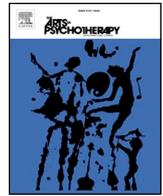




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Research Article

Verbal affordances of active and receptive music therapy methods in major depressive disorder and schizophrenia-spectrum disorder

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ABSTRACT

Previous research on active and receptive music therapy methods mostly reports on response to musical processes and therapeutic impact. Preceding such interests, our study examined qualitatively the verbal affordances during a course of eight individual music therapy sessions among twenty participants with a major depressive disorder or a schizophrenia-spectrum psychotic disorder. Audio-video recordings of 131 sessions were transcribed verbatim and subjected to thematic analysis, following which comparisons for music therapy method and diagnostic group were made.

The themes that emerged from the thematic analysis, reflect the content of verbal responses to participation in active music making, receptive music listening and client-therapist dialogue. These themes were i) not to feel; ii) to do or not to do; iii) grappling with the desired future; iv) hurt and fear of undesirable outcomes; v) sadness, brokenness and futility; vi) anger, trust and vulnerability; vii) desire for connection with and affection of others; viii) barricaded from being (in the) present; ix) tensing and un-tensing; x) personal relating to one's musical expression; xi) reflections on the music and music making in therapy, xii) resilience in courage and xiii) invigoration and liberation.

The emerging verbal affordances showed responses within a therapeutic relationship that express inter- and intra-personal connection, increased motivation, grappling with difficulty, emotional expression, and the reclamation of energy, spontaneity and resilience.

Introduction

Affordances of music therapy are defined as the way in which 'users' of music respond to it and incorporate it into their actions, so that they are afforded what music makes possible for them in that process (De Nora, 2007: 276). Affordances thus entail the yield of acting both on and with music. In music therapy, the affordances can be expressed in various ways: for example, verbally, through music-making, in gestures, and creating pieces of visual art. This article focuses on the verbal affordances of specific music therapy methods for the diagnostic groups of major depressive disorder and schizophrenia-spectrum psychotic disorders, which have not been reported before in the literature.

A survey evaluated psychiatric music therapists and their approaches, institutions, interventions and clinical objectives (Silverman, 2007). Most respondents indicated that they worked with music therapy groups rather than individual patients, and that their orientation is eclectic using improvisation, sing-alongs, lyric analysis, and music-assisted relaxation that addressed goals such as socialization, communication, self-esteem, coping skills and stress reduction/management. However, their study did not explore what the various

methods yielded for the respective diagnostic groups.

A meta-analysis of the effects of music therapy for patients with serious mental disorders suggested that the efficacy of music therapy involved a few symptoms that could be considered as being trans-diagnostic phenomena (Gold, Solli, Kruger, & Lie, 2009). It suggests that music therapy is a) a medium for emotional expression that may help patients improve their expressive range and thus diminish affective flattening; b) making music together is always a social act thus assisting patients with deficits in this area, primarily calling them from social withdrawal and isolation and c) participation in music can serve as a motivating factor for patients with low levels of motivation.

This meta-analysis showed that when music therapy is added to standard care, it has "strong and significant effects on global state, level of general symptoms, negative symptoms, depression, anxiety, functioning and musical engagement" (Gold et al., 2009). The study further showed that the effects of music therapy did not depend on diagnosis, neither on study design. The effect was dependent on the number of sessions with more sessions having a greater effect on outcomes than fewer sessions. Regarding specific music therapy methods, no direct link between such and diagnosis was observed, but the authors

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acknowledged that limited research had been conducted in this area.

