performers choose particular songs, instruments, and musical styles in order to communicate particular emotions to their audiences depending on the context. For example, when playing a song that is sad and heartfelt, a performer is most likely not communicating to the audience that s/he wants them to stand up, clap and dance. Or, by choosing a funny song to play, a performer may be attempting to convey a humorous character and to encourage laughing and enjoyment. Playing music with others is also a communicative process, whether in front of audiences or just with two people. Members of a musical group are constantly communicating what parts to play next, and how to play them. They may do this with nonverbal cues, or they may just let the music do the communicating and all follow along with one another. The fascinating nature of music, when purely instrumental, can be a form of nonverbal communication, conveying messages and expressing emotions that may not be possibly expressed by words (Crowe, 2004).
Communication is one of the main purposes of music (Crowe, 2004). Studies have shown that it is likely that music was actually one of the, if not the first type of human communication (Crowe, 2004). Some researchers even go as far as arguing that all human communication is musical (Trevarthen, 2002). Inskip, MacFarlane, and Rafferty (2008) suggest that music is itself a language, and those who enjoy it do so through musical experiences. Hargreaves, MacDonald, and Miell (2005) argue for a model of musical communication in which both the sender (performer) and the receiver (listener) are involved in the interpretation and making meaning of the message. As Bruscia (1998) describes:

What we are able to communicate in music, we are not always able to communicate in words, and vice versa: and the ways in which we are able to communicate musically we are not always able to verbally, and vice versa. Essentially this means that musical communication stands on its own without parallel or overlap, and as such cannot be replaced or superseded by any other modality of interaction and communication. (p. 64)

Hargreaves et al. (2005) propose a closer look at “real life situations” in which certain individuals are engaging in musical activities while interacting with others in order to expand on this model of musical communication. This review of literature will do just that. Expanding on this model can help encourage further discourse about the use of MT in medical practices. A closer look at the origin of music and the history of MT will better illuminate how it is being used as a CAM practice.

**Music in Ancient Times**

Music affects every person differently, depending on the context, the type of music, and the emotional, physical, and spiritual state of the person. The same song may get someone excited or motivated in one context, yet it could enhance one’s sorrow in another. What many of us are not consciously sentient of is the fact that the soundtrack keeps playing. Nearly every day, music lingers in the background of our busy lives, existing in the shadows, yet communicating to us in ways we are unaware of. There is power in music.

Humans have known this power for thousands of years. Medical doctor Edward Podolsky published a book in 1939 entitled *The Doctor Prescribes Music: The Influence of Music on Health and Personality*. From even this dated piece of literature, readers are reminded that the healing power of music is no new phenomenon. The first chapter touches on how many ancient cultures utilized music in a variety of situations with the specific goal
of healing. He mentions that the ancient Greeks, Hebrews, and Egyptians employed music in
cases of mental and physical illness. Podolsky (1939) claims that the first culture to employ
music “as a regular therapeutic practice” (p. 3) was the Greek culture, including the famous
philosophers Zenocrates, Arion, Sarapander, and Celsus. Celsus, in particular, “pointed out
different methods of influencing the minds of the insane, depending upon the nature of their
mania” (p. 3). This prevalent use of music is likely due to the fact that the ancient culture
believed that mathematics, sound and numbers were all interconnected and were the means to
gaining important divine knowledge (Crowe, 2004). In ancient times, music was said to calm
the minds and bodies of the people.

There are many stories and myths about music’s effects on people’s emotions in
ancient times. Podolsky (1939) explains that although calm music has a soothing effect on
its listeners, the opposite can also be true. He describes how Antigenides played a “fiery”
song that was full of emotion, causing Alexander the Great to brutally attack surrounding
individuals out of anger. Podolsky (1939) continues to illustrate how, while music holds
power in many circumstances, some people are more affected by music than others. The
remainder of the first chapter describes specific instances where music was used to heal in
certain cases, including those involving tarantula bites, addictions, fevers, anxiety in
operating rooms, and feelings of depression. He goes as far as to say that music deserves full
credit for the victory of many wars throughout history.

Regardless of whether or not these myths and stories from so many centuries ago hold
true, the following is clear: there has been debate regarding the power of music for many
years. What we also know is that every human culture has had music in some form (Merriam,
1964). Music does not aid humans in the most common survival goals such as alimentation
and shelter (Crowe, 2004). What does happen to have “survival benefits,” however, is
communication (Crowe, 2004, p. 3). In ancient times, music may have been used as a vehicle
of healing and as a “cure” for certain health issues (Podolsky, 1939). But modern MT has
shifted in its principle constructs. Modern MT is more concerned with the participation of the
patients with the therapist, which is referred to as ‘musicing’ (Elliott, 1995). ‘Musicing’ is
the idea that music is something we do by interacting and performing with others (Elliott,
1995). It is both cultural and social in nature (Elliott, 1995). So, in modern MT,
communication is the less pretentious objective (as opposed to curing a patient, which was
the goal in music usage in ancient times) (Ansdell & Pavlicevic, 2005). Since ancient cultures, music has been a form of expression and communication that nearly all humans have the ability to take part in (Crowe, 2004). Yet, due to the lack of sufficient scientific research, the use of music as a vehicle for healing is not as widely utilized in contemporary medicine as it could be. MT is still viewed in many cases as a bonus luxury as opposed to a necessary component of therapeutic practices that can truly improve the overall well being of people’s lives.

**AN OFFICIAL FIELD EMERGES**

Because music was used in diverse contexts for a variety of purposes in ancient times, eventually an official field emerged. Physicians began ruminating about the use of MT in Western medicine in the mid-1700s (Crowe, 2004). Among some of the authors of the first pieces regarding music and its possible medicinal effects on the human body were Louis Roger (who published a book in 1748) and Richard Brown (who published a book in 1729) (Crowe, 2004). Beginning in the mid-1800s, however, the idea of music having potentially medicinal properties was widely discarded by a public who was accustomed to more scientific medicine (Crowe, 2004). Nonetheless, the use of music in psychotherapies increased (Boyce-Tillman, 2000). In addition, music was being employed as treatment for those with mental disabilities, visual impairments, and auditory impairments (Solomon, 1981). In the United States, MT began developing more widely in the 1940s during WWII, and growing larger after WWII when veterans were returning from war (Crowe, 2004). Two universities developed degrees in MT in the 1940s, (now-called) Michigan State University in 1944 and the University of Kansas in 1945.

The National Association for Music Therapy (NAMT) was eventually established in 1950 (American Music Therapy Association [AMTA], 1998). By 1968, the NAMT had conducted ample research and proudly published a journal entitled *The Journal of Music Therapy* (Crowe, 2004). As research on MT was expanding, it does not come as a surprise that the American Association of Music Therapy (AAMT) was established in 1971 pursuing comparable objectives (AMTA, 1998). Following such accomplishments, the Certification Board for MTs (CBMT) was created in order to establish official credentialing programs for MTs (AMTA, 1998). Finally, two of the organizations merged (the NAMT and the AAMT)
in 1998, and the AMTA was established (AMTA, 1998). As of 2004, there were more than 5,000 certified MTs in the United States (Crowe, 2004). Many of these organizations have their own definition of MT and subsequently a specific notion of what such a job entails. The specific areas in which MTs are currently being employed will be discussed below, but first I will provide a working definition of MT.

Providing a precise definition for music therapy is challenging. Many organizations have developed a variety of definitions regarding MT, its goals and its components. One working definition that seems to encompass multiple definitions reviewed for this study is presented by Bruscia (1998): “Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change” (p. 20). Depending on the needs of a patient, MTs employ specific interventions keeping in mind the main goal: health (Bruscia, 1998). It is also important to note the emphasis on music experiences as opposed to simply the mention of music (Bruscia, 1998). Patients and therapists are ‘musicing’ (Elliott, 1995) during MT sessions. This means that simply involving music in a therapeutic session is not the strategy of a music therapist. Engaging in music experiences is much more productive. According to this working definition, MT patients experience music in a specific way, whether that is through the composition of music, the listening of music, or the playing of music, in order to reach their therapeutic goals (Bruscia, 1998). The following section elaborates on what ‘musicing’ is doing with a multitude of patients and a variety of diagnoses.

**Music Therapy in Action**

Music therapy is being used in a variety of settings and has had some surprising results with patients. It is used to assist individuals with developmental disorders such as cerebral palsy, autism spectrum disorder, Down’s syndrome, and attention-deficit hyperactive disorder (Brown & Patel, 2005). It helps them with social skills, behavioral skills, and motor skills (Brown & Patel, 2005). Music as therapy has also been used to help alleviate the symptoms of posttraumatic stress disorder (PTSD) (Bensimon, Amir, & Wolf, 2007). Bensimon et al. (2007) found that after drumming, MT patients with PTSD had more self-control, were more open, felt a sense of belonging, began to be closer and more intimate
with each other, and were able to access painful memories as well as express rage in a healthy way. Music therapy also helps the mood of those who are depressed (Maratos, Gold, Wang, & Crawford, 2009) and it is used to reduce addictive behaviors of individuals with substance abuse issues (Dingle, Dingle, Gleadhill, & Baker, 2008) and eating disorders (Dokter, 1994).

In addition to the abovementioned uses of MT, it has also proven to improve the mood, increase the verbalizations and body movement, and reduce the anxiety, pain, and shortness of breath of patients in palliative care (Gallagher, Lagman, Walsh, Davis, & LeGrand, 2006). Dementia patients also benefit from MT (Koger, Chapin, & Brotons, 1999). Koger et al. (1999) conducted a literature review of research concerned with MT and dementia patients. They found that MT was in fact an intervention that had success in enabling patients to improve their cognitive, social, and emotional skills. Music therapy enabled patients to maintain active participation and involvement with others. Finally, their behavioral problems decreased due to MT interventions. Another group of patients that have been benefiting from MT are stroke patients who have acquired speech aphasia and apraxia (Hurkmans et al., 2012). MT is used in order to help stimulate specific functions of the brain related to the (in)ability to speak (Hurkmans et al., 2012). As is apparent in these two paragraphs, MT is used in many settings to help with a variety of symptoms, many of which are communicative in nature.

Trevarthen (2002) argues that because all communication is inherently musical, communicative limitations may also be mended through the use of music: “(Music) has the capacity to give emotional companionship, and to heal, because it supports intrinsic, neurobiologically founded needs for qualities of human communication that are organized within musicality, ‘in time’ with the mind” (p. 25). Because of the connection between music, communication, and the brain, MT is a successful way of helping many different individuals. As it is still considered a complimentary/alternative medicine, it is not as widely used as traditional approaches. However, there are a number of reasons why MT is particularly successful with a variety of populations, including the role of the brain and the body during musical experiences, which will be expanded upon in the following section.
**Music’s Effects on Cognitive and Motor Skills**

Those who suffer from many of the developmental disabilities and neurological limitations presented above have cognitive limitations and struggle with motor skills. Music is especially effective in tapping into both of these areas in the therapeutic setting. The following paragraphs will explore how music affects the brain and body, and in turn affects our communication.

The brain is a complex organ of the nervous system that reacts in intense ways to musical phenomena. What many people do not know is that when humans listen to music, many different parts of our brain are stimulated, as expanded upon by Wieser (2003). He explains that rhythm stimulates our cerebellum, and musical melodies and harmonies activate our temporal lobe (Wieser, 2003). Our right frontal lobe and orbitofrontal cortex are stimulated when we begin to perceive consonant music (Wieser, 2003). When we perceive dissonant sounds, it is the right G. parahippocampalis that is activated (Wieser, 2003). Finally, in order to discriminate pitch, we use our planum temporale (Wieser, 2003). Music is unique from other modalities in that it is able to stimulate so many parts of our brain, which is one of the reasons why it is so successful as a CAM practice.

The act of listening to music, though seemingly simple, is actually a complicated physiological process. Crowe (2004) goes into extreme depth regarding the different ways that MT is able to help people with both early and late cognitive skills. Early cognitive skills that can be developed through music are sensation (sensory responses), perception (of a sensation), discrimination (comparing perceptions), and concept development (categorization of perceptions). Higher cognitive skills that can be accessed through MT are thinking and reasoning, behavior, motivation, learning, memory, intelligence, creativity, imagery, language, speech, and consciousness. While not every patient will be able master all of the above skills simply by attending MT sessions. Music is nonetheless beneficial in helping to improve cognition. Music therapists, based on the needs of a patient, assess which of those needs are the strongest and alter their interventions accordingly. Performance of music also utilizes particular parts of the brain, particularly ones that send messages to the body (Crowe, 2004), which will be discussed in the following paragraph.

Performing music draws on complex processes (Crowe, 2004). Those making music must be aware of their body position and posture in order to physically be able to produce
sound (Crowe, 2004). In addition, they must employ proper kinesics to cause their body to move, including their muscles, joints, and bones. Finally, they must be able to enact the “kinesthetic imagery” they have created (Crowe, 2004). That is to say, they must think about and put into action certain movements in order to project the particular image they are attempting to project by their performance.

Music affects other parts of the body as well, such as blood pressure and heart rate, primarily because of the specific rhythm a song may have when being listened to or played on an instrument (Crowe, 2004). Music therapy can aid those with motor rehabilitation needs because the tempo in music causes our bodies to move, at times subconsciously (Crowe, 2004). In addition, going back to the motivational aspect of music, it can be used in physical therapy to energize patients, as well as to distract them from any sort of discomfort they may be feeling because their bodies are partly focused on the rhythm and tempo of what they are hearing (Crowe, 2004). The effects music has on the brain and body are very important to the use of music as a CAM therapy and practice. However, there is more to music than these two aspects. The following section will discuss music’s effects on the particular population on which this thesis focuses, adolescents.

**Music with Adolescents**

Although the effects that music has on the brain and body are undeniable, there is an emotional aspect of music that allows certain populations to have experiences that they may not have with any other agent. This association makes music a complementary therapeutic method particularly successful with these populations. Music’s effect on human emotions makes MT unique from other medical practices that do not affect people at that deeper emotional level. Therefore, MT can be and is utilized to help individuals with a broad variety of illnesses that affect the brain, the body, and emotions, including mental illnesses, psychological illnesses, neurological illnesses, and physical illnesses.

One group of individuals with such illnesses that has been beginning to guide more recent literature on MT is adolescents. The number of publications per decade that focus on adolescents, including publications in academic journals, books, and Masters theses, has grown from 11 in the 1970s, to already 67 in the 2000s, which is still a small number considering the importance of adolescent health (McFerran, 2010). Music therapy literature
centered on adolescents has focused on those with disabilities, mental illnesses, emotional/behavioral problems, and those at-risk (McFerran, 2010). Whether neurotypical or not, all adolescents seem to have a deep bond with music (McFerran, 2010). In addition to this, they are in a phase of their lives in which they are beginning to question the world around them and form their own opinions about life that will shape the people they become (McFerran, 2010). Because music plays such a large role in the life of an adolescent, yet literature in this area is lacking, this particular thesis will focus on adolescents in MT, specifically those with developmental disabilities, those with emotional/behavioral problems, and those at-risk.

The stigmatized populations discussed at the beginning of this chapter, including those with developmental disabilities such as Down’s syndrome, autism spectrum disorder, cerebral palsy, and mental retardation is an ideal population in which to study MTs’ communication because these populations respond particularly well to MT as opposed to other CAMs. Though their diseases manifest themselves physically and neurologically, there are other inevitable symptoms suffered by those with neurological disorders including psychological, social, and spiritual effects (Butler & Zeman, 2005). These symptoms should not be overlooked when researching neurological disorders. Butler and Zeman (2005) argue for a “‘bio-psycho-social’ approach to illness” (p. i31), which identifies not only the symptoms patients suffer biologically but also the psychological and social effects that are caused by a disease that on the surface seems purely biological. With this type of approach, “we become less likely to neglect the treatable psychological origins of many physical complaints. . .and the treatable psychological consequences. . .of much physical disease” (Butler & Zeman, 2005, p. i31). This is not to say that all physical and neurological diseases can be cured at the psychological level. What it does suggest, however, is that although some disorders remain incurable, there are complementary and alternative medical therapies that can alleviate symptoms suffered by patients even if simply at the quality-of-life level.

Many MT interventions have goals more concerned with the well being of individuals on a psychological and social level rather than an observable cure for a particular disorder. Therefore, interventions with at-risk adolescents who have depression, substance abuse issues, or behavioral problems may be more similar to those used with adolescents with developmental disabilities than would be initially expected. One of the main ways in which
both of these groups of individuals relate is in the sense that they are both “outcasts” from the community by being stigmatized groups. The use of MT and the communication of community could help these individuals create community with each other, and potentially encourage them to integrate into the community at large, which is expanded upon further in the next section.

**COMMUNITY CONSTRUCTION**

The previous subsections have been a condensed overview of how music affects the brain and the body, which in turn affects our communication, both verbally and nonverbally. The implications of these interconnections go beyond the individual self and affect the society at large. Some recent MT researchers have made a shift from focusing solely on neurological aspects of MT to socio-cultural aspects (Ruud, 2004). When MT began emerging as an official profession, therapists were more concerned with one-on-one treatment than they were with outside cultural and social forces, which are the very forces that plague their patients each and every day (Ruud, 2004). More recently, however, the MT field is expanding its horizons as MTs are acknowledging that illness often goes beyond medical disabilities and disorders (Ruud, 2004). Illness may begin as a simple diagnosis with medical treatments, but oftentimes disempowerment can not only enhance an illness (Ruud, 2004), but perpetuate it. MTs are beginning to see that music is an important tool that can aid in giving power to the powerless and making visible the invisible (Ruud, 2004). These researchers argue that conceptualizing MT as solely one-on-one therapist-patient interactions limits the contributions MT can give to the broader community. Those researchers who have made this shift and are now focusing on MT as a communicative process of creating community within a community have begun a movement called Community Music Therapy (CoMT). The term Community Music Therapy was coined by Gary Ansdell and Rachel Verney in 2000 (Pavlicevic & Ansdell, 2004).

These particular researchers are not denying the neurological effects of music. Music’s effects on the brain are undeniably important, including within CoMT. But, looking at Community Music Therapy can give us an idea of the other mitigating factors that contribute to therapy and healing. In addition, sometimes, neurological disorders are immutable. Does this mean that MT would not be effective for people with these conditions?
CoMT research would suggest that MT and its possible contributions to society go beyond neurological effects. Music Therapy has the potential to build community within a group of people.

Community, as a term, is extremely broad. When we think of community, many of us may think of a group of people like our neighbors. Or, we may think of our actual city or town. Ansdell (2004), in his chapter on theoretical perspectives of CoMT, provides an overview of the various definitions and conceptualizations of community. All of these definitions, he argues, essentially make up three categories. One way communities are often defined is as “communities of place,” which refer to geographical groups of people. Second, communities are defined as “communities of hope.” “Communities of hope” are groups of people pursuing common, utopian ideals. Ansdell (2004) suggests that hippies and religious extremists could fit into this category. Finally, he presents “communities of interest.” These are groups that emerge from people’s common crafts or common political values. The category of “communities of interest” is similar to Wegner, McDermott, and Snyder’s (2002) idea of “communities of practice.” Wegner et al. (2002) focus on the idea that communities are groups of people that have a shared domain, a specific structure, and set goals. All of these conceptualizations of community, however, fail to address the construction of such a phenomenon. Considering the process of community construction is important in order to assess the effectiveness of various communities. This construction occurs through communication. After presenting the many ways communities are often conceptualized, Ansdell (2004) argues that community, contrary to many previously suggested definitions, is more of a process than a place. Other researchers have acknowledged the ongoing nature of community and have focused on community as a continual communicative process. One particular body of literature focuses on “communication communities,” which are constructed by individuals’ engagement in specific communicative actions like discourse and cooperation, verbally and nonverbally (Ansdell, 2010; Delanty, 2003).

The question remains, how do we define and conceptualize community in the context of Community MT? Many of the CoMT researchers have argued that a “one-size-fits-all” definition of CoMT would in fact be limiting of the many opportunities CoMT practices may lend to the broader society (Ansdell, 2003; Pavlicevic & Ansdell, 2004). They suggest that one single definition cannot possibly be all encompassing of every cultural context (Ansdell,
2003; Pavlicevic & Ansdell, 2004). Therefore, in conceptualizing CoMT, it is essential to acknowledge each specific socio-cultural context. Ansdell (2003) illustrates that CoMT promotes the resistance of a strict model that claims to fit every context. Instead, therapists should let the music and the client’s needs do the leading (Ansdell, 2003). What Ansdell (2003) is suggesting is that each cultural context would involve differing communicative processes that would lend to the construction of community.

Although much of the CoMT researchers resist a discrete, cohesive definition of community, for the purpose of this study, I will provide readers with the overarching dimensions of community that previous literature has highlighted in order to illustrate which aspects of community this particular thesis will focus on. Community Music Therapy literature has consistently demonstrated a range of ideas that can be split into a few main components of community formation. These dimensions will be particularly pertinent to the rest of this paper, as they will illuminate what I focus on in my interactions with participants who are primarily adolescents with either psychological or neurological limitations and their MTs. I provide more details about this in Chapter Two.

Each dimension of community discussed below seems to be a tension or balance because the process of community building is not simple and straightforward, but rather complex and multifaceted. The first dimension of community that is present in CoMT literature is autonomy versus togetherness. Recall that CoMT researchers focus on community as a process rather than a present state. The dimension of autonomy vs. togetherness, or individualism vs. belonging, is a continual tension that is negotiated in community formation. Community construction is a process in which groups of people are constantly growing and changing. This process can sometimes contain tension (Ansdell, 2010; Delanty, 2003). Ansdell (2010) illustrates that the construction of “communication communities involve(s) the active search for belonging, understanding and communication in often unpromising circumstances” (p. 45). These “unpromising circumstances” or tensions can be complex. One of these apparent tensions in community building is the encouragement of individualism yet togetherness (Ansdell, 2010; Delanty, 2003). Being both communal yet expressing a unique identity is the liminal space that characterizes the process involved in a building community. Ansdell (2004) argues that this balance between autonomy and togetherness is, in fact, the primary goal of community construction. Individuals within a
community must feel like they belong to the group, but that they are also able to be independent when outside of the group. The community should help build an individual’s self-confidence so that they can more effectively communicate independently. This particular tension is important when considering MT communities.

A second dimension of community within literature is the balance between being private and public. Music should not be contained in the private sector, but it should permeate throughout society (Pavlicevic & Ansdell, 2004). Pavlicevic and Ansdell (2004) refer to this as the “ripple effect.” This is the effect that describes how music and MT may start in one, rather small context, but expand to further saturate a larger context. It is important to note that CoMT does not encourage a complete fade away from individual therapeutic sessions that encourage privacy. There are times when MT can and should be individual and when it should be public (Pavlicevic & Ansdell, 2004). Pavlicevic (2004), in her experiences with a non-profit organization in South Africa called Thembalethu, presents a three-stage program of MT. This program suggests that the three phases in a setting where music is used as the vehicle of healing are as follows: “Individual music therapy,” “Group music therapy,” and “Workshops, visits, concerts, and learning opportunities” (p. 52). This goes along with the idea of the “ripple effect” (Pavlicevic & Ansdell, 2004). The idea is that the process of transformation begins with an individual and a therapist, and eventually should permeate out into the wider geographical community.

The third dimension of community, and potentially the most complex of the four dimensions mentioned here, is the performance of identity. While not necessarily a tension, this dimension still involves balancing and negotiating. Communities do not just exist and come to being on their own. These communities must be performed through communication (Ansdell, 2010; Delanty, 2003). By perform, Delanty (2003) and Ansdell (2010) are not referring solely to typical concert-performances with a physical stage and audience. Performance is used in the typical sense when referring to musical or staged performances. But, the term perform is also used to express Goffman’s (1959) idea of “all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants” (p. 15). Goffman (1959) compares life to a stage in arguing that “life itself is a dramatically enacted thing” (p. 72). Essentially, the idea here is that we are the performers in our everyday interactions with others and in these interactions we choose to enhance certain
aspects of our selves while omitting others, whether consciously or subconsciously. Through these communicative performances, others come to view us in a certain way, and we in turn view ourselves in a certain way.

Performance of identity, in this sense, plays an essential role in the construction of community. When building community in CoMT particularly, performance is used to refer to both performances in the theatrical sense, and performances in the “life is a stage” sense. Performance has a clear intertwine with MT insomuch as those engaging in MT are instructed to play certain instruments and sing certain songs in the form of a musical performance. But there are other performances that sometimes get overlooked. Aldridge (2001) suggests that we are all performed human beings in the world, so our mental, social and physical states are performed phenomena. This includes our mental, physical, and emotional health. Through MT we are able to see enactments of health through musical performances (Ansdell & Pavlicevic, 2005). Ansdell and Pavlicevic (2005) illustrate how MT is a means through which individuals may perform health because music is the medium through which they are able to begin to mend communicative limitations.

So through these musical performances, patients are able to express their limitations, but also potentially repair them. This performance of identity within the process of community construction can be empowering, humanizing, and can give voice to the voiceless, which brings us to our fourth dimension of community construction.

In this context of CoMT, the fourth essential dimension of community is the creation of a healing environment. While our third dimension, performance of identity, may be the most complex of the four dimensions, this dimension of creating a healing environment is possibly the most difficult to achieve. A combination of the first three dimensions, and whether all of the tensions are successfully negotiated, determines whether or not a healing environment is created, and to what extent. This healing environment is often where transformation may occur.

All of the above dimensions can be summed up by one term: communitas. Communitas is a term is helpful in understanding all of the negotiating balances that come together so that transformation is made possible and a healing environment is achieved. Communitas is a term developed by Turner (1974) and is used to describe “situations of being-inside, being-outside, (and) being-together” (Ansdell, 2004, p. 79). It refers to the
desired mode of a community, one that opposes stagnancy and embraces the procedural nature of community. As Ansdell (2004) describes, “Communitas is a way of being-together that functions to regenerate a group or institution” (p. 79). Encouraging revitalization within a group setting has benefits for the group as a whole and each individual member as well. Pavlicevic and Ansdell (2004) suggest that communitas in the context of CoMT “combines the notions of connection, changing identity, liminality, and transformation,” (p. 28). Essentially by nature communitas is a process of transformation.

Above I have presented four particular dimensions I find relevant to the conceptualization of community as it presents itself in this paper. First, community construction includes the tension between autonomy versus togetherness. Second, community construction must stress the private, yet public nature of communities. Third, the performance of identity is present and enacted within the process of community construction. Finally, with all of this negotiation and balancing, a state of communitas and a healing environment is made possible.

In short, MTs have a goal of not only communication with patients, but of playing a role in this “value system which links music to the wellbeing of people and society,” (Ansdell & Pavlicevic, 2005, p. 194). Music Therapy sessions may be one-on-one, or they may be group sessions. They may begin as individual sessions and later permeate into the form of community performances. Regardless of the type of session, building a sense of community is central to the therapeutic process (Boyce-Tillman, 2000). As Ansdell and Pavlicevic (2005) illustrate, “Music Therapists are trained to understand the process of musical communication, and to use music as a medium and a tool for initiating or enhancing interpersonal or social communication through developing musical companionship and musical community” (p. 193). Adolescents who suffer from neurological or psychological limitations are especially stigmatized in today’s society, and therefore, particularly in need of a community in which to belong. They are constantly dealing with being treated as “sick” or “abnormal” by those around them. Many of them have communication limitations that perpetuate their alienation from society. However, just like Power Works is able to help those with physical disabilities to perform “the personal in the public sphere” (Harter et al., 2006, p. 7) and cultivate connection and autonomy all through the use of art, other organizations can and are using music as a medium to accomplish similar goals with adolescents with
psychological and neurological limitations, developmental disabilities, and behavioral problems. Although very effective with adolescent populations, MT is still underused and under investigated in contemporary medicine and in today’s society as a whole.

**RESEARCH QUESTION**

It is apparent through this review of literature that the concepts of music, communication, and community are deeply intertwined on many levels. Therefore it is of no surprise that research in these areas is growing. These concepts unite to foster certain goals while dealing with tensions. In order for MTs to be successful in constructing community with their patients through the use of musical communication, they must embody the many roles of friend, authority-figure, therapist, confidant, musician, and researcher. Meanwhile, patients perform their limitations or disabilities as unique individual expressions while attempting to belong. This is a beautiful and complex process that should be expanded on in future research on MT, performance studies, and communication. This research will be designed to begin this exploration by answering the following research question.

RQ: How does the communication within the context of MT encourage community building for adolescents?

The following chapter will discuss how ethnographic methods will be utilized to answer these research questions.
CHAPTER 2

METHODS

Music as therapy, like music itself, is more than the sum of its parts. We can gain some understanding, some reasons how and why music can be therapeutic, but reducing this process to only small, measurable effects does not explain what is really happening. Music therapy must be looked at as a whole process in all its frustrating, beautiful complexity.

--B.J. Crowe

After sharing my original pieces of music with people, sometimes they begin to inquire about the process of writing a song. They might ask something like, “So, how does it work? Do you write the lyrics first or the music? Or is it the tune that you start with, and then add the guitar part?” They seem to want it to be comprised of three easily explicable parts: melody, guitar, and lyrics. Interestingly, a fellow musician has never asked me this question.

A lover of music knows of the complexities involved in the conception of a new original piece. For a passionate composer of music, the creation of a new song is not a simple three-step process. Instead, it is inspired, maybe by another song, maybe by a person, maybe by an experience, or maybe by a dream. This inspiration could cause a melody to emerge, or a set of lyrics. All of the parts could come together at once, or a song could be in the making for ten years and still never have all of the parts desired by its composer.

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Songs are not static; they may change and evolve over time. Just because an artist records a song does not mean they will never revisit it and make additions or newer versions. There is no one way to create a song. Research from an interpretive approach can be viewed similarly. Although patterns emerge and some of the steps of the methodology are consistent throughout interpretive research, each researcher understands a specific phenomenon in a unique way. Often, we want to simplify experiences and place them nicely into a series of boxes to make sense of things, when in reality maybe what we should do is not only accept the complexity of a certain phenomenon, but embrace it. Although each interpretive perspective may be unique, each approach should also have rigor and relative precision.
Similarly, a song’s melody should be in the same key as its chords, and its rhythm and beat should be consistent. An interpretive researcher should follow rigorous guidelines in order to ethically represent a phenomenon. The following chapter will describe the methods used for this research study. First, I will explain the paradigmatic approach that drives this research and the use of qualitative ethnographic methods. I will then provide readers with a description of the site, the observations, and the interviews that will be conducted. I will conclude with an explanation with how the data was analyzed and is represented in my final piece.

**PARADIGMATIC APPROACH**

I approach the topic of MT from a pluralistic interpretive perspective. This perspective will be the most valuable in understanding all of the “frustrating, beautiful complexity” described in the quote presented at the beginning of the chapter (Crowe, 2004). Scholars have been arguing for such a perspective for many years, particularly in the realm of MT. Aldridge (2005) argues for an interpretive perspective with “emic” qualities when studying MT, or rather, inductive research methods as opposed to deductive research methods. Earlier in his career, Aldridge (2000) argued for a pluralist stance when looking at research on therapies. This stance, which originated in studies of theology, is the idea that not one person or group can claim complete comprehension of the divine (Aldridge, 2000). In MT, there is no one person or group that can claim complete comprehension of the “truth” of MT (Aldridge, 2005). In both examples, no one can assert hegemony (Aldridge, 2005). In order to gain a wider depth of knowledge of MT, researchers coming from a variety of disciplines must communicate their narratives to one another so that this merging of “various understandings” (Aldridge, 2005, p. 16) may begin to paint the picture of this therapeutic method. These various understandings must be co-narrated and interpreted by researchers, therapists, patients, and musicians to gain some knowledge and understanding.

By communicating our understandings of the phenomena that surround us, we as researchers are able to co-create, with our participants, the meanings of the narratives that are emerging before us. Aldridge (2005) argues that what is missing in clinical research is a discipline that explores various avenues existing that enable researchers and therapists to communicate their evolving ideas to others and express the meaning of the development of
research. These avenues could be just as “artistic as they are scientific” (Aldridge, 2005, p. 17). Music therapy is typically scrutinized from medical perspectives (Aldridge, 2005). From a scientific perspective, the human body is classified in as normal or abnormal, and then manipulated when excessively deviating from the “norm.” The problem with this narrowed view of disease or illness is that “disease becomes a category like any other rather than the unique experience which it is” (Aldridge, 2005, p. 18). Because scientific research focuses on quantitative methods to understanding medicine, this poses a risk of overseeing important factors of the unique variance of experiences in certain contexts. Especially when considering neurological disorders, diseases, and limitations, each individual’s case is unique and should be treated as such (Aldridge, 2005). By ignoring this uniqueness that is apparent in the numerous distinctive neurological limitations and developmental disabilities that strike thousands of individuals each year, researchers could ironically threaten the reliability of their work. This thesis will not ignore the artistic aspects of MT, but will embrace them. In the sections below I will explain how aesthetics was explored throughout the entirety of my methodological approach, from my participation during observations, to my data representation. Meanwhile, I paid close attention to the individuality of each participant involved.

Instead of standing far away from our “subjects” when investigating such a rich and complex phenomenon such as MT, we as researchers should consider getting closer to the human beings with whom are engaging and who we subsequently label as our participants. As Aldridge (2005) explains, standing far away from our participants is not the goal here: “We have pretended too long, in a perspective loaned from natural science, that somehow we can stand back from what we do” (p. 28). Tillmann-Healy (1996) explains this in her autoethnographic account of her struggles with an eating disorder: “Physicians and therapists keep readers at a distance. I invite you to come close and experience this world for yourself” (p. 80). Scientific investigations of medical phenomena such as MT are functional and valuable in that readers learn statistics and measurable facts. However, in these examinations a patient is merely a number, a fact, or a piece of insightful information. I do not attempt to stand far away from my participants and observe them from a distance, but to engage in therapy sessions with them, and get to know their unique situations. The ways in which I engaged in therapy sessions are described in the section entitled “Site.” I also do not want my
readers to be kept at a distance. I hope that this study will be inviting and bring its readers close. This is further explored in the “data representation” section of this chapter.

Music therapy should not be removed from its context (Aldridge, 2005). Research on MT, in addition to being scientific in some cases, should also explore artistic avenues because it is aesthetic in nature. Alternative forms of “assessing” MT research and “presenting” MT research should be considered, regardless of the disciplinary approach, whether it is psychology, anthropology, communication, education, sociology, or some other discipline interested in looking at MT (Aldridge, 2005). Looking more closely at the context as a whole helps readers to fully comprehend the idea that each patient is an individual, with unique personalities and personal needs.

**QUALITATIVE ETHNOGRAPHIC METHODS**

In order to fully understand the complex and multi-layered process of the communication between a music therapist and their patients, qualitative methods will be the most valuable. There are many benefits to qualitative research, particularly when attempting to make sense of a certain phenomenon in a way that is rich and encompassing of all of the senses. In this study, qualitative methods are employed from a pluralistic interpretive perspective, as researchers who fall under this paradigm desire to uncover what is co-constructed between knowledge and reality (Tracy, 2013). Conducting qualitative research aids researchers in comprehending various complexities within specific contexts, complexities that could be overseen or completely omitted when conducting similar research quantitatively (Tracy, 2013).

This study in particular is an ethnographic study. Ethnography is a type of qualitative research characterized by full immersion in a specific culture (Tracy, 2013). The word “ethno” refers to a culture of people, while the word “graphy” is the act of writing and describing (Tracy, 2013). So, ethnographers, by the nature of the word, devote themselves to writing about a particular culture to better understand it. By immersing themselves into a particular context, ethnographers are able to observe and better understand a variety of unique features of that culture which could be aspects such as rituals, artifacts, and relationships (Tracy, 2013). I fully immersed myself in the MT context, specifically spending large amounts of time with the therapists, including before and after MT sessions. Geertz
(1973) describes the goals of ethnography as follows: “to draw large conclusions from small, but very densely textured facts; to support broad assertions about the role of culture in the construction of collective life by engaging them exactly with complex specifics” (p. 28). By repeatedly watching the MTs in their employment, as well as interacting with them and their patients as a “play participant,” expanded upon below, I had the opportunity to see many different angles of what occurs both during sessions, as well as behind the scenes. The bonds created when researchers immerse themselves into a specific cultural group are important when considering key research data such as self-disclosure (Tracy, 2013). A participant may feel more inclined to share personal experiences when interacting with a familiar face.

SITE

The clinic was fairly small. Upon entering the clinic, I was greeted by a delightful girl in her early twenties with a huge smile on her face and Christian rock music playing in the background. “Are you Melanie?” As she gestured for me to sit, I began to observe my surroundings. The room was bright with teal walls and florescent lighting. Flyers were hanging on all of the walls advertising upcoming events hosted by different non-profit organizations, like the Project for Autism (a pseudonym). There were toys and children’s books on the small tables around me.

Shortly after, I was invited by the therapist to join her in the back room, where they hold daily sessions with patients. Hanging on hallway walls toward the back room were guitars of all shapes and colors: a red one, a blue one, an electric, an acoustic, each one unique, just like the patients that come into this clinic daily. Entering the room where the sessions occur, I was immediately taken back to my years in preschool. Perfectly labeled cubbies filled with toys, instruments and books covered the left wall; 16 perfectly symmetrical cubbies. The teal walls had children’s art projects displayed proudly for visitors to see. Beige, round lamps dangled from the ceiling, and a miniature table sat in the corner with its miniature chairs. A plethora of musical instruments were placed throughout the room. Next to the back wall there was a full drum set, draped with a beige-colored sheet. A keyboard leaned against the right wall. Two colorfully painted djembe drums sat in the other corner. Suspended above the piano were three black and white photos side by side, one with
the picture of a drum, one with a hand playing a piano, and one with a classical guitar. The room felt inviting and welcoming. This is exactly what I was expecting.

***

This research was conducted at the California School of Music Therapy (CSMT) (a pseudonym). This center works with children and adults of all ages who suffer from a variety of physical and neurological limitations. The most common limitations include autism, Down’s syndrome, strokes, Thomas syndrome, and dementia. The center has a total of approximately 200 patients, the majority of whom attend/participate in weekly sessions with one or more therapists. There are three full-time therapists employed at this particular center, and periodically interns and part-time contractors will accompany them. Each session is approximately one hour long. These sessions can be one-on-one, or can be in groups of up to about 15 patients at one time. Many of the patients who are children also attend summer and spring camps, which are usually four days where children are engaging in MT activities for about four hours each day. Most of the patients who are adolescents have other opportunities to interact with each other out in the community through various programs and nonprofit organizations. Most of the sessions take place within the walls of one of the official CSMT buildings (there are two total). However, there are sessions that take place in retirement homes, actual homes of patients, and other venues like schools or churches. Most of the performances and recitals put on by the patients take place in outside venues and coffee shops, so as to accommodate to larger audiences. This is a private center not funded by governmental organizations. However, the center does partner with a variety of other organizations that share the goals of helping children and adolescents with developmental disorders and making progress and change.

**Observations and Field Notes**

Fieldworkers in qualitative research collect a variety of forms of data in order to yield the richest possible results. Some of these data forms include brochures, e-mails, dialogues, and photography (Tracy, 2013). All of these types of data were collected on site, the goal being a comprehensive representation and understanding of the community created within the CSMT. The majority of the data for this study, however, was collected through participant observations. Please see Appendix A for the observation guide, and Appendix B
for informed consent forms for observations. These consent forms were given to therapists, as well as to parents of minors. During therapist-patient sessions, I engaged in activities playing the role of what Tracy (2013) refers to as a “play participant.” In this particular role, expanded upon in the following paragraph, I conducted observations while also taking part in many of the activities during sessions. For example, each therapy session varies in its organization depending on the goals of the particular patients. However, all sessions with adolescents include music playing, music listening, and music composing. The individuals are taught through music specific social skills, behavioral skills, motor skills, and speech skills. When they were singing during a session, I sang as well. When they were dancing, so did I. When they were composing or songwriting, I helped them. In other words, I was essentially playing the role as the therapists’ assistant, participating and helping out wherever needed, as opposed to being solely an observer. By becoming a part of the culture, I was able to relate more fully to the patients, and I had the benefit of being part of the group as opposed to an outsider so they did not feel uncomfortable having me there.

The benefit of being a play participant is that I had more of an opportunity to become connected to the environment, both emotionally and physically (Tracy, 2013). As Tracy (2013) explains, “Play participants are able to go beyond reports that rely on the five senses of what they see, hear, taste, touch and smell, to what they also intuitively feel” (p. 109). As a play participant I was able to interact with my participants on a deeper level and consequently come to better understand their therapeutic journey as a process. In addition, playing the role of a play participant encouraged the patients to act as they normally do during sessions, and reduced the possibility of a shift in behaviors due to a new body in the room. During these sessions, on-site note taking (or “raw records” as referred to by Tracy, 2013) was minimal. Therefore, so as to not rely solely on “headnotes” (Lindlof & Taylor, 2011), audio recordings were taken with the permission of all participants. These recordings were useful when reproducing field notes.

My fieldnotes elaborated on all of my raw records, headnotes, and recordings, and were produced within 24 hours of the sessions. The fieldnotes were descriptive and reflected on the occurrences during the session, as well as my own reflexivity regarding my own personal experience with music as a therapeutic phenomenon. A total of 77 hours of
participant observation were utilized for this study, although not all 77 hours were with the same population.