Edwards (2016a) refers to the four methods of music therapy as receptive, creative, improvisation, and re-creative. Without precluding a blended practice, the two methods employed in this study are receptive and active music therapy. Receptive music therapy refers to music-listening whereas active music therapy involves conjoint music-making. The term active music therapy is specifically employed as an umbrella method term for this study because musical interaction between client and therapist included both improvisation and structured musical techniques. Both receptive and active methods provide for ways of communicating, active, deep listening and relating (of content and with the therapist) intertwined with verbal communication. Various models and specific techniques fall within the broader methods of receptive and active music therapy (Edwards, 2016a, 2016b). Bruscia (1998) summarised receptive music therapy as "...the client listens to music and responds to the experience silently, verbally or in another modality. The music used may be live or recorded improvisations, performances or compositions by the client or therapist, or commercial recordings of music literature in various styles (e.g. classical, rock, jazz, country, spiritual, new age). The listening experience may be focused on physical, emotional, intellectual, aesthetic or spiritual aspects of the music and the client's responses are designed according to the therapeutic purpose of the experience".

Grocke and Wigram (2007) outline the following receptive music therapy techniques as commonly used in clinical music therapy practice in various settings: i) music relaxation ii) imaginal listening, whether guided or unguided, iii) song (lyric discussion), iv) song reminiscence, v) music listening based on client's preferred music, vi) music appreciation activities, vii) music collage, viii) somatic listening and eurhythmic listening.

Various music therapy approaches use receptive methods centrally. The premise of the Bonny Method in Guided Imagery is that music acts as a projective tool, and that through images, associations and memories that are evoked through the music, material from clients' unconscious world can be brought into consciousness and processed during clinical sessions (Bonny & Summer, 2002). Short, Gibb, and Holmes, (2011) describe this approach as a method that "combines reflective and spontaneous imagery with carefully selected music to promote psychodynamic change, enhancing spontaneous inner exploration and development of the person". There are adapted versions of this, including Guided Music Imagery (Grocke & Wigram, 2007; Bonny & Savary, 1990), Unguided Music Imaging, Directed Music Imaging, Group Music and Imagery, and Music, Drawing and Narrative (MDN) that use these three modalities as a vehicle for story making (Booth, 2005; Grocke & Wigram, 2007).

Active music therapy methods do not place primary emphasis on verbal processes. The therapeutic work happens principally within the (conjoint) music-making, notwithstanding the supportive role of other communicative means such as verbal exchanges and creative arts (Van Lith, 2015). Because of this, the means of communicating, listening and relating are extended beyond the verbal, which may be particularly helpful when clients' verbal capacity is compromised by mental disorder. Metzner (1999) refers to the complementary and structuring role of the verbal and the musical used in combination, particularly in psychiatric settings stating that

"in contrast to the purely verbal-oriented therapies, I believe that this approach is particularly appropriate for the treatment of patients who have problems with the regulation of closeness and distance, whose introspection and symbolisation ability is disturbed, and who otherwise are hardly capable of therapeutic splitting of the ego and partial regression. The alternation between improvisation and talking evokes ego functions and so has a structure-developing effect... This leads to my opinion of the usefulness of psychoanalytic music therapy in psychiatry, which is contrary to the prevailing view that music therapy is too ego disintegrating – especially in the case of psychotic patients – and so is contraindicated. Surely, this may be true in

individual cases but cannot be generalised" (Metzner, 1999).

Active forms of music therapy express the role of music in different ways. Creative Music Therapy highlights the communicative, creative and non-verbal role of music, expressed primarily through clinical improvisation (Nordoff & Robbins, 1977; Ritholz, 2014). Analytically Oriented Music Therapy highlights the role of music as a way of sounding unconscious processes, processed further through verbal reflection (Trondalen & Bonde, 2012). Integrative Improvisational Music Therapy holds as salient clinical improvisation and verbal processing and is a model used in the treatment of depression (Erkkilä, Punkanen, & Fachner, 2012). Behavioural Music Therapy deploys music's structuring and functional role (Wigram, Pedersen, & Bonde, 2002) and Resource Oriented Music Therapy (which can include both active and receptive forms of music therapy) emphasises music as a means to accessing strengths and potential (Rolvsjord, 2014).