Before beginning the writing process of this thesis, I did not know which population would be the focus of this research. Therefore, the observations I conducted were of MTs with children, adolescents, and seniors. These included one-on-one sessions and group sessions. After narrowing the scope to adolescents, I attended band practices with one therapist and two or three adolescents, and jam sessions with other volunteers, adolescents with developmental disabilities, and MTs. More details about these jam sessions will be presented in Chapter Three of this thesis. Most of the observations used for this study were of patients that I observed weekly and biweekly, though some one-time observations were utilized as well. I also observed four guitar classes with teenagers with behavioral problems, although the instructor was not a certified music therapist. These observations were only used as background information for music as it is used therapeutically for at-risk youth.

**INTERVIEWS**

I also used interview data for this study. The three MTs at the CSMT were interviewed two times each, once at the beginning of the study, and once at the end of the study. By interviewing the therapists twice, they were able to elaborate on progression that was occurring with their specific patients. In addition, towards the end of the study, they felt more comfortable with me on a more personal level because of the time we spent together during sessions. Therefore, the final interviews were more informally conducted. Please see *Appendix C* for my interview guide, and *Appendix D* for the informed consent for interviews. These interviews were one-on-one, face-to-face interviews. I also had a lot of casual conversations and e-mail communication with the therapists at the CSMT because of the amount of time I spent at the center volunteering and observing. Some of these conversations were utilized in the data analysis process, discussed below.

Further interviewees were recruited by “snowball sampling” (Tracy, 2013). I asked the three therapists at the CSMT if they knew of any other licensed therapists that they thought would be willing to take part in the study. The new therapists were contacted via e-mail, and were then interviewed in person or via Skype. A total of 12 interviews were conducted for this study, six interviews of the three therapists at the CSMT, five interviews
of therapists from other centers, and one interview of the guitar instructor for the at-risk teens. The interview data from the guitar instructor is not referenced in the results section of this thesis because he was not a board certified therapist. The interview with him was only utilized for background information although I do discuss some practical implications in Chapter Four inspired by my interview with him.

The official interviews that I conducted were a combination of “informant interviews” (Lindlof & Taylor, 2011) and “narrative interviews” (Tracy, 2013). Informant interviews are intended to better understand a specific context from an interviewee who is particularly experienced in that scene and can provide the interview with extensive information (Lindlof & Taylor, 2011). Narrative interviews are more open-ended and interviewees are encouraged to share their own stories as opposed to giving short responses to questions (Tracy, 2013). I began the interviews in a more structured fashion, progressing into the narrative portion of the interviews toward the end of each meeting. Informant interviews usually need to take place in a relationship that has already been developed as the informants should have already developed trust with the researcher (Tracy, 2013). Over the course of my research, I volunteered at the CSMT for a total of 13 months. I was able to develop close connections with the MTs, so these informant interviews were attainable. In addition, because the MT community in San Diego is very tight-knit, even the interviews with the therapists I had never met before were informant interviews. We were able to talk about the different programs and therapists around San Diego as if we already knew so much about each other. All of these interviews helped in solidifying background facts and information about the therapeutic relationships and processes that I was observing.

The narrative portion of the interview had a more unstructured organization compared to informant portion of the interviews. I asked the therapists to tell stories about their experiences and elaborate in detail as much as possible. Although I do not view narratives and stories as synonymous, the word “story” was still used to explore the narratives of the therapists because participants are generally not aware of the scholarly term “narrative.” I used “story” as more of a colloquial phrase that the participants would understand. For the purpose of the remainder of this paper, I will describe how I conceptualize the two distinct terms. A story has a beginning, middle, and end, usually with a climax or conflict, and some sort of cessation. It usually focuses on one particular event or a limited number of related
events. A narrative, on the other hand, is more wide-ranging, can span several years and can consist of multiple stories. It may have a traditional beginning, middle, and end, but sometimes it does not. The narrative portion of the interviews was very important for this study because narratives played a primary role in the data analysis. Narrative interviews helped me to fully grasp the narrative nature of therapeutic relationships and gave therapists an opportunity to more fully open up and share their experiences. (See Appendix A for interview guide).

All interviews were audio-recorded. After the interviews are completed, they were transcribed in order to prepare for data analysis. These transcriptions yielded a total of 153 double spaced typed pages, size 12 font.

**DATA ANALYSIS**

One of the main factors of the data analysis of this study were the narratives that were told, created and understood by all participants involved, myself included. The narratives that are utilized in this study are not only the narratives told to me by participants, but the narratives that came to life throughout my fieldwork process. Narratives are a customary way in which all cultures communicate understandings (Aldridge, 2005). Aldridge and Aldridge (2002) argue for an approach entitled “therapeutic narrative analysis” when studying therapeutic relationships, particularly MT relationships, understanding the importance that narratives hold within the context of therapeutic methods.

This approach is characterized by the following steps: (1) identifying the narrative, in which the researcher identifies all of the components of the narrative including the characters and plots involved, (2) defining this narrative within the context of other narratives, in which the researcher compares the narrative with other narratives being told, potentially across disciplines, (3) generating categories, or noting the patterns that shine through the data, and (4) clarifying the “research narrative,” or identifying the importance of these patterns as they apply to research. This last phase will not be expanded upon below because it will be discussed in Chapter Four of this study, which will explain the implications of such patterns as they relate to the context of communication, MT, and research as a whole.

As opposed to solely focusing on therapeutic narrative analysis throughout the entire process of data collection for this study, therapeutic narrative analysis helped guide the
analysis portion of this study. Guided by therapeutic narrative analysis, I combined my field notes, interview transcriptions, personal diary entries, photos, e-mails, and brochures in order to write out the narratives. These included narratives that each of the therapists offered, as well as my own autoethnographic narratives, further discussed below. For an example of one narrative, Zoe, one of my participants who works with children, seniors, and adolescents, was the first therapist whose sessions I observed. For her narrative, I combined my interview transcripts from both the first and second interviews, all of our e-mail communication, the notes about the stories she told me before and after sessions, and my field notes that were written out after my sessions with her. Throughout the writing process, I kept in mind the Geertz’s (1973) idea of thick description. Geertz (1973) explains that cultures are extremely complex and in attempting to understand them we must take into account every side of the story, and every description of the context.

The second phase in therapeutic narrative analysis is defining the specific narrative from the data. In this case, the data included observations, fieldnotes, and interview transcriptions, within the context of other narratives. This is where I engaged in what Tracy (2013) refers to as an “iterative approach.” This suggests that researchers not only focus on the emerging aspects of the data, but also on other existing research, including the theories and models that drive that research (Tracy, 2013). By comparing my data to research that already existed in MT and communication, I was able to contrast theories and models to my raw data, identifying gaps in explanations of meaning and affirmations of existing research. This sort of etic/emic variation yields results with more depth and richness when compared to results that use a more narrowed approach.

For the third phase of data analysis, I identified patterns through coding. Coding is defined as “the active process of identifying data as belonging to or representing some type of phenomenon” (Tracy, 2013, p. 189). All of the data was printed out in hard copies, and I first engaged in primary cycle coding. This is the process by which the researcher inspects the data and uses phrases or terms that encapsulate the core of what is being presented (Tracy, 2013). These terms were general and were manually written on the hard copies of the data sets in the margins. Some of the terms included were the following: humor, comfort, motivation, connection, expression, individuality, power, group cohesion, communication, closeness, intimacy, and togetherness.
Once these terms or phrases were all written out directly on the data, I wrote them all on a separate sheet of paper and began to search for terms that were synonymous or related to group them together. Terms and phrases that related to one another were highlighted in certain colors to begin to color-code the patterns. Some of the terms that were joined together, for example, were “expression” and “individuality,” “closeness” and “intimacy,” and “group cohesion” and “togetherness.” Each of those pairs were color coded as the same color on the data set.

Then, I separated each color from the other. I physically cut out all of the green portions of the pages and grouped them together, and did the same with the blue, yellow, red, and orange. Following, I read through all of the data for each color and began to contemplate potential overarching patterns. This is called secondary cycle coding (Tracy, 2013). After much reflection, I came up with five overarching patterns that answered my research question: autonomy, connections, motivation/encouragement, togetherness, and individuality. Next, I began to reflect on the coding process in order to ensure that I was completely honest and thorough with my readers for how the specific patterns in my research were determined.

DATA REPRESENTATION

After coming up with my main patterns, I began contemplating how to represent my results. Because my research question focuses on the construction of community, I knew a significant percentage of my results would discuss the jam sessions I attended because they seemed to highlight the communicative patterns related to community building the most. The music therapist who spearheaded the idea of the jam sessions sent me the grant application she used to apply for funding (See Appendix E for the complete grant application). After printing it out, I was able to locate my five patterns throughout the application. However, one of the five patterns, motivation, seemed to be throughout the entirety of the schedule from beginning to end. It seemed as though motivation and encouragement were actually a part of all of the other four patterns. So, I discovered that motivation and encouragement were actually communicative strategies used to promote the four other patterns. Therefore, I decided to remove this as one of the four overarching patterns and instead included examples throughout the results of how encouragement and motivation were used to advance the communication processes involved in community construction.
There was also a sample schedule on the application that illustrated what the volunteers, patients, therapists, and guest musicians would be doing throughout the three hours that made up the jam sessions. I began to locate my categories within the different parts of the schedule. For example, I located the pattern “the communication of autonomy” under the schedule at 7:05 which was the time when patients would engage in the “drum circle/rhythm warm-up, take turns leading solos.” Because the ideas of autonomy and leadership are related, I saw this as the perfect place to discuss the role of the communication of autonomy in the community construction process. After locating all of my categories in the jam session schedule, I started to incorporate photos, my own song lyrics, and snippets of my own autoethnographic narrative into each section.

Throughout the entirety of this research, I present personal stories and excerpts that either arose during fieldwork and interviews, or that simply arose during moments of self-reflexivity. This process is called autoethnography. Autoethnographic studies are introspective as the researcher analyzes her or his own thoughts and feelings regarding the issue at hand (Ellingson, 2009; Tracy, 2013). The word “autoethnography” refers to both the process of doing autoethnographic research, and also the product constructed during such a process (Ellis, 2004). By engaging in this type of self-reflexivity, researchers are able to add thought-provoking additions to their studies because they are able to understand their personal “subjectivities” and how those affect the research data. Aldridge (2005) argues that the researcher, instead of attempting to eliminate or avoid personal biases, should embrace them, especially in the context of MT. The idea here is that the researcher engages in reflexivity recognizing that the biases exist and that they affect the research at hand. Through this dialogic process, researchers are actually gaining a more encompassing understanding of the world, which is co-created in nature (Aldridge, 2005). These personal narrative excerpts are separated from other passages with three asterisks (***(***)). The asterisks represent a change in time and/or place and they have a more conversational tone rather than a scholarly tone. It is in these excerpts that I share with the readers my personal thoughts and reflections either about the MT sessions, or simply about how music has played a role in my own life.

In addition to yielding rigorous and ethical results, reflexivity makes the subject matter more accessible. My hope is that sharing personal accounts of how music has played a role in my own life will help the common reader relate to what is being discussed, and
therefore, better understand the power of music in our lives and the power of MT. Through an autoethnographic approach to data analysis, readers are able to access the information at a much deeper level. MTs make an effort to deeply connect with their patients, so, I feel inclined to deeply connect with my readers.

In representing the data for readers, I paid close attention to the aesthetic nature of MT. I engaged in crystallization, or the combination of “multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts building a rich and openly partial account of a phenomenon” (Ellingson, 2009, p. 4). By representing my results in a variety of art forms, I am able to show many different sides of each story and narrative. My goal is for many different groups of people to enjoy the piece in its aesthetic creativity. Some of the genres that are explored in my representation of the data are photography, song lyrics, poetry, and story telling (See Appendix F for the video/image consent forms presented to both therapists and parents of minors). This representation has also been inspired by Minge (2006) who presents the idea of a “fusion of embodied art” (p. 119). She defines this type of representation as “the process of inquiry that adds depth of emotion, perception, sensory detail, meaning, and creation of meaning to both the lived and re-created experience through the blending of various art forms” (p. 119). Complementary and alternative therapies such as MT are continuously challenged to provide evidence for the use of their therapy (Aldridge, 2005). Aldridge (2005) argues that in the context of MT, not only should empirical findings be seen as evidence. Personal ethics, knowledge, and aesthetics should also be presented in order for readers and researchers to see a complete picture of the practices of MT (Aldridge, 2005). The objective of this study is to present the knowledge and understandings that have been co-created and gained in a way that is both ethical, and understandable to the general public, while being true to the aesthetic nature of MT. The following chapter will discuss the results found after engaging in data analysis, illustrating the emergent themes and patterns in the data.
6:00 p.m. Mentors and music therapists arrive and set up instruments and songbooks around the room. It is 6 p.m. and I am one of the first of 15 volunteer mentors to show up at the day school for this week’s jam session. I ask the MTs what I can do to help set up.

Lexi says, “Go ahead and find some chairs in the other rooms to bring in and build a circle around the room.”

The room where the jam session will be occurring looks like a room where they may have music classes, with the large piano by the door, drums of all sizes spread throughout, three microphone stands, and a guitar in the right corner. As I begin to drag fold up chairs into the room, I ask how many students will be coming today. Jill, the other therapist, says that there will be about 15, depending on how many are not able to come. “15 youth and 15 volunteers…hmm.” I start to wonder how 30 chairs are going to fit in this small room once I start unfolding them. Not knowing how this will all work out, I continue with the task at hand.

Meanwhile, one volunteer is tuning up his guitar to get ready for when his mentee arrives and they need to tune up their guitars together. As he continues plucking the strings, he gets to the G. I chuckle and think to myself, “ahhh the infamous G-string.” It never tunes up as quickly as the rest of the strings.

I am taken back to the times I played my guitar without tuning it first, and for some reason, it was always the G that was a little bit different, like there is something about this string that makes it unique from the rest. Just like these teens that will soon be arriving. There’s something different about them, something unique. I don’t mean the way they talk, or the way they walk, though so many illuminate these features when referring to individuals with special needs. I mean the way their joy permeates and spreads contagiously throughout this room during each and every jam session regardless of their daily struggles, frustrations, and hardships.
The volunteer plucks the string a few times, moves the tuning pegs around, and continues onto the B string. Lexi starts shuffling around with her sheets of music and begins to practice on the piano. Her fingers move so effortlessly along the keys of the piano and her quiet humming is relaxing. The guest musician arrives with her electric guitar, her fluffy unstyled hair, and her tan-colored moccasins. She reminds me of a modern-day hippy. As she is plugging her guitar into the amplifier and getting set up, she begins to discuss with Lexi her song choices for the evening and how the youth will be able to participate during these particular songs.

Other volunteers are helping me by placing songbooks around the room, one for every two chairs so that each mentor/mentee pair has their own book to share. Jill is cheerfully welcoming the new volunteers as they arrive, thanking them for coming. She asks that they please put their names on nametags, then enter the room to begin helping with the setup. I realize I forgot to put on a nametag so I scurry over to the nametag station and brand myself as “MEL” for the evening. “Melanie” is just too long for these little decals. Fitting every letter of my full name on this nametag would be like trying to squeeze 30 chairs into this circle so everyone can fit. As I go back to my chair duty, I feel like I’m trying to rearrange my refrigerator after a recent trip to the grocery store. Chair legs are overlapping and microphone cords are beginning to tangle as I utter to myself, “Looks like we’ll be getting close tonight!”

The smell of pizza fills the room as our dinner arrives from the local Pizza Hut, a thank you from the therapists to all of the volunteers for helping out tonight. The MTs tell us to grab a piece and take a seat in the circle. They pull out a big white binder and begin to tell each of us who our mentees will be for the evening. Mentees and mentors are paired up “based on the mentor’s skills, experience and personality” (Appendix E). They go around the circle telling each mentor a few important facts about their unique mentee. First: name. Second: age. Third: instrument of choice. Fourth: musical experience. Fifth: diagnosis. I start to wonder what it would be like if everyone in the larger society saw these students like this, as actual people with hobbies and interests. Instead, much of society sees one thing first: diagnosis. Today I’m paired with a lovely girl. Name: Sofia. Age: 17. Instrument of choice: Voice. Musical experience: Student of one-on-one music lessons and performer of various recitals. Diagnosis: Cerebral Palsy. This would be far too much information to put on Sofia’s
The following sections will help illuminate the findings of this study as they pertain to my research question: How does the communication within the context of MT encourage community building for adolescents? Community, as defined in Chapter Two, is made up of four dimensions: the tension of autonomy versus togetherness, the balance between the private and the public, the performance of identity, and the creation of healing environment. All of the patterns presented in this paragraph give us insight into how these dimensions are communicatively constructed. Table 1 illustrates the therapists’ communication strategies that lend to community construction and examples of each strategy. It is important to note that although the four patterns found in the data are expanded upon separately in this chapter, they are all interrelated. The first way in which MTs are able to advance community construction is by communicating connections, which will be explained in the following segment.

**CONNECTING THE NOTES: COMMUNICATING CONNECTIONS**

Through the initiation of relationships between mentors and mentees, the MTs are able to facilitate a unique connection that these students may not have the opportunity to experience in any other situation. Most of the students who attend jam sessions are either almost, or are completely out of the school system, but lack a job or any other avenue to form relationships with people other than family. Therefore, a major goal of MT with adolescents is fostering rewarding and positive social relationships. The following excerpt is a portion of the grant application (Appendix E) that the therapists wrote in order to pitch their idea of the jam sessions to potential funders. They argue that connections between mentors and mentees will be specifically important for the larger goals of the jam sessions:

Pairing youth with special needs with mentors (high school and college students) will facilitate positive relationships and peer friendships through modeling social skills. These connections with mentors will provide safe, consistent, and trusting settings for our students with special needs to further understand and develop non-verbal and verbal social cues, communication styles, conversational mannerisms, and one-on-one and group dynamics. The need for our target population to
<table>
<thead>
<tr>
<th>Communication Strategies</th>
<th>Pattern 1: Communication of Connections</th>
<th>Pattern 2: Communication of Togetherness</th>
<th>Pattern 3: Communication of Autonomy</th>
<th>Pattern 4: Communication of Identity/Expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraging</td>
<td>Leading the group in “the hello song”</td>
<td>Giving the band an official name</td>
<td>Asking patients who would like to lead the next song/drum circle</td>
<td>Limiting instructions during an activity to leave room for interpretation</td>
</tr>
<tr>
<td>Modeling</td>
<td>Walking around, shaking hands, and giving high fives to model relationship initiation</td>
<td>Smiling and giving eye contact to other therapists/mentors to model acceptable social skills</td>
<td>Demonstrating strategies used to lead a drum circle</td>
<td>Engaging in improvisation during a song</td>
</tr>
<tr>
<td>Motivating</td>
<td>Telling students to grab their favorite instruments</td>
<td>Leading a drum circle so all students are playing the same rhythm together</td>
<td>Picking a student to lead the band in a drum circle/song</td>
<td>Leading group in “12 bar blues” with various places for students to improvise</td>
</tr>
<tr>
<td>Offering Critique</td>
<td>Offering alternative ways to give compliments to peers</td>
<td>Instructing group to try a song again but to end together on the same note and beat</td>
<td>Offering ways to improve on leadership skills “next time try…”</td>
<td>None</td>
</tr>
<tr>
<td>Facilitating</td>
<td>Deciding which mentors and mentees will be matched up</td>
<td>Facilitating a song-writing activity about how to keep friends</td>
<td>Leaving places in lesson plan where students get to make decisions</td>
<td>Facilitating drum conversations</td>
</tr>
<tr>
<td>Providing Positive Feedback</td>
<td>“You should be a drummer!”</td>
<td>Giving students high fives and clapping for students</td>
<td>“Wow, look at how you lead your peers!”</td>
<td>“Amazing job being creative in your songwriting”</td>
</tr>
</tbody>
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strengthen these essential life skills is a key component for successful inclusion in schools and integration in the community. This program will give individuals a greater skill base and confidence to reduce anxiety, frustration, disruptions, misunderstandings and incidences of bullying to thrive in mainstream environments.

As is mentioned here, the creation of connections between youth with special needs and other high school/college students has a variety of benefits for both types of students. This was the first pattern throughout the collected data for this study. Throughout interviews and observations, the communication of connections emerged as one of the main patterns that promoted the construction of community for adolescents, helping me to answer in part the research question: How does the communication within the context of MT encourage community building for adolescents?

Figure 1 is a photo of a mentor and mentee demonstrating their connection to one another. Although this mentor (left) and mentee (right) seem to be about to enact a simple handshake here, a lot more is going on. Both of these students are beginning the process of community construction. Their relationship has the potential to grow into one that is fruitful for both the mentor and mentee, beyond the current jam session. These two individuals will begin to share with one another and communicate in ways that they normally would not in their everyday lives, through performance and ‘musicing.’ And, what is going on outside of the scope of this photo is equally important: connections are forming all around the room.

Figure 1. Creating a personal connection during the jam session.
Connections are essential to the idea of *communitas* (Pavlicevic & Ansdell, 2004). As presented in Chapter One, *communitas* is the state in which transformation is made possible within a community. Part of this transformation within *communitas* is the ability of individuals to connect and make a sacred bond and “comradeship” (Turner & Turner, 1978). In the MT context, by connecting with mentors of a similar age, students are able to observe the socially acceptable communicative behaviors so that they can then enact those behaviors in the larger community. The following paragraphs and interview excerpts will further describe this pattern and how it relates to MT, communication and community.

Emma, a certified music therapist with more than five years of experience working with adolescents, explained that connections in general are what separate MT from music education. According to Emma, without connections, a MT session would be equivalent to a music class, lacking specific therapeutic goals. When referring to her sessions with at-risk youth, Emma described:

> Music therapy instead of something you do to someone, it’s something you do with someone. So it’s very much about the process, how they’re interacting with you, how they’re interacting with each other, so I guess that would be the main difference is music education is very didactic. Whereas music therapy is more process-oriented and it’s not so much about how much the kids learn. It doesn’t matter if they learn to play the drum in eight different rhythms. It’s more about what happened before during and after that little bit of drumming. Did people make eye contact? Or actually share a smile- the people that were just beating each other up at lunch? They’re making more connections; it’s more about the connection than just learning how to do something. (Personal Interview, February 4, 2013)

By thinking about music in this way, we can discover the important role of communication in the context of MT. As argued in Chapter One, communication is the main goal of modern MT (Ansdell & Pavlicevic, 2005). Music therapists understand that although they may not be able to cure their patients of whatever they are suffering from, they can facilitate communication (Ansdell & Pavlicevic, 2005). They can create a place where the students are able to openly communicate and interact with one another. And, they can also use their expertise to do what they can in their attempts to mend their patients’ communicative limitations (Trevarthen, 2002). But hearing these words and experiencing this...
communicative process during my observations has helped to solidify what I had “known” all along: Without the interactive process that takes place in the MT setting, MT would be music education. As argued in the literature cited in previous chapters, MT is about “musicing” (Elliott, 1995). Patients should be participating just as much as therapists are in this interactive process (Elliott, 1995). It is all about the music experiences that the patients have (Bruscia, 1998). Through experiences, patients are able to more intimately communicate and as a result, connect, with and connect with their mentors, their therapists, and each other. Connections then help each group of patients, therapists, and mentors to build community within sessions. That process of community building on this micro level can serve as a starting point for adolescents to begin integrating into the community at large.

In addition to connections between volunteers/mentors and students/mentees, MTs who work with teens with special needs sometimes create very close personal connections with their patients and the patients’ families. Many examples of this were apparent throughout my interviews and observations, but one particular story really exemplifies this connection. When responding to a question about a time when closeness was experienced with a patient, Zoe, a music therapist who works primarily with youth that suffer from neurological limitations, told the following story:

I did Applied Behavioral Analysis with him, but I was wanting to make it more fun, so I was doing the music too...and then got really close to the family. The boy had autism and Down syndrome. When I first started seeing him he didn’t really like many people...but he could be very strong, and he could run off and throw things and hit people, but we developed such a relationship over that time that his parents were wanting me to do more than just the music. . .And so I became his personal care assistant. So I would bring him out into the community. I’d take care of him. . .when they had to go somewhere I would watch over him. . .So that shows tons of trust because nobody else really understood him, I suppose. . .the mom once said, you know, if her and her husband were to pass away, I’m the only person that they would want to take care of him. (Personal Interview, March 12, 2012)

From this story, and many others from therapists, I was able to begin to understand the importance of connections between the therapists and the families, particularly with youth who suffer from neurological limitations. By creating and fostering a connection with the youth and their families, MTs are able to encourage more use of the therapeutic strategies in a home setting. They can tell the parents about what they are doing in the sessions and about any improvements being made to motivate the parents to engage in similar activities with
their children. When parents continue therapeutic strategies within the home setting, the community building can grow outside of the session itself and further help the youth with their social development so that community integration on a larger scale is more feasible.

Although the creation of connections with patients was consistent across the various populations of adolescents, the creation of connections with parents/families was not. In addition, the nature of this connection was fairly inconsistent. For example, when dealing with at-risk youth who have grown up in difficult situations such as foster homes, or youth that are in rehabilitation for substance abuse issues, a “close” relationship with the patient may not always be the goal. Also, a relationship with the parents may not even be an option, as many of these students do not even have relationships with their own families. Fay, a music therapist whose main passion is working with at risk youth, told me “Developing a close relationship is not one of my goals. I would say developing a trusting relationship is very important. They need to trust me,” (Personal Interview, January 30, 2013). This trusting relationship is still a type of connection, though it may be in a different form.

The fact that in some cases a close relationship would not be an objective was not something that was specifically addressed in the literature. Most MT literature assumes that developing a close relationship with patients is a goal. So hearing Fay say that it was not one of her goals seemed, at first, contradictory. However, once she explained that whether or not a therapist’s aim is to create a close relationship or not is determined by the population at hand and the goals for that population, I was able to further understand her stance. For this particular population, Fay is given a short amount of time to help her patients as much as possible. In this short time, developing a close relationship is not particularly important in order to reach the objectives at hand. Instead, making patients feel safe and respected so that they can begin their own processes of personal growth is more important than fostering a close patient-therapist relationship. So, the amount of time a group of individuals will spend in the particular group has an influence on the way community is constructed and the way particular connections play a role in that process.

In addition to making human connections, there are other connections in MT that allow for a unique additional bond between students and their teachers, mentors, and therapists. This is the connection that students feel with their instruments of choice. Not every student enjoys playing the drums, or the guitar, or the keyboard. Likewise, not every
student feels comfortable singing in front of others. As previously mentioned, students in the jam sessions are matched with mentors that have experience with the same chosen instrument. This enables for an even deeper bond between the mentor and mentee. The fact that students and patients feel that they are able to connect with a certain type of music or instrument keeps them interested in MT and returning week after week.

The facilitation of this connection was particularly apparent in Zoe’s description of the initial assessment of a patient when meeting them for the first time. She mentioned that this first assessment is very important in terms of affecting whether or not that student returns for future MT sessions. She said:

> It’s mostly nonverbal assessment. It’s reading their eye contact, reading where they’re looking, what their body language is saying. It’s just a ton of assessment, throwing different instruments at them and seeing what they gravitate towards, whether it’s the piano, or they like to strum the guitar, they like to play drums. . .and so then after that it’s creating that bond and relationship with the child in like ten, fifteen minutes, and then. . .kind of talking about okay here’s what I saw. I start off with, is there that natural music ability? Is it how the music created a soothing, you know a soothing feeling. It calmed them down. It helped put down that barrier in wanting to connect with me and communicate with me more. It’s seeing. . .that there’s that potential that music will be really beneficial. (Personal Interview, March 9, 2012)

By engaging in this nonverbal assessment, therapists can determine which instruments are most compelling and motivating for their students. Telling students to find their favorite instruments and play them during an assessment session can motivate the patients to form this initial connection with the instruments of their choice. Once therapists find out a student is particularly drawn to a certain instrument, they provide positive feedback to the patient when the patient plays that certain instrument. For example, they may tell a student, “You’re such a great drummer!” to give that patient the confidence to further pursue and solidify their connection with a particular instrument (See Table 1). Then after facilitating this connection, they are able to further unite with their patients and open the doors for enhanced communication. Lexi, the music therapist who was the visionary for the jam sessions, also stated that one of her strategies to create closeness in a relationship with a patient was finding which instruments the patients feel drawn to:

> I think every client is different. It’s basically just meeting them where they’re at, you know, figuring out what it is that motivates them. What is it that you can find that connection point with, what are the songs that they love? What are the instruments that they love? You know, basically, what makes them tick you. . .
And sometimes that takes a while to figure out, like what is it that really makes this client tick and makes them come alive. (Personal Interview, March 9, 2012)

Allowing the patients to make this connection point with the songs and instruments allows MTs to have a better understanding of what motivates the patients. With this knowledge, MTs can better plan patient-specific interventions that aid in community construction. Although Lexi is referring specifically to the therapeutic setting, connections to music are all around us, though they may be deeper for some than for others.

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As I held my uncle’s guitar in my arms, I began arranging the fingers of my left hand in different formations while my right fingers plucked the strings. Feeling the sound’s vibrations throughout my body was an experience unlike any other. I had never played an instrument; I had never learned how to read music. But somehow my body knew what to do. It knew which sounds went together. It knew which rhythms to strum. Before I could blink, my voice was following along and the words were pouring out from a place inside me that I didn’t even know existed. At 11 years old, I found what made me tick. I found what made me come alive.

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Maybe not every person has experienced a connection with an instrument or with singing, but most people can say that at one point their lives they connected to a song. How often is it that we turn on the radio and hear a song from our past and suddenly we’re back in that place we were where we first heard that song? Autumn, a young and motivated therapist who specializes in working with at risk youth, used this idea to inspire an intervention with her teens at a substance abuse rehabilitation center.

We did a musical timeline where we talked about our whole life as a timeline like in history class. So you think of events in your life and you connect them to songs. So you’re making your own life’s play list. But then what you do is, “What’s my song right now? What’s my present song?” and project your future. “What would my future song be? And what do I want for my life?” So visioning positive things for the future and making a change, like “Today was the day I decided, I’m clean, I’m sober, I’m ready to have a different life.” (Personal Interview, February 2, 2013)

Autumn also mentioned in her interview, “This is why I love music, because it (is) about connecting people and healing people and not about competition.” (Personal Interview, February 2, 2013)
Music therapists’ communication of connections is vital to the community building process with adolescents in the MT context. This finding was consistent with previous literature on Community Music Therapy (Ansdell, 2004, 2010; Pavlicevic & Ansdell, 2004). However, the role of connections as a part of community building is given little space in the literature, while in this research it was an overwhelmingly apparent starting point for the facilitation of the remaining patterns. Also, existing research has failed to acknowledge the different types of connections made between patients and therapists depending on the population (for example, a close connection verses a trusting connection). The fact that one interviewee felt the need to specifically point out this distinction shows me that it is an important one.

In addition, the nonhuman connections are fairly overlooked in terms of being essential for community construction, such as connections with specific songs and particular instruments. This is noteworthy because MTs should know how to most effectively facilitate these nonhuman connections, but more importantly, they should know what to do if those connections are lacking.

When these students are able to collectively make these connections to their mentors, their therapists, and their instruments/songs of choice, they have a common ground with their peers who are dealing with similar situations. At this point they can begin to build relationships with one another and learn how to work as a group, as elaborated on in this next section.

**VOICES IN UNISON:**
**COMMUNICATING TOGETHERNESS**

*7:00 p.m Welcome/opening/introduction song.* At 7 p.m., once all the students arrive at the jam session and they are with their mentors, it is now time for the introduction. Lexi gets all of the students excited about the night by yelling into the microphone, “Who’s ready to jaaaaammm?” The students laugh and scream. At this point Lexi says, “Okay let’s start out by saying hello!” This is when the hello song begins and everyone sings along.

When you see someone for the first time
  We smile at them and say hello
When you see someone for the first time
  We smile at them and say hi
  We can wave
Look at their eyes  
Shake hands  
Give a high five
These verses repeat and the students are encouraged to look at their neighbor and do exactly what the song says. They look into each other’s eyes, they say “hi,” they shake hands, and they give each other high fives. Then they walk around the room and repeat these actions with another one of the students.

Following the “hello song,” Lexi sings another song so that everyone begins giving compliments to one another. In the middle of the room, Jill has a white board where she writes down all of the nice compliments the students give to one another. If a student says a somewhat simple compliment like, “nice hair,” the therapist will sometimes offer critique and tell the student some other examples of compliments like, “you’re very beautiful,” or “great job playing your instrument.” By encouraging the students to interact with one another, the MTs are helping, once again, to facilitate important connections. While connections between mentors/mentees, students/instruments, therapists/families, and therapists/patients were discussed separately in the previous section, all of these bonds combined create for an environment in which patients are able to feel comfort, safety, and enjoyment as a whole group. Thus, in these environments they can learn various social development skills with each other that can later be transferred into the community at large. Lexi expressed, “The group experience is really more focused on the social aspect (and) group cohesion and doing things together as a group versus an individual.” (Personal Interview, December 17, 2012)

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In doing this research, I first asked: how does the communication within the context of MT encourage community building for adolescents? The response to this research question is illuminated in the second pattern found in the data analysis: the MT context communicates togetherness. By making adolescents feel like they belong to this group full of connections, therapists can begin to teach important social skills and can encourage their students to integrate into the community. This section will explain how the communication of togetherness offers insight into the research question for this paper.

Figure 2 is a visual example of mentors and mentees playing and singing a song together as a collective group. The mentors and mentees are paired up based on common
musical interests, as mentioned in the previous section, and once these connections are formed, the group plays music together as a whole. Mentors and mentees are not instructed to isolate themselves from the larger group, but rather to interact with everyone. As you can see, the two individuals in the left of the photo are both playing guitar. The mentor (far left) is helping the mentee (second from the left) to stay on beat with the collective group and contribute his part during the song by playing the right chords. I (far right) am singing along with my mentee (second from the right) and encouraging him to sing in unison with the group and shake his shaker to the rhythm. This one-on-one assistance is motivating for the students and promotes the group cohesion.

Figure 2. Two mentors and two mentees play a song together.

As mentioned in the beginning of this chapter, all of the four patterns are intertwined. The communication of togetherness is enabled by the creation of connections. Forming connections between mentors/mentees, therapists/patients, patients/patients, and patients/instruments is the first step to the facilitation of group cohesion. What separates the first pattern (the creation of connections) from the second (communication of togetherness) is
at what point the two occur in the process of community construction. Connections must be formed early on in order to catapult the remaining patterns. A connection could be a one-time occurrence, and once it repeats, togetherness can be fostered. In addition, a one-time connection can make a difference in community building, while togetherness must be an ongoing characteristic of a group in order for the strength of community to be sustained and grow. Connections are one-on-one between patient/therapist, patient/patient, or patient/instrument. On the other hand, togetherness is a state of cohesion between all members of the group rather than one-on-one.

In addition to encouraging community integration, the communication of togetherness can begin to facilitate meaningful experiences for students. As previously mentioned, all humans desire and need a sense of belonging (Baumeister & Leary, 1995). Some researchers have found that individuals with social connections are more likely to survive than those without (Holt-Lunstad, Smith, & Layton, 2010). Recall that some scholars even argue that belonging is equally as important as food for humans (Baumeister & Leary, 1995). Positive interactions with others are an important aspect of every human’s health, including the health of adolescents. As previously discussed, a sense of belonging becomes particularly important during the process of individuation-separation (Lapsley & Edgerton, 2002). Young people in this chapter of their lives are beginning to develop new relationships outside of the family that greatly affect what kind of people they become (McFerran, 2010). Whatever group they feel belongingness with will influence their identities (McFerran, 2010). Therefore, the communication of togetherness in the MT context can give adolescents a positive place to belong.

One of the most common interventions therapists use in group-settings that help promote togetherness are drum circles, whether they be with adults, children, adolescents, or seniors. Within drum circles, all members are given some type of percussion instrument and they are forced to work together as a group by listening to one another and playing a cohesive rhythm. When a music therapist leads a drum circle, they are motivating the students to play the same rhythm as a group. When I first heard about these drum circles, the immediate image brought to mind was a crowd of barefoot hippies chanting and shaking around their dreadlocks. However, my first drum circle was nothing like this. I soon came to learn that a music therapy drum circle is a unique setting in which the therapist is able to
foster enhanced nonverbal communication between the members of the group. Fay who works at a rehabilitation center for teens explained:

You get a groove going and there’s this energy that starts to flow, and a connectedness that many of us have never experienced before, in fact even adults quite often have not experienced that feeling until they’ve been in a really good drum circle or something. So for them, it’s this new way of relating and something inside of them opens up where they start to feel kind of their soul and they start to feel something different. And yet it’s connected. So once they get a taste of that feeling it makes them less likely to go back (and use). Even the most superficial of people that come in are changed by that experience, because for the first time in their life they get close to this deeper way of relating to their peers. (Personal Interview, January 30, 2013)

Finding this alternative way to relate to peers is an important experience for at-risk youth. Many times they feel so much pressure to fit into a social group that they do whatever their other group members are doing. So, providing a group where they can belong that has more positive goals is a good alternative to the groups in which they are used to belonging. As the group continues, students are able to encounter a feeling of togetherness that encourages personal growth. Fay further elaborated on this:

They’re among their own age group so they’re more natural in their interactions with each other. They know what each other is going through and for them to build their own trust in their own peer group, they begin to trust and be more honest with them and to be learning to learn how to cope and to be learning to learn how to say “no,” to be learning how to relax in their own peer group. And they need to also expand their worldview and they can do that by hearing other people’s stories. Then they know that they’re not alone and they’re not some kind of weirdo. They know that they’re not weird at all. (Personal Interview, January 30, 2013)

Once students feel that they belong to this new group, they can begin engaging in self-disclosure and reciprocation, as opposed to holding everything in like they might normally. Facilitating songwriting activities for the students is also a strategy used by MTs to communicate togetherness to patients. On a few instances, the songwriting activities I observed were related to keeping friends, or getting along with others. This communicative process is very positive to the development of these teens. By engaging in this way, the teens are able to experience companionship, which can help give the students’ satisfaction, and improve their moods (Rook, 1987). Autumn described how belonging to a group makes her students feel safe which helps them to open up to their peers:
What I see a lot is that as the group continues, people feel safer. And I think that’s a really elemental piece to having success. Because at first people aren’t going to say anything and they’re not going to act like they like it if it’s not considered cool or the leader doesn’t like it. They’re not going to take risks, they’re not going to put themselves out there, but once they start to feel safe and the group is more cohesive and connected, then they begin to take risks and they come out of their shell and they share their thoughts. (Personal Interview, February 2, 2013)

The words of Autumn are consistent with what MT literature suggests: MT gives patients a space where they can belong and feel unthreatened and safe (Crowe, 2004). By feeling that they are in a safe space where they can fit in, they experience togetherness. This communication of togetherness and belonging is not unique to at-risk teens and adolescents who struggle from substance abuse. This pattern is consistent across all groups of adolescents who receive MT. Youth with neurological limitations also need this feeling of belonging within a group (Butler & Zeman, 2005). Specifically, adolescents who suffer from Autism Spectrum Disorders have enhanced difficulty initiating interactions with others and socializing with them (Association for Science in Autism Treatment [ASAT], n.d.). So, by therapists communicating togetherness to these adolescent students, students are able to begin to feel like they are in a safe place and that they belong. This helps to form a sense of community within the smaller group, and also helps to encourage the students to interact with the larger community.

As part of the observations conducted for this interview, I became a member of a band. The band included two adolescents, the therapist, and myself. Both adolescents in this band have autism. At the time of my observations, they were actively searching for more band members as they had recently lost a couple of their members. One boy played the drums, the other played the piano, the therapist played guitar, and I became the singer for the period of time that I was observing. We had weekly sessions, and we would practice songs and on occasion record them. This “band” environment gives these students a feeling of belonging in a social setting. They come together weekly, practice songs together, listen to one another, make decisions, develop a common interest, and create common goals: to improve their skills as a band. This type of social belonging is difficult for them to engage in on a daily basis.

Zoe, the therapist who runs this band, explained to me in two separate interviews the importance of being a band and learning group cohesion for these boys:
The band, they think their goal is to make music, and to get through the songs, and to hopefully be able to perform and have fun. Whereas my goals for them are the social interaction, the communication, being able to listen to each other. . . In some case I’ll bring in how important it is as a band to be listening to each other, to be able to stop and finish together. (Personal Interview, March 9, 2012)

By practicing listening to one another, the band members are learning social skills that can improve their communication in their everyday lives. Another strategy Zoe used to encourage togetherness was giving the band a name. Spending a whole session on choosing a band name may have seemed like a waste of time, but Zoe explained to me how having an official name made these boys feel like they were part of something bigger, something important. In the second interview with Zoe, she further illustrated how this togetherness lends itself to the creation of community:

I think just the band in general is a huge example of community and it's taking the different instruments maybe that you are playing, so your talents, and bring them together to create then music. I think it's being able to interact with each other musically; but it's being able to work on those nonmusical skills. The eye contact, the compliments, the listening skills. So it's being able to work on those nonmusical skills but also the music skills together. (Personal Interview, December 18, 2012)

Adolescents, through MT sessions, are able to engage in open communication and self-disclosure, which helps them experience a unique form of companionship. The communication of togetherness encourages further developed social skills, which can eventually transfer into the larger community outside of MT sessions.

In short, communicating togetherness helps to encourage community building in the MT context. Much of the literature cited in Chapter One mentions group cohesion and how one of the goals of MT with adolescents is to teach them how to work together. Although this is similar to what has been found in this research, it is not synonymous. Not only does this study show that teaching group cohesion helps foster community, but it shows that just the act of being in a group helps facilitate companionship. Companionship has shown to serve as a “buffer” against people’s minor stresses in life (Rook, 1987). There is a missing link within the literature between MT and companionship, which leads to community construction. Thus, a deeper look at companionship literature can help us further understand why the communication in the unique context of MT encourages community building. This implication will be further explained in Chapter Four. While this group cohesion is
emphasized significantly throughout MT sessions with adolescents, the communication of autonomy is equally important.

**THE POWER OF THE PERCUSSIONIST: COMMUNICATING AUTONY**

7:05 p.m. *Drum circle/rhythm warm-up, take turns leading solos.* After the introduction song and welcoming, it is now time for the drum circle. Volunteers pass out all different types of drums and percussion instruments to the students: djembes, little drums, larger drums, congas, bongos, tambourines, and mallets. One therapist stands in the middle of the drum circle with her drum and begins to bang on it. Soon the entire group is hitting their drums. The therapist begins to model ways to lead a drum circle, guiding the group to follow her rhythm. She raises her drum up high and the group starts hitting their drums harder. She lowers her drum towards the ground and we all quiet down. She speeds up and we follow her lead. She signals a rumble and everyone hits their drums as loud and fast as they can. Then she puts her two hands up, and signals us to stop. We do so in one cohesive bang. This start to the drum circle gets all of the students excited, ready for another round. After leading a few rounds, the therapist invites students to come up and lead the drum circle. Some students are eager to lead and they shoot their hands toward the sky. Others feel more timid and shyly sink down in their chairs, avoiding all eye contact. She uses her discretion to ask students who would like to lead the next drum circle, to choose students who are ready for the limelight. But she will also motivate those who do not feel ready to lead the group simply by calling on them to come up next. The goal is to evenly distribute this leadership role to students. Through this leadership position, students are able to take control of something, even if just for that short amount of time.

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In Figure 3, the MT, Jill, is leading the group in a drum circle. As Jill stands in front of the group as the leader of the drum circle, she is demonstrating ways that the students may then direct the group once it is their turn to take the leadership position. She begins by banging on her own drum at a steady beat, and then begins to speed up, signaling to the group that they should speed up with her. She will raise her hand high to signal that they get
Figure 3. Jill leads the group in a drum circle.

louder. She will then put her hand toward the ground to indicate that everyone should play more softly. She will continue this exchange and will eventually raise her hands up toward the ceiling and gesture that the group stop on one cohesive bang, like a conductor would. Soon after, she will choose someone else to lead the drum circle. Now that the students have tools they can use to lead the group, they are more motivated to step out of their comfort zones and take that next step and to lead the group themselves.

The third pattern that emerged in response to the question “How does the communication within the context of MT encourage community building for adolescents?” was the idea of therapists communicating autonomy to the students. Doing this allows them to not only further build community within their group therapy sessions, but to also understand different roles they can play out in the larger community, particularly the role of an autonomous individual. This section illustrates how the communication of autonomy is constructed, and how it is empowering the adolescents in the MT setting.

The role of communicating autonomy is present in the formation of many communities, and the balance between communicating togetherness and communicating autonomy can be a complicated one (Ansdell, 2004). As Delanty (2003) and Ansdell (2010) describe, one of the most obvious tensions in community formation is the balance between encouraging autonomy, and togetherness simultaneously. Ansdell (2004) actually argues that arriving at this negotiation successfully is the main objective of community construction. The following paragraphs describe what this looks like and how MT is a unique environment in which this balance is consistently achieved.
One of the therapists who played a large role in my thesis work, Lexi, has worked with a group of her patients for many years. She began providing MT for them when they were very young children, working on mostly language and speech skills, as well as some academics. But now that they are adolescents, they are in a band together. Her goals for them have evolved over the years, and autonomy is currently a major objective.

As they get older, if they’re able to make decisions, we try to give them the choices and preferences in the session so...like, what instrument do you want? What activity do you want to do next?...You know we always try to give them some form of control and choice in the session as well so it’s not always “Do this, do this, do this, do this.” Because I think that’s really important that the client is self-motivated to want to be able to come and participate. (Personal Interview, March 9, 2012)

On a micro level, by giving them the ability to make decisions and focusing on their preferred music, Lexi is able to make a space where students feel self-motivated. But more importantly, if they are able to feel that they played a role in the formation and growth of the band, their experience in the band can grow from being a simple hobby into being something they are very proud of and can further affect their lives on a deeper level than just “music class.”

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I find that for myself, songwriting can be an empowering experience. It has proven to be a particularly successful way for me to progress from one emotional state to another. The process involved in putting a song’s pieces together helps me to let go of some of the painful emotions I am experiencing in any given moment. For example, a number of my songs turn out to be subconscious ways of providing myself with positive self-talk. The verses are words expressing particular feelings I am having. Then, once I am completely consumed with my feelings and take ownership over them, I move forward in the songwriting process by standing away from what I am feeling. By stepping outside of my own feelings, I am able to look at them as an outsider and engage in positive self-talk. Subconsciously, I begin thinking about what I would say to someone experiencing the feelings I have in that moment. These song lyrics demonstrate a time when the songwriting process took me from a place of pain and self-doubt to a place of growth.

Sometimes it feels like there is nowhere you can run to escape the pain you feel inside you; it eats at your soul.
Sometimes it seems like all that’s around you are shattered dreams
like the world is crumbling, and lives are ending all the time.

Well let me tell you I know where you are
in that deep and darkened place
and in the midst of the realm of the unknown
there lies a hope.

Even though I was experiencing deeply intense emotions of hurt and loss while writing the first verse and chorus of this song, once I started singing the melody I created, playing the chords I put together, and writing the lyrics, I was able to step outside of my emotional state and feel a sense of hope, even if just for a moment. The process of empowerment through songwriting has helped me to better understand my emotions and myself.

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In addition to feeling autonomous due to their ability to make decisions, share opinions, and express preferences, the patients are able to develop a sense of ownership once they begin to improve as a band. Feeling ownership and pride can be very empowering. Later on in her interview, Lexi expressed what it’s like to see such progress in her students:

It has been cool to see them learn some of the skills of working together and building friendships with each other and really developing that sense of ownership over the group where they are excited about taking the music out and performing it. So in that sense they are really forming their own little community, their own little friendships and having to work together on things or communicate. People get frustrated in the rehearsal process then helping them work through that that type of things. (Personal Interview, December 17, 2012)

Being in a band with other peers of similar ages and similar diagnoses, these students have a safe place where they can learn more complex communication skills, such as negotiation and conflict management. Not only that, but a sense of pride can begin to develop which is very important for their self-esteem. As Crowe (2004) demonstrates, as MT patients begin to realize that they are developing and getting better at a skill that people deem as worthy across cultures, their confidence increases.

Zoe also described what it was like after her band of adolescents (all with autism) was able to play in the community:

I think they really grew afterwards because then they really came together and trusted each other. And then I think they are practicing, like our band practice became more, we are able to then go out into the community, we are able to perform and people were dancing, and singing and so it was just a really, I think they were really proud of themselves. (Personal Interview, December 18, 2012)
This experience was triumphant for these individuals as well as for their families. This is the same band for which I sang during my months volunteering at the CSMT. I remember when we recorded one of our first songs together. After returning from winter break, one of the mothers told me that she had played the recordings for her entire family on Christmas. She was playing the recording of the song in their house to everyone and even sent the YouTube clip to family members that were not able to come in town. Not only did that give this particular student a feeling of pride, but also the family was able to get a sense of accomplishment, further solidifying their belief in MT and its positive effects. The feeling of pride and confidence gained by MT patients is important to their autonomy. A lack of self-esteem can hinder self-sufficiency, while an increase in confidence can help foster the motivation for autonomy.

Similarly, at-risk youth have a need for autonomy and control. They also need to feel a sense of ownership over their lives and to feel validated and proud. As previously mentioned, Autumn feels particularly drawn to this population. She has done work all over the state, as well as abroad in countries like Kenya and places in South America. She said the following about the group of adolescents she currently works with in one of the roughest neighborhoods in Los Angeles:

Well first of all I think that one of the main reasons (making them leaders) works so much is because. . .they’re having such a hard time is that they’re never in a power position. Their teachers, their parents, the police, and the society. Everyone’s sort of telling them what to do and who to be. . .So when you make them a leader, it’s a really positive thing with those roles. Otherwise gangs will give you that feeling, right? So hopefully this is another alternative to that is to empower them to be leaders within the group. . .And it absolutely would impact everything. . .So I think if they’re getting power in a positive way they don’t seek it outside of the group in negative ways. (Personal Interview, February 2, 2013)

Through MT with a group of at-risk students and students with autism, MTs are able to communicate autonomy to their students and by doing this they give the power back to these students who at times feel so completely powerless. Instead of taking their power away to be sure they don’t make the wrong decisions, giving them a little bit of power can help them realize they need to take control over their lives by making the right decisions. Adolescents are on the verge of becoming young adults. This process is sometimes referred to in literature as “individuation-separation,” which is defined as “a process whereby internal working models of self-in-relationship are updated or reconstructed in light of new relational
experiences of separation and connectedness” (Lapsley & Edgerton, 2002, p. 485). One of the many challenges adolescents experience during individuation-separation is the tension between autonomy from their family and the new connections they are making with their peers around them (Lapsley & Edgerton, 2002). Therefore, this finding that the communication of autonomy is essential to community building shows that a successful individuation-separation process is also important for the construction of community. In order for adolescents to make this change in a healthy way, a balance between this autonomy and belonging is essential (Lapsley & Edgerton, 2002). By being in this conflicting process together, adolescents are able to further unite.

Adolescents are in a place where they will soon be encouraged to take charge of their own lives out in the community. Giving them a dose of what it is like to make important negotiations and life-changing choices can help them begin to prepare for this, whether they be adolescents with neurological limitations, adolescents with substance abuse issues, or simply adolescents who have experienced a difficult past for whatever reason. Giving them leadership roles can help facilitate that autonomy.

This communication of autonomy within the MT context helps contribute to community formation in a variety of ways. The adolescents in these small groups are coming from a similar place. They are all experiencing the need for autonomy and can understand one another’s situations. Music therapists are able to give students the opportunity to lead their group of peers, which can empower each student separately, and therefore unite them more fully. If no one student is empowered, it would be more difficult to foster a sense of community because patients would have an “us” and “them” experience in which the “us” would be the patients and the “them” would be the therapists. On the other hand, having the students lead each other empowers the leaders, and also those being led by fostering a sense of ownership that the patients can share. When a group has pride in what they are doing collectively, the group becomes more unified and the sense of community can continue to flourish. Previous literature on Community Music Therapy has shown that balancing the tension between autonomy and togetherness is essential (Ansdell, 2004, 2010; Delanty, 2003), but it has failed to make a distinct link to the process of individuation-separation. Better understanding this process helps us to comprehend why balancing these tensions can be so important.
Not only do these students need a space where they are able to take control, they also need a place where they can feel safe to express their own identities and individuality, which will be further illustrated in the following section.

**Performance of Self: Communicating Identity/Expression**

7:40 p.m. Improvisation jam/ youth select songs from songbooks. For the past twenty minutes, the students have been able to interact with the guest musician. They have been singing and playing their instruments to all of the songs that the guest musician has brought for the group. In between songs, they were able to give each other compliments and high fives. And, they were able to tell the guest musician how much they liked her guitar playing. As a group, we practiced each song a few times, and then recorded each song. Students got to feel like they were a part of something. But, now is the time they have been waiting for. Instead of following the guest musician’s creativity, they get to express their own. Instead of being told to sit in their seats and play the song choices of the guest musician, they get to choose what songs they would like for the group to play. They get to play shakers, or drums, or keys, or sing into the microphone. Or, if they want, they can just get in the middle of the circle and express themselves through a dance. They have been craving this avenue for self-expression throughout the entire jam session. They have been fidgeting in their seats, swaying from side to side, reaching for the microphones, and trying to request songs. This is their last chance to express their individuality and experiment outside of the box before the closing of the jam session. It is finally time for everyone to take the labels off and just be.

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The fourth and final pattern represented in the data collected for this thesis is music therapists’ communication of identity and expression. When considering the research question, “How does the communication within the context of MT encourage community building for adolescents?” the pattern of facilitating self-expression emerges as yet another way that MTs are able to encourage adolescents in their construction of community on both a micro and macro level through communication.

Cameron, the student holding the drum stick up in Figure 4, was one of the most expressive individuals that I observed at the CSMT. His emotions glowed through his facial expressions, his body movements, and his energy. When he was happy, the group fed off of
his energy. Whether or not Cameron expressed himself in this way during his everyday life, I cannot say. But what I can say is that, within the context of MT, when the group would begin a song that Cameron liked, his excitement was contagious. He would begin to dance around with more joy than I knew a person could have. If on the drums, he would play each beat like it was the last time he would ever be seated at a drum set. He never held anything back during the jam sessions and always expressed himself fully, unafraid of any consequences of being labeled as “strange” or “different.”

Figure 4. Cameron’s self-expression shows during a song.

Many youth with special needs have come to live with this stigma that they are strange and different from the rest of their peers. They are constantly taught certain ways to successfully live within the molds of a “normal” teenager. Although they do need to learn how to work in groups and how to be effective leaders, the creative side of their brain also needs to be able to find comfort in the fact that there is a safe place where their individuality can be expressed. The context of MT provides this for them, which will be expanded upon in the remainder of this section.

This pattern is related to the previous pattern of the communication of autonomy. In fact, the majority of the literature cited in Chapter One of this thesis groups these two concepts together. They describe the tension between autonomy and togetherness by using words like “individualism” as synonyms for autonomy (Ansdell, 2010). Although the concept of individual expression may seem similar to the ideas of leadership and
empowerment, people can be to a great extent autonomous, yet not the slightest bit expressive and creative. Creative expression is more of an emotional release. Adolescents, in order to be encouraged to build community with one another, must also feel that their collective group is a safe space to be truthful and honest and able to release whatever emotions they may be bottling up inside.

The process of releasing is a complex one to explore, and one that is essential to the pattern of communicating identity/expression. Many times, adolescents don’t have the best use of their words to express a feeling. They may not even know that they have a feeling. Simultaneously, others may be experiencing them as angry, or depressed, or excited. Communication, in this sense, is not always strategic or intentional. We communicate all the time and sometimes it is not deliberate. What makes this interesting in terms of MT, is that when individuals play and perform music, different parts of the brain are activated that are not activated during regular speech (Taylor, 2010). This helps individuals to access something that they would normally not be able to access: a memory, a thought, a feeling. And as they are playing, they are processing that and communicating that. It is coming in the front. It is getting released because they no longer carry this “thing” anymore.

All of this could be completely unintentional on behalf of the teenager, and the MT may have no idea what has been locked up. But something happens because of this process of ‘musicing.’ Because music affects the human brain differently than other types of communication (Taylor, 2010), it enables the unlocking of memories, thoughts, and feelings that are buried in the adolescent and allows them to release that locked up memory or emotion through the performance of music. Through this process, these young people to be more conscious of their being in this world and in this community. They may not be able to verbalize or say what is being communicated through their music, but there is a recognition that something is different in this context, which is allowing them to release what is locked up, and thus, communicate. All of this illustrates that sometimes it is not necessary to put into words what is coming from the background to the forefront. What is important, however, is that the individual is experiencing something different that allows them to self-express. This range from engaging in completely intentional strategic communication to unintentional, unconscious communication is a fascinating one that should be explored further.
The MT context is a place where patients are able to belong to a collective group, but still express their individuality, as Emma explained:

The great thing about music is that it takes individuals to create a collective group of music so each person is individually making their own beat, their own song. . .that was kind of the underlying. . .mantra that “we’re all pieces to a bigger puzzle”. . .So I’m not (always) telling them what to play, that’s their own individuality and their creative expression coming out. . .And so in making music or creative arts or whatever it is artistic, you are being an individual, but you’re also contributing to a bigger whole. (Personal Interview, February 4, 2013)

One reason music is very helpful in this process, as Emma shared with me, is because one can self-express without words:

I think there’s a lot of great arts therapies in general. I think because of the fact that you don’t have to say what you’re feeling. Because I think teens also sometimes don’t know how to express how they are feeling. They themselves can’t say, “I feel this” to themselves. They maybe are just feeling it. (Personal Interview, February 4, 2013)

The nonverbal properties of music can help aid students in self-expression. One way in which MTs encourage students to self-express during a session is by limiting instructions during an activity to leave room for interpretation and let the students “do their own thing”. In addition, to promoting the performance of identity, MTs model ways to engage in improvisation during a song, and then play a song that leaves various places for each student to improvise, such as the “12 Bar Blues”. In this song, the blues scale is played repeatedly and students can jump in at whatever moment they would like in order to improvise and express themselves. This idea of individual self-expression was present in various articles and books cited in Chapter One. Music is fascinating because when it is instrumental, it is its own form of nonverbal communication (Crowe, 2004). Music is also referred to as its own language (Inskip et al., 2008). This is why sometimes MTs will facilitate drum “conversations”. These conversations are purely instrumental and nonverbal. One student will bang on a drum in a certain way, and another student will respond on their drum in a way that might mirror the emotion of the other student, or might differ completely from the emotion. The students have complete freedom to express whatever emotions they would like to one another through drum conversations. Bruscia (1998) reveals that what individuals express verbally in words, they may not have a way of expressing musically. The opposite is also true. What individuals express musically, they may not have a way of expressing verbally in words (Bruscia, 1998). Therefore, music provides an avenue of self-expression.
This is especially true for students who have no other avenue to self-express in such a way. They can bang on a drum to release some built up anger, or they can sing an emotional song to let go of some feelings that have been eating away at them. Because they are able to release, and thus communicate, their built-up anger and negative emotions, the individuals can begin to feel a sense of relief and peace. Autumn talked about how she was able to foster self-expression with one of her students in a program she leads with at-risk teens:

I definitely think they can express themselves and their uniqueness. Music lends itself to that. I think being flexible is really important because a lot of that stuff doesn’t just pop up unless you make space for it. Like I have one kid who is illiterate, well not illiterate but he doesn’t read very well, and he doesn’t write in my class, but he is a freaking amazing drummer. And he loves to do beats with pencils on desks. What would most teachers say? “Stop; stop drumming on your desk!” Right? So for me I’m like, well, I brought drums, but let’s play with pencils on a desk. It’s still music. (Personal Interview, February 2, 2013)

The first time Autumn encouraged this particular teen to continue his individual expression, he was probably surprised that for once his authority figure was not demeaning his individuality and uniqueness. If he and other students feel that their self-expression is a positive thing, they will most likely feel more comfortable and motivated to engage in these creative activities. If they are less afraid to express their individuality, they will also feel safer when it comes time to open up to their peers.

One of the goals of therapists who work with at risk youth, adolescents with special needs, and adolescents with substance abuse addictions is to let the pain emerge and let what is difficult and intense to be released. As mentioned in previous chapters, we also do this in our every day lives through the use of music. We as humans are sometimes inclined to listen to a certain song or type of music to reach certain goals whether those be to relieve stress, to feel pleasure, or to help us change/emphasize our current emotional states (Juslin & Sloboda, 2010). In sessions with adolescents who suffer from eating disorders the emotional nature of music is essential.

Erin, a therapist who specializes in working with teens who suffer from eating disorders, enlightened me on the way music can serve as a vehicle for healing for these adolescents.

Music can be very non-threatening so it can open up the discussion and open up the process of all the things that are involved in that recovery or treatment. . .We use music to stimulate that. We might analyze song lyrics. We might create a song; we do a lot of song writing. We also do a lot of self-expression. . .a lot of
the women I’ve worked with, it’s hard for the to express themselves in an organic kind of way. So just to be able to be more open in that way is a lot easier with music almost as a transitional object. “Well we’re going to do this, but hey do you see what you’re doing while we do this? You’re being you; you’re expressing yourself how you want to express yourself today.” (Personal Interview, January 13, 2013)

Similar to the other adolescent populations, these women have a stigma attached to them. They constantly feel that they are not good enough for society’s idea of “perfection.” Thus, they resort to this place where they are stuck and unable to move forward. If they were able to self-express and learn more about themselves, perhaps this could contribute to some progress, or perhaps even a breakthrough.

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This pressure to be society’s idea of perfection is something that many teenagers experience. Their identity crises cause self-doubt and negative self-esteem. As a teenager, there were many times when I was feeling like the women Erin spoke of in our interview. I was always too something or not something. Too shy. Too nerdy. Too tall. Too awkward. Not popular. Not funny. Not skinny. Not confident….Not good enough.

It’s always strange to fall in love with someone who isn’t falling for you.
It’s always strange to be the girl who’s just there for some short piece of time.
When some other girl comes along who has something special that you just didn’t.
He takes what’s his and walks away like you were never there in the first place.

It’s always strange to put on a smile when everyone knows who you really are.
It’s always strange to live out a dream and realize things aren’t always what they seem.
When some other girl comes along who has something special that you just didn’t, they take what’s theirs and walk away like you were never there in the first place.

Why do you let them take you back again?
It’s as if you want to move on, but you don’t think that you’re worth it.
You don’t think you’re worth anything.
So you lie on the ground, naked and broken to pieces.
And you let them treat you like some piece of trash.
to be used and thrown away, 
thrown away, thrown away, thrown away.

Life is so ironic sometimes. 
It’s like we all have veils over our eyes. 
We’ll never see things how they are; 
what we see will always be so far. 
You are not what you think. 
You are something that’s worth keeping. 
I said you are not what you think; 
you are something that’s worth keeping.

This is one of the many songs I wrote while experiencing these feelings of inadequacy as a teenager. If I didn’t have this musical outlet as an adolescent, I don’t even want to imagine what other avenues of escape I would have experimented with. Adolescents worldwide experience these feelings yet many have no healthy expressive outlet. So, the chances that they turn to unhealthy coping mechanisms such as drugs and alcohol are, unfortunately, very high.

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Fay expressed to me what she would like to see come out of MT programs with adolescents:

I hope that what they would take is their own sense of value. Their own sense of person. One thing that I really don’t like about our culture is that they want to put everybody into a box. . . For some kids that’s fine, they can do that. But it’s not for everybody; not every body can fit into a box. So with these kids who have really struggled and then they’re trying to fit into a box that doesn’t really fit them, I hope that they can find their individuality, that they still have value and self-esteem. And to be creative in how they approach life, to realize that they have a choice in matters. They have a choice in how they respond to matters. That you have options. (Personal Interview, January 30, 2013)

Through the creative process, the adolescents are able to discover more about themselves, as one therapist shared, “They get into this zone, and they discover this really exciting part of being alive is being in the creative process. When they discover that, they discover their uniqueness, they discover who they are in the process” (Personal Interview, February 4, 2013).

This discovery of the importance of self-expression is very important to the future of this generation. Music can help them, and everyone else, have a sense of self (Crowe, 2004; McFerran, 2010). McFerran (2010) argues that Erik Erikson’s (1963) idea of identity formation is one of the fundamental processes that take place during adolescence. According
to Erikson (1963), when young people are in their adolescent years, they will either experience the construction of self-identity, or they can become confused about their role and lack a sense of self. A number of factors influence this process. Adolescents are in a stage in which they are beginning to negotiate their self-perceptions and others’ perceptions in order to form an identity, but this can be challenging and confusing when the two identities are conflicting (Erikson, 1963). Music is a medium through which adolescents are able to self-express through this process of negotiation aiding in a successful identity formation. This is an example of performance of identity (Ruud, 1997), a term described in Chapter One. By performing their identities through musical preference, adolescents are further solidifying their identities and forming a sense of self. The expression of musical preference is a communicative act that conveys to others a number of messages about the self, including beliefs, attitudes, and morals (Frith, 1981).

Chapter One of this thesis discussed performance of identity as one of the four main dimensions of community found throughout the literature. What was not specified in Chapter One, however, is that this idea of identity formation is enabled through the communication of self-expression. This space helps the students honestly open up and be truthful about their feelings of uncertainty. Without communicating about these feelings with others, adolescents are in danger of bottling them up and releasing them in unhealthy ways. In terms of adolescents with neurological limitations, this is also the case. Many times they are taught by society to do what it takes to “blend in” with those around them. Well, in their MT sessions they are allowed to communicatively express their individual unique selves. In answering the research question “How does the communication within the context of MT encourage community building for adolescents?”, this study illustrates that MTs create a space where adolescents feel understood, thereby facilitating community construction. The adolescents find themselves in a safe place and they grow closer to one another while releasing bottled up emotions.

Without self-expression, these youth will not be able to understand their own value, which could be detrimental to their self-esteem and consequently many other aspects of their lives and the lives of those around them. Patty, a music therapist who has been working in the business for over thirty years, expressed her concern for many of the adolescents in today’s society, “Early intervention is always good to create healthier young adults…Many
weren’t mentored properly and didn’t have a way to express themselves in a way that they were heard. It’s all about being listened to and being understood” (Personal Interview, January 28, 2013). By giving these students a voice, we can begin to validate them and show them that their thoughts and experiences are important to those within the larger community. The following section will further emphasize the importance of the need for MT with adolescent populations.

**ENCORE**

8:45 p.m. Clean up/pack up instruments. Now that the jam session has ended, it is time for everyone to go their separate ways, the therapists, the patients, the volunteers, the guest musician. All of us lead our own separate lives and each one of us will take something different away from this experience. The hope is that with more jam sessions will come more community building.

The previous sections have helped to answer the research question, “How does the communication within the context of MT encourage community building for adolescents?” The findings illustrate that, in the context of MT with adolescents, MTs promote community construction by illuminating connections, communicating togetherness, encouraging autonomy, and facilitating a safe place for the creative expression of individuality.

Communicating connections is the first step toward community construction in the MT context. As presented in Table 1, in order to create connections, MTs use encouragement by leading the group in the “hello song”. They also model ways to engage in relationship initiation. MTs motivate students to pursue connections with certain instruments giving them the freedom to choose their favorite instruments from a variety. Offering critique is a strategy that used to aid students in their understanding of way to give complements and be kind to others. MTs facilitate connections by deciding which mentors and mentees will be matched up during a session based on their common interests. And, finally, MTs provide positive feedback when a student is connecting with an instrument. Once adolescents feel a connection to their therapists, their peers, and their instrument/songs of choice, they can enter into the phase of togetherness.

The communication of togetherness enables students to have a sense of belonging, which is very important to adolescents going through the process of individuation-separation.
Some of the examples of strategies used to communicate togetherness to students are encouraging them by giving them an official band name, modeling acceptable social skills like smiling and giving eye contact, motivating them by leading a drum circle so they all play together on the same rhythm, offering critique regarding their ability to play as a group, facilitating songwriting activities such as ones that discuss how to get along with others, and finally, providing positive feedback by giving students high fives and clapping for them when they do a good job as a group (See Table 1).

Then, within this collective group, adolescents are given leadership positions over the group, which not only enhance group cohesion but also encourage autonomy. MTs rely a lot on drum circles to communicate autonomy to their students (See Table 1). They first model ways to effectively lead the group in a drum circle. Then, they promote leadership by encouraging students to lead the next song or drum circle. If students feel shy, MTs motivate them to lead the group even if they do not feel that they are ready to do so by simply choosing someone. In addition, MTs facilitate this communication by leaving room in their schedules where students get to make decisions and express their preferences in terms of what to do/play next. Finally, providing positive feedback when students take on leadership roles and make decisions is very important to the process of communicating autonomy. The communication of autonomy gives these teens empowerment, which aids towards community building.

Finally, the communication of identity and expression gives students a place in which they can feel safe to self-express and not be judged. As presented in Table 1, providing a place that encourages expression of individuality has a lot to do with leaving room for interpretation during activities. Also, MTs model improvisation during a song, and motivate students to do the same. Songs such as the “12 Bar Blues” are great for this type of creativity to be launched because each student gets a chance to improvise. MTs also facilitate drum circles which promote self-expression and performance of identity. Finally, MTs are sure to always provide positive feedback when a student expresses her/his individuality by giving compliments such as “Amazing job being creative in your songwriting!” or “I loved your improv during that song!”

Through these communicative strategies, adolescents are able to begin building a sense of community within their small groups. This helps them learn how to more
successfully integrate into the community. Although snippets of this process were found in previous research on CoMT, literature has yet to lay out and put together all of the pieces of the process of community construction in this type of procedural format. There are missing pieces from each pattern as discussed in the segments above.

If we can begin to further develop these relationships and connect the dots, then community building can be more commonly successful within therapeutic settings.

In Chapter Four, I will present some interpretations of the results illustrated in this section. Then, some theoretical and practical implications of this research will be demonstrated. Next, I will discuss some limitations of the current study, and directions for future research. Finally, I will close with some reflections about the process of conducting this research.
CHAPTER 4

CONCLUSION

During the final jam session, all of the students were provided with “rockstar awards.” Each mentor wrote all of the great things about their mentees on the awards telling the students why they were rockstars. We told them they were great at the drums, super dancers, awesome singers, always energetic, fun to be around, fantastic at playing the keyboard, and the list goes on. Each and every individual got recognized. They were called to the front of the class and presented with their awards. The smiles they wore on their faces were contagious. They jumped around, dancing, clapping and singing. But, the idea that this was going to be the last jam session “until further notice” was hindering my ability to enjoy the session in all of its energy. I wished that we could tell the mentees, “See you in a couple of weeks!” the way we had been able to before. This group of mentors and mentees may only have met six times for the jam sessions, but the community aspect was there. By becoming personal with all of the individuals involved in the jam sessions, I was able to not only learn, but feel what it was like to be part of such a community. This has been a very rich experience for me that I would not trade for any other.

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As was presented in the previous chapter, this study revealed that music therapists’ use of various communicative strategies (shown in Table 1) foster the communication of connections, togetherness, autonomy, and expression/identity. Through these strategies, the construction of community helps to advance the competencies of adolescents to integrate into society at large. The need for a space where at-risk adolescents and adolescents with developmental disabilities to engage in this process of community building is growing at a rapid pace as funding continues to decrease for creative arts projects and interventions in organizations. This research illustrates that the arts do make a tangible difference in the lives of students.

In the following paragraphs, I will first discuss some interpretations drawn from my results. Second, the theoretical and practical implications that stem from this study will be
presented. Next, I will illustrate the idea of community building, both on a micro and macro level, and how the construction of community contributes to the lives of many adolescents in the MT context. Then, I will give an overview of the limitations of this research that illuminate some directions for future research. Finally, I will provide some final thoughts and reflections about the process of writing this paper.

INTERPRETATIONS

Through this research, I have come to better understand the complex nature of community building within the MT context, particularly with adolescent patients and students. That said, there are threads that unite all of the above sections together. Within the MT context, when working with adolescents, my results have shown that negotiation is crucial, innovation is necessary, and “rules” must be broken. I have also found that MTs, through all of their communicative strategies, create a space that both motivates and communicates trust to their patients. These conclusions will be expanded upon in the remaining paragraphs of this section.

First of all, constant negotiation on behalf of the MTs is a regular part of the job. The therapeutic process involves a lot of give and take, trial and error, and flexibility. This is partially due to the fact that at-risk adolescents deal with many struggles that require them to be flexible in their own lives as well. During her interview, the MT Autumn said, “This profession is a lot about flexibility and this population has to be very flexible to get through their childhood because so many unpredictable factors are in their lives at all times” (Personal interview, February 2, 2013). MTs must be willing to be accommodating to the individuals they work with and make adjustments based on their patients’ needs and reactions.

The process of negotiation draws on assessment and reflexivity. MTs must first assess a patient’s circumstances, determine the goals of that patient, and then establish which interventions will be used to reach those goals. However, one intervention may work with one group of students or patients, and fail to be compelling with others. So, therapists must be reading the verbal and nonverbal expressions of their students, assessing them, and determining what to do next. If within the first five minutes of a session, an intervention is
not working, the MT must move onto another intervention that may have more success. Zoe shared an example of this process of assessment and negotiation:

I am playing the guitar for turn taking intervention and the client isn't focusing on the instrument we are using, instead they are fixated on the guitar and trying to grab it. I'll use the guitar as the turn taking instrument instead of the previously chosen instrument, or I'll take away the guitar and use only my voice and the other instrument. (Personal Communication, April 26, 2013)

This negotiation shows the necessity of improvisation as well as having knowledge of each client’s needs. Ansdell (2010) discusses how both collaboration and negotiation are communicative processes inherent to “communication communities” and how “togetherness is negotiated through communicative processes of timing and ‘spacing’” (p. 58) by members of a community. Here, Ansdell (2010) highlights the process of negotiation of the group as a whole and how their musical negotiation contributes to their collaboration as a group.

Because he is focusing on Community Music Therapy, Ansdell (2010) is less concerned with the MT’s contributions and more concerned with the roles that the community-members play. The current study, however, focuses more on MTs and how they use particular strategies to foster community building. When I write about negotiation, I am particularly referring to the MTs and how they engage in negotiation. Similarly, Stige (2010), in his chapter that discusses cultural rituals in CoMT acknowledges the importance of negotiation on behalf of the MTs: (There is a) “need to negotiate on the formation of the rituals themselves. This requires reflexivity on behalf of helpers and therapists, who need to develop consciousness about themselves as participants in interaction rituals” (p. 141). Here, Stige (2010) illustrates how MTs and helpers are not present in sessions only to lead and facilitate, but to also be part of interactions. Therefore, their own presence must be negotiated through reflexivity. Not only does their presence need to be negotiated, but the rituals they decide to facilitate (or interventions as I refer to them above) need to be negotiated.

Within a group setting, this process can be especially challenging because the needs of each member of the group should be met while the collective needs are also satisfied. As Jill described when discussing group sessions:

Within each intervention that we do, we have to adapt it to each person’s level so we are constantly trying to make it right for each person but within a group context and working on things they all need to work on. (Personal Interview, December 13, 2012)
In a sense, community seems easier to foster in group sessions because patients and students are able to engage in communication not only with the therapist but also with each other. However, this further complicates the process of negotiation. After a session is over, MTs must reflect on what occurred and modify interventions for future sessions with the same patients and other patients, which is the process of innovation.

In addition to negotiation, innovation is always necessary within a MT session. Theoretically, patients are always improving and changing. Thus the therapist must be adapting their interventions to maximize success. Autumn described how, “You just have to constantly be doing new things, and just rolling with it” (Personal interview, February 2, 2013). This complexity can make the means of reaching certain goals fairly difficult. Interventions cannot remain stagnant and unchanging. As patients’ emotional and developmental states improve, interventions are transformed to meet the current needs of the patient. If there are no existing interventions to reach particular goals, MTs may resort to designing new ones. This innovation is key to the therapeutic process, but is by no means simple. Jill described this process as “juggling.” She said:

You’re really juggling a lot of different hats at once. It’s like driving a car, looking at the rearview mirror, looking at your side, your blinker, your breaks and you know constantly adjusting based on that. . .it just takes practice and being aware of yourself and getting feedback from other professionals and evaluating yourself and having the desire to improve. Without any of those things you wouldn’t be able to be successful. (Personal Interview, December 13, 2012)

Similar to other professions, moving forward is always a must. Without innovation, improvements would be minimal.

Finally, within a therapy session, “rules” must be broken in order to maximize success. Because of the flexible nature of MT sessions, MTs rarely give their patients “rules” per se. In a sense, certain individuals will immediately hear the word “rule” and close off. Emma told me in her interview that she never presents a classroom with a list of rules. Instead, she calls them “expectations.” The teens know that they are expected to engage in certain activities, but in a sense, engaging in this communicative framing by naming them “expectations” is a way for therapists to encourage as opposed to restrict. The idea of breaking “rules” is related to the idea of breaking societal “norms” as well. The results also show how some societal norms are broken within the MT sessions with adolescents.
One of the goals of the jam sessions was forming social skills and showing students how to successfully function in society. However, recall the interview with Fay presented in Chapter Three. She said:

I hope that what they would take (from the sessions) is their own sense of value. Their own sense of person. One thing that I really don’t like about our culture is that they want to put everybody into a box. Especially parents. They want to put their kids, they want to dress them a certain way, and it’s for the parent’s comfort; it’s not for the kid. . .For some kids that’s fine, they can do that. But it’s not for everybody; not every body can fit into a box. (Personal Interview, January 30, 2013)

What Fay is saying here is that each individual is unique and should be able to present themselves as such. If society is telling someone to dress a certain way, they are limiting the individuality of each person. So, within the session, this societal norm of “fitting in” is broken as patients are encouraged to be themselves regardless of what others think. This relates to the research of Harter and colleagues at the organization Passion Works (Harter et al., 2006). They illustrate throughout their piece on performing a counter-narrative of disability how Passion Works provides people with disabilities (PWDs) with a place where they can, through their artistic expressions, challenge society’s tendencies to isolate PWDs. Harter et al. (2006) describe how “through art, clients confront their cultural alienation and enter various sectors of the mainstream to explore, clarify, and critique the dialectic of selfhood and social participation” (p. 19). Although PWDs are continuously alienated in their daily lives, at Passion Works they are able to break this “norm” in their formation of self.

Another example of breaking the “norm” in Chapter Three was presented by Autumn. She spoke during her interview about a boy in one of her classes that loved to bang pencils on his desk. Other teachers would tell him to stop making noise during class and stop tapping the pencils. Instead, Autumn encouraged this behavior saying, “Well, I brought drums, but let’s play with pencils on a desk. It’s still music,” (Personal interview, February 2, 2013). Other teachers might frown on this because it is a societal norm that banging on a desk with a pencil is inappropriate classroom behavior. However, by allowing this student to break this “rule,” Autumn is providing an outlet where this student can express himself in ways he wouldn’t be able to in other classrooms.

Some of the conclusions above have been explored in previous MT literature. McFerran (2010) describes how she “frequently leave(s) a session wondering ‘what just
happened?’ and it is only in writing up progress notes that I begin to see patterns or make interpretations that restore my confidence” (McFerran, 2010, p. 48). This supports the idea that negotiation is crucial, in that sometimes interventions do not go as planned and the therapist must reflect on this. After reflection, the therapist must then adapt and be innovative. Her advice to other people working with adolescents is to “stay calm,” “go with it,” and “stay one step ahead” (McFerran, 2010, p. 51). Future research however, should further explore the conclusion that “rules” must be broken, sometimes simply by shifting communicative framing, because minimal literature explores this phenomenon.

In addition to engaging in negotiation, innovation, and “rule” breaking, across all four patterns, MTs create a space that both motivates and communicates trust to their patients. Although these two concepts were not presented as overarching patterns, they are undeniably vital to community building for adolescents within the MT context. One of my participants, Erin, explained that trust and motivation are the two key components most central of the development of a relationship with a patient. (Personal Interview, January 13, 2013)

In Chapter Two, I described how motivation was an idea that I originally thought could be one of the patterns that answered my research question. However, after more research and reflexivity, I came to understand that motivation is actually key to all four patterns and is apparent throughout the entirety of an MT session. Music therapists choose certain types of music and songs to be sure that the student remains motivated. They also might speed up the tempo of a song to motivate the student to keep their energy level up. And, MTs attempt to engage the students to the point where they are self-motivated to enact certain activities without being told to do so. Motivation is what keeps adolescents engaged and excited to participate and continue to do so.

The concept of communicating trust is another common thread. Within all four patterns, MTs attempt to create a safe space for the adolescents to be able to experiment with their emotions and musical abilities. A lot of individuals in their adolescent years tend to distrust others, particularly adults. Although this may be more so the case for adolescents with behavioral or emotional issues, it could also be the case for those with developmental disabilities simply because they may feel that they are never in a “safe space” to really be themselves. The stigma they carry of being out of the “norm” may cause this distrust and,
perhaps, a fear. Thus, by making sure that their patients are motivated and experience the MT session as a safe space, MTs ensure the possibility of community construction.

Throughout the results, it is apparent that in order to reach particular goals, MTs must engage in negotiation, innovation, and must leave room for breaking “rules.” Through constant assessment, modification, adaptation, flexibility, reflexivity, and communicative (re)framing, MTs are able to communicate connections, togetherness, autonomy, and identity/expression. They are also able to create a safe space and motivate their patients to return. All of these aspects contribute to the process of community construction. The following section will explore the theoretical implications derived from this study.

**THEORETICAL IMPLICATIONS**

The findings of this research have implications that go beyond the current study. The paragraphs below will discuss ways in which my results contribute to research on community, performance studies, aesthetic organization theory, and narrative research.

Ample literature has focused on different types of community. As discussed in Chapter One, scholars have studied communities as “communities of place,” “communities of hope,” and “communities of interest” (Ansdell, 2004). They have also been presented as “communication communities” (Ansdell, 2010; Delanty, 2003). The dimensions of community as per my own definition presented in Chapter One most closely relate to the idea of communication communities, which is itself focused on the overall process of community building founded in communicative strategies. As Ansdell (2010) describes, “creating community today often involves actively cultivating such ‘communicative competencies’ as dialogue, collaboration, and negotiation--both verbal and nonverbal” (p. 45). This research contributes to the ongoing study of communication communities, both micro and macro, and how they are formed throughout society.

For example, in the results I have shown that community is constructed in the MT context by communicating both autonomy and communicating togetherness. In communicating autonomy, a therapist may ask a group of students who will lead the band in the next song and take charge. On the other hand, in communicating togetherness, a therapist may let the group know that no one member is more important than another and they all need
to work as a group to end the song together in rhythm. Although these two examples may seem contradictory, they both lend themselves to community construction in the MT context.

This tension between togetherness and autonomy confirms previous research on community, particularly that of Ansdell (2010) and Delanty (2003) on “communication communities.” As discussed previously, Ansdell (2004) argues that achieving a balance between autonomy and togetherness is important to the process of community construction. While confirming the idea that the balance between autonomy and togetherness is important, this research adds that autonomy is not to be considered synonymous to individualism in the context of music therapy. Although slightly related, communicating autonomy to students and providing them with a space in which they can perform their own uniqueness are two distinct processes. In addition, this research transforms the abstract idea of balancing autonomy and togetherness into a list of particular strategies that can be used in the context of MT to engage in this balancing.

The tensions that occur within the context of MT with adolescents, and the ways in which those tensions are managed, are greatly related to the research of Leslie Baxter and colleagues. Baxter and Montgomery (1996) have presented and expanded upon Relational Dialectics Theory to explore the ways in which individuals manage both conflicting yet essential needs in relationships. These conflicting needs are referred to as dialectical tensions (Baxter & Montgomery, 1996). We manage dialectical tensions through communication. One of the tensions that Baxter and Montgomery (1996) present is that of autonomy versus connections. In this particular tension, individuals in intimate relationships want to be independent from their partners, but also connected to their partners simultaneously. Similarly, in the MT context, MTs communicate autonomy to their patients (independence), but also togetherness (group cohesion). Although Baxter and Montgomery (1996) may be referring to two individuals in an intimate relationship, this research shows that these dialectical tensions can be seen in communities as well.

One of the strategies of managing dialectics that Baxter and Montgomery (1996) present is “recalibration.” Recalibration refers to when the individuals experiencing the dialectical tension reframe the tension so it no longer seems conflicting (Baxter & Montgomery, 1996). In this case, those involved accept that both needs are equally important. Locating recalibration in the MT context, MTs have to recalibrate so that the
tension between autonomy and togetherness is no longer a tension, but that they are instead synergistic. To have one (togetherness), you have to have the other (autonomy). So although it may seem that there is a tension, through communication these two work in concert with each other.

This research adds to Relational Dialectic Theory. In the context of MT, how community is facilitated or constrained has a lot to do with how community members move along these dialectical tensions. Managing dialectics is not simply located in one particular interaction between two individuals in a relationship. Every community is made up of a number of relationships. The dialectical management in the MT context plays off of a lot of different people within the community or particular jam session. This research extends Relational Dialectics Theory to be not just about relationships, but also about communities of people making music.

I also have found that creating a space that encourages the performance of identity and individual self-expression is important in community construction. Each person must feel that their micro community is a safe space to self-express. The collective community is made up of various unique individuals, and without freedom of expression, community building would be hindered. One way in which MTs create this safe space, for example, is by encouraging improvisation during a song, or giving patients positive feedback during individual songwriting sessions. So, through the findings, I have presented various specific communication strategies that are used in the MT context (See Table 1) in order to achieve the dimensions of community, contributing to both communication research and MT research. Providing these specific strategies adds to established theories on community which have simply mentioned the role of communication without presenting concrete examples of strategies.

Literature on community construction can also benefit from the findings in Chapter Three in terms of looking more closely at the idea of companionship. As presented in Chapter Three, research on ‘communication communities’ should explore communication research on companionship which suggests that companionship is important for stress-management, social fulfillment, and psychological health (Rook, 1987). The link between companionship and community construction is one that could be very insightful to MT literature if further considered. Music Therapists are able to provide a sense of
companionship for their patients which makes the construction of community more successful.

The results of this thesis also contribute to performance studies literature. As presented in Chapter One, Goffman’s (1959) idea of *performance* is distinctive from the typical way we think of theatrical “performances” in that by using the word *performance*, Goffman (1959) refers to “all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants” (p. 15). The results of the current study use the term “performance” to refer to both types of performances.

As presented in Chapter Three, both MTs Zoe and Lexi expressed musical performance as a contributing factor to encouraging autonomy. Lexi said that performing for audiences gave her group of patients a “sense of ownership” over the band (Personal Interview, December 17, 2012). Also, Zoe’s band felt very “proud” after being able to perform for the community (Personal Interview, December 18, 2012). Both of these examples are ways that more theatrical performances contribute to the performance of autonomy of the individuals involved. This is interesting in that both types of performance, musical performance and performance of identity, are equally lending to community construction in this context. Goffman’s (1959) idea of performance focuses on performance in the “life is a stage” sense, so essentially everything that we do is a type of performance. In the MT context, musical performances significantly contribute to the performance of self and, thus, toward the outcomes of a MT session.

Further toward the end of Chapter Three is where we see more examples of Goffman’s (1959) idea of performance. In the section entitled “Performance of identity: Facilitating self-expression,” I explain the ways in which the communicative strategies enacted in the MT setting this context a space where the performance of individualism and creative expression are made possible to individuals who may not have that outlet in any other space. For example, MTs encourage patients to engage in improvisation during a song. This creates a space in which patients are able to perform their own individuality and uniqueness. In addition, MTs may limit the instructions they give to their students to leave room for interpretation which allows the patients to be creative and unique.

So we now know that in the MT context, both types of performances equally contribute to the construction of community. Music is undoubtedly performative in nature.
Patients are constantly performing musically by singing, dancing, and/or playing an instrument for their therapist and for other audiences. But, at the same time, they are performing their own unique personalities through these musical performances. By creating a space in which musical performances contribute to identity performances, MTs can encourage community building on multiple levels. This can eventually contribute to community performances in the larger society. Therefore, researchers should further explore the links between performance, identity, and community to better understand the interconnectedness of these theories.

This research also confirms and contributes to the theory of aesthetic organization (Harter, Leeman, Norander, Young, & Rawlins, 2008). Informed by Dewey’s Art as Experience (1934/1980), Harter et al. (2008) argue that aesthetics are knowledge-producing and, therefore, the consideration of such should be interwoven throughout organizational research. Exploring creativity and imagination helps contribute to research perspectives, particularly those concerned with social change in organizations “as it offers enriched insights, an enlarged sense of possibility, and fuller interactions” (Harter et al., 2008, p. 448). However, there are complications when encouraging imagination within organizational structures. Organizations tend to focus on the logical and remote the aesthetic/creative. However what Harter et al. (2008) argue for a fusion of strict standards, yet aesthetic creativity, when bureaucratic organizations tend to focus on the standards and ignore, or even degrade imagination.

The MT context is a great one in which to explore the knowledge that aesthetics help to inform and produce. Harter et al. (2008) propose “that organizing in general constitutes an aesthetic endeavor” and that “organizing offers multiple occasions for exercising our imagination” (p. 450). The results presented in Chapter Three confirm that this is also the case within the MT context. As presented in the beginning of this chapter, negotiation is crucial to the success of a therapeutic session. MTs may go into a session with a structured plan, but they must leave room for flexibility as well. If a session is not going as “planned,” a MT must use their imagination and think on their feet in order to come up with new and innovative ways to reach the set goals. Through this imaginative process, MTs are going “beyond the books”. They must take the knowledge they have regarding particular
interventions and weave that knowledge with their own imaginative ideas to create new interventions on the spot, and thus, new knowledge that they apply to future interventions.

The notion of aesthetic organization fits nicely with the conclusion that within the MT context, “rules” must be broken. Harter et al. (2008) argue that “to tap into the imagination is to break with what is supposedly fixed and carve out new orders” (p. 450). This research explores the idea of breaking “rules” in order to create new ones. Instead of only teaching patients socially “correct” behaviors, MTs encourage patients that they don’t always need to fit “inside the box.” In one way, this process lets therapists and patients be imaginative and creative within the organizational structure of the therapeutic session. MTs must constantly search for the balance of providing structure yet enabling imagination. What this research adds to Harter et al.’s (2008) literature on aesthetic organization is the specific communicative strategies used by employees in order to promote this type of organization. Some of these strategies are encouragement, modeling, motivating, offering critique, facilitating, and providing positive feedback. For specific examples of all of these strategies as they are enacted in the context of MT, see Table 1.

This research helps to expand on the literature arguing for the use of therapeutic narrative analysis (Aldridge & Aldridge, 2002). Throughout the process of answering the research question, “How does the communication within the context of MT encourage community building for adolescents?” I primarily utilized excerpts derived from narratives found in interviews and fieldnotes. These narratives guided the remainder of my data analysis and writing process. Without the therapists’ narratives, and my own narratives, I would not have been able to achieve theoretical saturation because the narratives helped me make sense and meaning of the various abstract processes I was observing and hearing about in narratives. As Harter (2009) explains, “Narratives endow experiences with meaning” (Harter, 2009, p. 141). Aldridge and Aldridge (2002), in their piece on therapeutic narrative analysis, focus particularly on case studies in music therapy and how therapeutic narrative analysis can aid in the understanding of particular interventions and how they lend to reaching particular therapeutic goals. I, on the other hand, used this methodology to contribute to my research on the communication occurring in music therapy sessions, not necessarily whether or not certain therapeutic goals were being met. Through the current
study, then, we now know that narratives can help to inform us about community construction and the communicative aspects of it.

In addition, this research expands on Aldridge and Aldridge’s (2002) idea of therapeutic narrative analysis in providing the idea that autoethnography can contribute to this process. In their article, Aldridge and Aldridge (2002) focus on analyzing narratives of patients within particular therapeutic contexts. Although the authors do emphasize the role of the researcher in the process of interpretation, they fail to consider that the researcher’s personal narratives interwoven with the narratives produced by patients and their therapists may contribute to the knowledge production in a particular context. Throughout this research, I have included some of my own autoethnographic pieces in order to explore this possibility.

In addition to the theoretical implications this research provides, there are practical implications that are important to the broader society. The following section will present and expand upon some of these.

**PRACTICAL IMPLICATIONS**

In addition to theoretical implications, this study also has practical implications for a variety of groups. This section will focus on families, education employees, those who work in MT, and society members in general.

First of all, families that have children either approaching or in adolescence can benefit from this research. The benefits are not limited to families with adolescents that have developmental disabilities or neurological limitations. Much of the current MT literature separates adolescents with developmental disabilities from adolescents with behavioral problems. However, as presented above, many of the issues being faced by both sets of individuals are similar. Adolescents in general have difficulty transitioning into early adulthood. Therefore, the results can be understood as relatable for many families, not just those with adolescents with developmental disabilities. All families with adolescents should be able to read this research and take something from it. For example, perhaps a family has a teen that seems very closed off and unwilling to express her/himself. This family, after reading this paper, may be encouraged to use music in some way within their family life or encourage the teen to pursue their own musical abilities. Or, families may gain from the idea that “rules” must be broken at times with this particular population. So, perhaps by
communicatively reframing some of the ways in which they present rules or norms to their teen, parents could evoke more positive reactions from their child.

Also, those who work in education can take pieces of this research to utilize with their own students. Middle school and high school teachers and their students could benefit from the incorporation of music in lesson plans. For example, English teachers can use a song to encourage creative writing from their students. They could play a song in the background while their students are doing a writing project in order to promote more creativity. Also, teachers could lead a short drum circle session after lunch to bring the students back into the listening mood. Or perhaps even more beneficial, each class a student could lead the session. This may help promote leadership, also calm students down after an hour with their friends. Finally, songs are already utilized in some schools but should be used more so when dealing with items that require memorization. By repeating certain words with melody and rhythm, students may better retain certain concepts (Rauscher, Shaw, & Ky, 1995). As more research on MT is published, schools will hopefully begin to see how music can be very useful in the classroom setting for a variety of objectives.

Throughout the process of doing this research, I was repeatedly confronted with the idea of the two levels of community construction that MTs working with adolescents attempt to achieve. These two levels are the micro level, meaning the group within each MT session, and the macro level, meaning the community at large. Both levels of community building were important to the participants in this study. As the therapist Zoe expressed, “as you move forward, showing how what we do in the MT session is going to transfer outside. That’s the ultimate goal.” (Personal Interview, March 9, 2012). Lexi mentioned a similar goal: “so moving forward because he is turning 18, so vocationally, how can he integrate into the community, how can he have a skill or a leisure activity that he can do basically for the rest of his life.” (Personal Interview, March 9, 2012) And finally, Jill described “for the older kids we really shift in our goals to what can be functional for them in the community.” (Personal Interview, December 13, 2012) This shift in objectives is consistent across the board.

As children become teenagers, MTs are mostly concerned with micro and macro community building rather than other goals. Much of the reason for this shift in objectives is
because there is a significant need in the community as the visionary for the jam sessions, Lexi, expressed in her interview, focusing on teens with neurological limitations:

There is a huge breakdown once students leave the school setting. There isn’t a lot of services or things for them to be doing out of the community and so there is really like a huge drop off and I think as this huge population especially with kids with autism is getting older I think the society is going to have to figure out a way or something for them to do you know and so, for instance, the California Department of Education in 2000 there were approximately 650,000 youth with special needs between 0-22 in California and a lot of these individuals have like brain injury, multiple disabilities, speech and language impairment, autism. Then they have deficits in social skills, emotional expression and communication, and then in 2010 this number had increased to 670,000. So despite these increasing numbers state funding for services has decreased. (Personal Interview, December 17, 2012)

Many members of the community are unaware of the severity of this need in today’s society. Therefore, some may hold the view that when funding gets cut in every other area, it seems only fitting that it would be cut in services to adolescents with developmental disabilities and at-risk adolescents as well.

Unfortunately, the need is growing more quickly than the means to fulfill it. One of the practical implications for this study is for community members. Creating more awareness of the need that exists in our society to help educate community members of the current situation. Lexi demonstrated how MT can be a bridge to community:

Music therapy for, especially I see it, as kids start to get older music therapy can be a bridge to community, can be an entrance point especially as they are getting older and maybe there isn’t necessarily a place for them in the society or in the community. I think music could be something that brings people together. (Personal Interview, December 17, 2012)

Regardless of the growing evidence that shows the power that music and communication have to construct this bridge to community, much of society either ignores or refuses to accept this support. Fay is a passionate advocate for MT with adolescents and she shared her frustration with me during an interview:

Yeah, I mean, it just doesn’t make sense does it? That a generation of adolescents who love music, live by music, are ruled by music, wouldn’t get treatment through music. . .(Our society) they don’t really get it, that music and expressive arts in general are so much more effective with adolescent populations. (Personal Interview, January 30, 2013)

Music therapy has the potential in adolescent populations to form the “ripple effect” that Pavlicevic and Ansdell (2004) describe in their articles and books. Music in the private sector
never has as much influence on communities as does music that permeates throughout our society (Pavlicevic & Ansdell, 2004). So, maybe this idea of taking the private into the public and giving music back to the people has the potential to transform our community, one mini community at a time.

In addition, MTs, and those working in the MT context, can benefit from research on the communicative processes that occur within a session that lend to community building. This research may prompt them to more critically reflect on their own strategies and perhaps add others when there are particular goals in mind. For example, if a therapist is working with an adolescent and having difficulty communicating the idea of autonomy to their patient, they may engage in some of the communicative strategies presented in the results section of this paper. For instance, they may provide an opportunity for the patient to choose the next song or may encourage the patient to express her/his musical preferences. By doing this, the therapist can encourage the patients to have personal opinions and to be independent. Or, if in a group setting, the therapist may tell the patients to come up with a band name. This gives the patients a sense of ownership over the group, which also lends to autonomy. Although MTs are already engaging in these practices, a better knowledge of how communication is playing a role in this process may be insightful.

Music therapy literature claims that communication is a goal of MT (Ansdell & Pavlicevic, 2005). MTs work with their patients in teaching them how to effectively communicate with others (social skills), but also how to verbally communicate in general (speech skills). However, what the literature only slightly touches on is the idea that the process that occurs in a MT session is entirely communicative, both verbally and nonverbally. In order to reach particular goals with patients, MTs use particular strategies that are only successful if being effectively communicated. The next section will overview the methodological limitations of this study, and then provide directions for future research.

**LIMITATIONS AND DIRECTIONS**

**FOR FUTURE RESEARCH**

This study does have limitations that future researchers should keep in mind when investigating the many complexities of the MT context. First of all, only 12 interviews were conducted for this study. The interviews were of eight certified MTs and one guitar
instructor. Although the patterns were consistent across all 12 interviews, future researchers may consider conducting more interviews to be sure their findings are still consistent, and to expand the perspectives represented.

In addition, although the guitar instructor was not board certified as a therapist, and therefore his interview transcripts were not used directly in the results portion of this study, he did have insightful information regarding the therapeutic use of music with at-risk adolescents. In addition, many of the communicative strategies used in his classes aligned with those used by the board-certified therapists. Perhaps future studies could compare observation and interview data from board-certified therapists with other individuals who utilize music therapeutically, but are not certified or trained to use it as “therapy.” They might find that many of the communicative strategies between both groups are similar. This could broaden scope of using arts with at-risk populations and make it more accessible to additional organizations that may not be able to afford to pay a certified therapist. They may also explore which communicative strategies are distinct and set certified therapists apart from other individuals using music therapeutically. This could help further determine which populations need to be served by a therapist and which populations could equally benefit from an individual using music therapeutically.

One limitation that is important to point out is the fact that while rich in insight, the interview data only includes the voices of the therapists. In order to more fully grasp community building within MT settings, scholars should obtain interview data from more individuals involved in this context. This could include, patients, families, and mentors/volunteers. Community is not built solely by the therapists but by the interactions that occur between all individuals during a session. Therefore, their insight is undeniably important.

While this study includes information about adolescents with developmental disabilities and at-risk youth, the observations (with the exception of the observations of the guitar class) were only of adolescents with developmental disabilities. Therefore, all of the examples in the results regarding at-risk youth, or youth with substance abuse/behavioral issues, come from interview data. I did not want to separate these two groups of people (adolescents with developmental disabilities and at-risk adolescents), not only because they both fall under the category of “adolescents” who will play a part in society’s generational
changes (McFerran, 2010), but also because each group can be characterized as “at-risk.” However, observations of at-risk adolescents, as opposed to just interviews, could have further solidified the idea that the same communicative strategies can be used across both groups to lead to community building. Future research should have more observation data of at-risk adolescents when drawing such conclusions.

Finally, when conducting interviews, I did not ask therapists which perspective they held in terms of their MT background and training. After further investigation, I came to learn that MT has a variety of paradigms and scopes and not every therapist shares the same one. A better understanding of these paradigms and knowledge of where each therapist was coming from could have better shaped my interview guide. The final section of this thesis will provide some final thoughts and reflections, and will highlight the portions of this research that I found particularly relevant to the society at large.

**Final Reflections**

As people read through this thesis, my hope is that they begin to comprehend the inherent need in society for aiding adolescents through their transition into early adulthood, particularly at-risk adolescents and those with developmental disabilities. The potential of MT, one type of complementary and alternative medicine, to begin to meet this need is what has driven this research. Music is a way for adolescents to communicate their identities and unpack difficult situations. It is also an avenue for individuals to connect to the community at large. On a broader spectrum, music is often a way for all community members to connect. As presented throughout the literature in previous chapters, every human culture has had music in some form (Merriam, 1964). For many years, in ancient cultures, music has been a way for humans to express themselves and communicate (Crowe, 2004). Therefore, music is one art form that has therapeutic elements, which can be especially useful in working with all populations, including at-risk adolescents.

Unfortunately, with the increasing number of dollars being put into music for entertainment purposes, much of society has been blind to the power of music for the common person. Perhaps by making more of the general society aware of the healing properties music possesses, not only on a personal story level, but also from an evidence-based perspective, some of the billions of dollars that the “professionals” in the music...
industry collect could be translated into monetary contributions necessary for the improvement of the lives of our future generations. If more members of the community were aware of the importance of music beyond entertainment, perhaps its effects on society could be more apparent. Autumn was very insistent on expressing these desires for the public:

You have a community within every single (music therapy) session. That’s your little mini community. But the idea is that as we grow as a profession and as these kids go out into the world, they’re spreading it and it’s getting bigger and bigger. ..What I always say is that “I want to give music back to the people” Like it’s not just about entertainment; it’s not about something you have to spend a ton of money for or just not participate in if you’re not amazing. It’s for everybody, which is how it’s been for thousands and thousands of years until there was so much money in it right? So and this is, music is how you rise up from the trenches. People sing together, they have community together; you can’t take away the joy. (Personal Interview, February 2, 2013)

Writing this thesis has opened my eyes to the realization that music has become something that has been handed off to the most talented. People laugh at others when they don’t have perfect pitch on American Idol. The judges tell some of the people who audition that music just “isn’t for them” and this serves as enhanced entertainment to the show’s viewers. Conversely, then we have L.L. Cool J opening up the Grammys with the phrase, “We hold these truths to be self-evident: music brings people together.” In today’s society, does music really bring all people together? Or does it only bring fame and fortune? What about the other millions of people who could benefit from the use of music but are taught that if they are not musical, then music just “isn’t for them”? Let’s not forget that in the midst of the fame and fortune and the competitive aspects of music as entertainment, there is still a place where music can be beneficial to the common person. Through my observations of MT sessions and my interviews with the very dedicated and passionate MTs in this study, I was able to find where my interest in MT stemmed from all along: the idea that music is in fact for everyone.

***

When I picked up my uncle’s classical guitar for the first time and began to move my fingers across the strings, my 11-year-old brain could not fathom the idea that music would become such a large part of my life. I now look back on the experiences I had as an adolescent when I thought that life would never move past that very moment and I am grateful that I had music to provide an outlet for me. All the heartbreaks, the friendships lost,
the loved ones who passed, and the constant pressures to be perfect. Had I not been able to
crawl into a corner in my room and write a song to let it out, I can only speculate the outlets I
would have found to escape. Although I do not remember ever meeting my uncle, the one
artifact of his I do have reminds me that giving up is never the option. I can always strum that
last chord, sing that last note, finish that song, and start a new one.
REFERENCES


Stige, B. (2010). Musical participation, social space, and everyday ritual. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), *Where music helps: Community music...*


APPENDIX A

OBSERVATION GUIDE
Pay close attention to the following:

➢ What nonverbal gestures and nonverbal immediacy behaviors does the therapist use in order to make the patient feel…
  Comfortable?
  Calm?
  Enjoyment?
  Belonging?
  Confidence?

➢ Which interventions are being used during the session, and for which goals specifically?
  Ex.- An instrument circle with 4 participants in order to engage in sharing and turn taking
  Ex.- The “Hello Song” in order to get the patients to say hello to each other and have a conversation (speech skills and social skills)

➢ What are the specific roles the therapist is enacting during sessions? How are they performing these different roles and how are they intersecting?
  Ex.- Roles typical to a parent, teacher, friend, therapist, psychologist, etc…

➢ How does the therapist create a sense of community with the patients? What strategies are being used to cause the students to interact with other students?

➢ How does the therapist use music to communicate motivation to the patients?

➢ How does the therapist use music and communication to help the patient(s) create an identity, either individually or as a group (for the band)

➢ How are the patients communicating with one another?
APPENDIX B

OBSERVATION CONSENTS
Therapist Observation Consent Form

Dear Study Participant,

I am a Graduate student in the School of Communication at San Diego State University. I am requesting your participation in this study based on your experience as a music therapist. Participation in this study will involve being interviewed to discuss your experiences as a music therapist. This interview should take no more than an hour and a half and may be as short as 30 minutes. With your permission, I would like to audio record the interview so that I can later transcribe it. You may still participate if you prefer not to be audio recorded. As a participant, you may listen to your own recordings at any time and have any parts of the interview removed from the data set upon request, though you may not listen to the recordings of others nor can others listen to yours. There are no financial costs associated with participation in this study. I would also like to observe communication between you and your patients that may occur before, during, and after sessions at the California School of Music Therapy (CSMT) (a pseudonym). As part of the study, some of the sessions may be video recorded and photos will be taken if allowed by all participants. If you allow sessions to be video recorded and photos to be taken, you will be presented with a separate video/photo consent form. If you do not wish for sessions to be video recorded or for photos to be taken, there will be no penalty. At any time you may review the video footage and photos of the session and have any footage/photos deleted that you do not want included in the data set. You may also ask me to stop video recording or taking photos at any time during the session.

Your participation in this study is voluntary. You may choose to stop the interview at any time. Additionally, you may choose not to be observed. If you choose not to participate, or to withdraw from the study before, during or after the interview, there will be no penalty. The results of this research may be published, but your name will not. The published paper will not refer to the CSMT and all other identifying information. Other persons names mentioned in the interview will be altered or omitted to ensure confidentiality. The tapes and transcripts of this interview will be retained indefinitely for archival purposes and will be stored in a locked file cabinet in a locked office. Notes that may identify participants will be
stored separately in a locked deck drawer. If you decide to take part in this study, your interviews and observations will take place at either one of the two CSMT locations.

If you have any questions concerning this research study, please call me at (619) 672-4985 or melaniefrontz@hotmail.com.

Cordially,

Melanie Frontz  
Graduate Teaching Assistant  
School of Communication  
San Diego State University  
5500 Campanile Drive  
San Diego, CA 92182-4561

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Institutional Review Board at SDSU (619-594-6622) or irb@mail.sdsu.edu to report problems or concerns related to this study.

________________________________________________________________________
Name of Participant (please print)

________________________________________________________________________
Signature of Participant  Date

________________________________________________________________________
Signature of Investigator  Date
Parent Consent for Observation of their Child

Dear Study Participant,

I am a Graduate student in the School of Communication at San Diego State University. I am requesting your permission to include your child in this study based on their experience as a patient of music therapy. The study is primarily focused on the therapists and the strategies they use during sessions in order to meet specific goals. Your child’s participation in this study will involve being observed during their weekly sessions. If you decide to allow your child to participate in this study, they could be observed over the course of 16 sessions with their therapist (one one-hour session per week for four months). I will be watching the sessions, occasionally taking notes, and occasionally participating in the sessions by playing music, singing, or assisting the therapists in whichever tasks with which they may need help. As part of the study, some of the sessions may be video recorded and photos may be taken if allowed by all participants. If you allow sessions of your child to be video recorded and photos to be taken, you will be presented with a separate video/photo consent form. If you do not wish for sessions to be video recorded or photos to be taken, there will be no penalty for you, your child, or your child’s standing at the California School of Music Therapy (CSMT) (a pseudonym). At any time you may review the video footage or photos of your child and have any footage deleted that you do not want included in the data set. You may also ask me to stop video recording/photo taking at any time during the session. There are no financial costs associated with participation in this study. I would simply like to observe communication between your child and their therapist that may occur before, during, and after sessions at the music therapy center.

Your child’s participation in this study is voluntary. Participation in this study or lack there of will not affect your child’s standing at the CSMT. You may choose take your child out of the study at any time. If you choose not to participate, or to withdraw from the study before, during or after the interview, there will be no penalty. The results of this research may be published, but your child’s name will not. The therapist will also verify with your child that they are okay with my participation during sessions. The published paper will not refer to the CSMT and all other identifying information. Other person’s names mentioned
during, before, or after sessions will be altered or omitted to ensure confidentiality. Any fieldnotes and copies of this consent form will be stored in a locked file cabinet in a locked office. Notes that may identify participants will be stored separately in a locked desk drawer. You should be provided with a copy of this consent form.

If you have any questions concerning this research study, please call me at (619) 672-4985 or melaniefrontz@hotmail.com.

Cordially,

Melanie Frontz
Graduate Teaching Assistant
School of Communication
San Diego State University
5500 Campanile Drive
San Diego, CA 92182-4561

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Institutional Review Board at SDSU (619-594-6622) or irb@mail.sdsu.edu to report problems or concerns related to this study.

__________________________________   __________________
Signature of Parent/Guardian of Participant   Date

___________________________________
Name of Child (print)

__________________________________   __________________
Signature of Investigator   Date
APPENDIX C

INTERVIEW GUIDE
Opening: Hello, how are you today? Great! So, as I mentioned before, I’m doing a project for school about music therapy. Would you still like to participate in my study?

If yes,

Great! Okay, first of all, do I have your permission to record this interview for my project?

If yes,

Okay thanks! Well I’m just going to ask you a few questions related to your experience working in music therapy. If at any time you do not wish to continue, we can stop the interview.

Questions:

1. How long have you been a music therapist?
2. Why did you decide to go into music therapy?
3. How do you view your role in a child’s development?
4. Typically, how does a therapeutic relationship with a child begin and develop over time?
5. What are some of the strategies you use to create closeness or connections with your patients?
6. How do you deal with negatives during a session when a patient is not behaving how you would expect?
7. What is the parent’s role during the session? Have you ever experienced a conflict with a parent when a child did not show growth?
8. How do you deal with the emotionally draining aspect of the job?
9. Can you tell me about a time when you felt really close to when of your patients? How did the relationship start and form?

Follow up questions:

1. How would you describe the difference between individual sessions and group sessions?
2. Do you think a sense of community is easier to foster in group sessions?
3. How do you decide with your bands when they are ready to perform for the community?
4. What strategies do you use to get your patients out performing in the community?
5. How do you balance working with patients one-on-one and as a group band?
6. What is the importance of individual sessions versus group sessions?
7. What is the importance of group sessions versus individual sessions?
8. When do you think one is more effective than the other?
9. How do you foster individuality in your sessions?
10. How do you create therapy sessions to be a safe place for them to express their individuality?
11. Would you describe some of your environments as more “healing” as other? Why?
12. How do you balance between the various roles of therapist, teacher, performer, and musician?
13. How do you think your patients perform their own identities during sessions?
14. Can you tell me about a time when you really felt like a group of your patients were a true community?
15. How would you define community as it relates to music therapy?

Closing: Great, thank you so much for participating and answering all of my questions! I really appreciate it. Now the last thing I wanted to ask you is which pseudonym or nickname you would like me to use while I’m writing my project?
APPENDIX D

INTERVIEW CONSENT
Dear Study Participant,

This consent form will be presented to you before each interview requested from you for this study. I will provide you with an electronic copy of this consent form. If you are still willing to participate in this study, this interview should take no more than an hour and a half and may be as short as 30 minutes. With your permission, I would like to audio record the interview so that I can later transcribe it. You may still participate if you prefer not to be audio recorded. There are no financial costs associated with participation in this study.

Your participation in this study is voluntary. You may choose to stop the interview at any time. If you choose not to participate, or to withdraw from the study before, during or after the interview, there will be no penalty. As a participant, you may listen to your own recordings at any time and have any parts of the interview removed from the data set upon request, though you may not listen to the recordings of others nor can others listen to yours. The results of this research may be published, but your name will not. The published paper will not refer to the center at which you are employed and any other identifying information. Other persons names mentioned in the interview will be altered or omitted to ensure confidentiality. The tapes and transcripts of this interview will be retained indefinitely for archival purposes and will be stored in a locked file cabinet in a locked office. Notes that may identify participants will be stored separately in a locked deck drawer. If you decide to participate in this study, your interview will take place either in person or via a videoconferencing chat, like Skype.

If you have any questions concerning this research study, please call me at (619) 672-4985 or melaniefrontz@hotmail.com.

Cordially,

Melanie Frontz
Graduate Teaching Associate
School of Communication
San Diego State University
If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Institutional Review Board at SDSU (619-594-6622) or irb@mail.sdsu.edu to report problems or concerns related to this study.

____________________________________
Name of Participant (please print)

____________________________________  _________________
Signature of Participant                  Date

____________________________________  _________________
Signature of Investigator                 Date
APPENDIX E

JAM SESSION GRANT APPLICATION
Western Region Chapter
Professional Development Grant

Music Therapy Jam Sessions to Promote Social and Community Inclusion: A Pilot Program for Individuals with Special Needs

1. Description of the project:

What did Charlie Parker, Duke Ellington and the Beatles all have in common? They understood the power of music making with others through an improvisational group experience to transform life from the mundane to the magnificent, to use music to communicate their ideas and to make lasting change in their communities and the world. Individuals with special needs who have difficulty with communication and emotional expression, this music-making experience may not be available to them because of finances. This pilot program seeks to bridge this gap and provide group music making experiences with mentors who can help individuals connect with others and their local community.

According to the California Department of Education, in 2000 there were approximately 650,719 youth with special needs between the ages of 0-22 in the state of California. These special needs include a variety of disabilities such as mental retardation, traumatic brain injury, multiple disability, speech and language impairment, and autism. Individuals with special needs may demonstrate deficits in social interaction, emotional expression and communication and language skills. In 2010, this number had increased to 678,929 individuals. Yet despite these increasing numbers (approximately 3%), state funding for services has decreased. A letter dated August 30, 2011 from the San Diego Regional Center to service providers stated “A Special Legislative Session Budget action was approved last year to reduce regional centers’ payments to service providers by 4.25 percent.” This need provides the rationale for the creation of this pilot group music therapy program.

The purpose of this proposed program is to provide a once a month music therapy group and mentoring program for 15 youth with special needs. This program would enable Banding
Together to provide six one-hour music therapy groups (aka as “jam sessions”) at a local community library to promote socialization, emotional expression and communication. Banding Together (BT) is a non-profit organization that provides music therapy scholarships, mentorships and instruments for youth with special needs based in San Diego County. Each jam session will feature a special “guest artist” from the community who will provide a music community connection. A guest artist is defined as a musician who is active in the local music community who wants to give back to youth with special needs. Board certified music therapists would coordinate with the guest artist and facilitate the music therapy group. Each youth will be strategically matched with a peer mentor and they will attend the music therapy group together. Mentors will be encouraged (but not required) to spend time together outside of the music therapy group to help further develop their relationship. Peer mentors would include high school and college youth (typically who are enrolled in music or helping profession programs) who express an interest in wanting to volunteer and connect with families with special needs. They would be paired with youth, similar to the “Big Brother/Big Sister” program.

The concept of apprenticeship and mentorships has been around since the 15th century and continues to play an important role in the development and acquisition of a job, skill or trade. Many professions, including music therapy, understand the importance of mentors through requirements such as internships and practicums. According to Miriam Webster’s dictionary, a mentor can be described as “a trusted counselor or guide.” Successful national programs such as “Best Buddies,” and “Big Brothers/Big Sisters” evidence the importance of this trusted guide in the life of a young person. On their websites they state that some results of their programs include higher aspirations, greater confidence, better relationships, avoidance of risky behaviors and educational success.

Youth with special needs have the capacity to benefit from mentoring, especially when strong relationships develop and when best practices are employed. Youth who have special needs often grow up in settings that limit their social interactions, promote dependency and have few opportunities to interact with “typically-developing” peers (Rousso & Wehmeyer, 2001). Successful mentoring may provide improved relationships with parents, greater
connections with the community, more supportive peer relationships and engagement in positive, goal-oriented extracurricular groups (Britner, Balcazar, Blechman, Blinn-Pike and Larose, 2006).

Successful mentoring programs have been found to incorporate three key elements: structure, involvement and support (Britner, Balcazar, Blechman, Blinn-Pike and Larose, 2006). Structure involves the extent to which mentors are provided guidance and information necessary to enable their mentee to be self-determined. Involvement includes a mentor being interested and attentive to his or her mentee, spending time with them, being helpful in regulation of mentee’s emotions, and helping the mentee access support or help when needed. Lastly, support for the mentee includes the mentor affirming the mentee as a unique individual, acknowledgement of the mentee’s needs and encouragement towards independent thinking and problem solving through age appropriate responsibilities. This program will demonstrate these three elements by requiring mentors to attend a training, specifically targeted to these areas, prior to the first music therapy group. In addition, the mentor will be provided ongoing support from the music therapists throughout the mentoring process.

This program will be open enrollment to members of the San Diego special needs community who would benefit from a music therapy outreach program to develop social, emotional and skill growth through building of peer relationships with mentors. Recruitment efforts will expand into the community to seek peer mentors to match with our target population. Prior to each jam session, flyers will advertise the group through various special needs outlets (autism organizations, newsletters, etc.) to recruit interested individuals. Each individual will participate in a screening process by a music therapist to determine criteria for inclusion in this program including:

Ability to communicate: must have some expressive speech
Cognitive ability: must be able to understand and follow basic directions
Mobility: must have functional mobility to be able to handle and pass instruments to others
Behaviors: must be able to participate in a group setting with minimal to moderate assistance
No youth will be denied services regardless but not limited to ethnicity, gender, or financial means.

Sample Schedule for Jam Session
6-6:30 Mentors and music therapists arrive and set up instruments and songbooks around the room
6:30 Guest musician arrives and sets up equipment
6:45 Youth with special needs arrive and are matched with mentors
7:00 Welcome/opening/introduction song
7:05 Drum circle/rhythm warm-up, take turns leading solos
7:15 Blues jam
7:20 Music therapists and guest musician teach new song
7:25 Practice new guest musician song
7:35 Record new guest musician song
7:40 Improvisation jam/youth select songs from songbooks
7:55 Closing song/rhythm exercise
8:00 Parents arrive/consult with music therapists and mentors
8:15 Journal time for mentors
8:20 Wrap up meeting/evaluation
8:45 Clean up/pack up instruments

Peer Mentors
Pairing youth with special needs with mentors (high school and college students) will facilitate positive relationships and peer friendships through modeling social skills. These connections with mentors will provide safe, consistent, and trusting settings for our students with special needs to further understand and develop non-verbal and verbal social cues, communication styles, conversational mannerisms, and one-on-one and group dynamics. The need for our target population to strengthen these essential life skills is a key component for successful inclusion in schools and integration in the community. This program will give individuals a greater skill base and confidence to reduce anxiety, frustration, disruptions, misunderstandings and incidences of bullying to thrive in mainstream environments.
Criteria for acceptance as a mentor include but are not limited to:
Effective communication skills
Ability to work within a group setting
Friendliness
Interest in working with youth with special needs
Positive attitude
Music experience

Each mentor will also be required to participate in an hour-long training prior to assisting at the jam session. Music therapists will match mentors with youth with special needs based on the mentor’s skills, experience and personality. Pre-test and post-test evaluations will be provided at the training to evaluate learning by the mentors. In addition, immediately following each jam session, mentors will gather to complete a post jam session evaluation and participate in a feedback meeting.

Guest Musicians
Incorporating guest musicians into the jam sessions provides the opportunity for and community integration with this population. Guest musicians will be recruited through social marketing (including Facebook and e-newsletters), networking with music organizations, word of mouth and distribution of flyers at community music events. The selection process for guest musicians will involve an application process, which will include character references and a personal interview with a music therapist. Guest musicians will possess strong musical skills as well as be active performing members in the community. A music therapist will train the guest musician on expectations for the jam session as well as coordinate how to best utilize the musicians skills with the group. Prior to the guest musician’s scheduled jam session, he or she will select an original song for the group to learn. The guest musician will send the music therapists a copy of the song so that the music therapist can plan how to teach the chorus of the song to the group. The jam session group will record the song during the jam session.
Location
Mentor trainings and jam sessions will be held in the community room at the Encinitas library (http://sdcl.org/locations_EN.html). Screenings will take place at a music therapy clinic in Mission Valley or in Encinitas, where Banding Together music therapy sessions and adapted music lessons are provided at The Music Therapy Center of California.

2. Outcomes of the Project:

15 individuals (ages 13 to 22) with special needs will develop social skills, emotional expression and positive communication skills through six group music therapy experiences with mentor modeling.
Mentors will learn and be able to implement socialization and cueing strategies (as presented in the mentor training) with their mentees during the music therapy group.
This program will facilitate the development of positive relationships between individuals with special needs and members of the community. We estimate this program will result in the training of 15 mentors and 6 musician mentors (artists).
This program will promote advocacy of music therapy to community members through hands-on experiences with guest artists and peer mentors.
This program will expand music therapy programs offered to families with special needs, especially those who are unable to afford services.
A CD of the six jam session recordings will be made and provided to each of the youth families and to each guest musician at the completion of the project.
This pilot program will determine the feasibility of the replication of this protocol on a larger scale to be able to impact more youth with special needs.

3. Individuals Impacted by this Project:

This jam session pilot will benefit 15 youth with special needs, approximately 13 through 22 years of age. According to the California Department of Education, in 2010 there were approximately 57,273 individuals with special needs in San Diego County. Of that total, 23,544 are within are target range for this pilot. Parents of youth with special needs will
complete a pre and post social skills assessment to determine progress made on the targeted
goal areas. In addition, they will receive consultation after each jam session from the music
therapist. Mentors will grow in knowledge and skill level in working with students with
special needs.
APPENDIX F

VIDEO/IMAGE CONSENTS
SDSU Video Recording Release Consent Form (Therapist)

Instructions: Video recordings/photos will be made of you while participating in aspects of this research project. The informed consent document describes how the video images/photos will be used for this specific study as well as who will have access to the image and where the records will be maintained. The researcher would like your permission to use your video images/photos for purposes outside of the study. Please use this form to indicate whether you are willing to allow the use of your images for the purposes described below. Your name will not be associated with your images in any case. You may request to stop the video taping or erase any portion of the tape/photos at any time.

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1. The videotapes/photos can be shown to subjects in other experiments.

2. The videotapes/photos can be used for scientific publications and/or presentations.

3. The videotapes/photos can be shown in non-scientific publications and/or presentations.

4. The videotapes/photos can be shown in classrooms to students.

Your signature indicates that you have read the information and made a decision about how your video image may be used.

____________________________________
Name of Participant (please print)

____________________________________  ________________
Signature of Participant                  Date

____________________________________  ________________
Signature of Investigator                  Date

Project: ____________________________
Instructions: Video recordings/photos will be made of your child while participating in aspects of this research project. The informed consent document describes how the video images/photos will be used for this specific study as well as who will have access to the image and where the records will be maintained. The researcher would like your permission to use your child’s video images/photos for purposes outside of the study. Please use this form to indicate whether you are willing to allow the use of your images for the purposes described below. Your child’s name will not be associated with your images in any case. You may request to stop the video taping or erase any portion of the tape/photos at any time.

1. The videotapes/photos can be shown to subjects in other experiments.
   - [ ] Yes  [ ] No

2. The videotapes/photos can be used for scientific publications and/or presentations.
   - [ ] Yes  [ ] No

3. The videotapes/photos can be shown in non-scientific publications and/or presentations.
   - [ ] Yes  [ ] No

4. The videotapes/photos can be shown in classrooms to students.
   - [ ] Yes  [ ] No

Your signature indicates that you have read the information and made a decision about how your video image may be used.

Signature of Parent/Guardian of Participant __________________________  Date ____________

Name of Child (print) __________________________

Signature of Investigator __________________________  Date ____________

Project: __________________________