Across all methods within music therapy, music is regarded as a strengths-based resource where the focus shifts from pathology alone, to eliciting inner resilience and building capacity for intra and interpersonal communication. Music allows for the expression of unmanageable and silenced unconscious material as well as what is innately creative, resilient and healthy (Ansdell, 1995; Priestly, 1994). Music making, music listening, verbal responses, creative visual processes and symbolic material co-exist interdependently and form the substance of each session. In particular, the relationship between the music and the words suggest that they operate as an extension of one another. Andersen (2012) refers to verbal interaction as relationally responsive practice where the focus is on dialogic conversation with clients. Knowledge and language are viewed as relational, generative and social processes. Nolan (2005) suggests that verbal processing affords increased client awareness through enhanced i) awareness about the music, ii) awareness about musical behaviour, iii) awareness about interpersonal processes, iv) awareness about emotional or cognitive experiences, v) verbal and non-verbal integration and vi) transition to a more defended state (Nolan, 2005).

Improvised song writing in music therapy exemplifies the interdependence of musical and verbal expression, with therapeutic benefits being described as "a) experiencing mastery, develop self-confidence, enhance self-esteem; b) choice and decision making; c) develop a sense of self; d) externalising thoughts, fantasies, and emotions; e) telling the client's story; and f) gaining insight or clarifying thoughts and feelings" (Baker, Wigram, Stott, & McFerran, 2008: 120). Songwriting is also valuable as music conveys messages and emotions, has clinical purpose and enhances self-expression (Baker, 2015).

The verbal content that emerges in a course of individual music therapy has not been examined qualitatively before as far as we could establish. Previous research on music therapy methods and diagnosis mostly reports on response to musical processes and therapeutic impact. A Cochrane review on music therapy and depression captures this for depression (Maratos, Gold, Wang, & Crawford, 2009), as do more recent studies conducted for group therapy and group music therapy settings respectively (Garrido, Eerola, & McFerran, 2017; Silverman, 2013). A review on music interventions for the treatment of depression found that music improved depression symptoms and quality of life across a range of age groups (Leubner & Hinterberger, 2017). Erkkilä et al. (2011) employed an improvisational, psychodynamic music therapy intervention (Integrative Improvisational Music Therapy) with working age individuals. The results suggested that those receiving music therapy in addition to standard care improved more so than those who received standard care only. This improvement was seen both in their general functioning as well as on measures of depression and anxiety.

Similarly for serious mental disorders, the effects of music therapy as a complementary treatment to standard care were the interest of two Cochrane reviews concerning music therapy for schizophrenia. The review by Gold, Heldal, Dahle, and Wigram, (2005) suggested that music therapy improves patients' mental state and life functioning,

especially the negative symptoms, if a sufficient number of music therapy sessions are provided. The more recent review by Mössler, Chen, Heldal, and Gold, (2011) addresses the effects of music therapy on motivational, emotional and relational aspects, helping patients to reconnect to both intrapersonal and social resources. It concludes that music therapy may be especially important for improving negative symptoms such as affective flattening and blunting, poor social relationships, and a general loss of interest and motivation. Improvement for these symptoms, the review asserts, seem to be specifically related to music therapy's strengths even though they do not typically respond well to other treatment. (Mössler et al., 2011). Results of this review and other studies underpin the recommendation that music therapy should be part of standard care for people suffering from schizophrenia in national guidelines of Norway, Sweden and the U.K. (De L'Etoile, 2002; Hayashi et al., 2002; Pavlicevic, Trevarthen, & Duncan, 1994; Pedersen, 2016; Talwar et al., 2006; Tang, Yao, & Zheng, 1994).

In adult mental health care, music therapy has been found to yield pivotal moments, through music making and verbal discussion, in which emotional regulation, new perspectives, behavioural change and transfer outside of the therapy situation are possible (Gavrielidou & Odell-Miller, 2017). Resonance Frequency Breathing, employed within Integrative Improvisational Music Therapy sessions for the treatment of anxiety and depression, has been found to be an adaptive intervention, supporting the client and modulating the emotional difficulty of the therapeutic process (Brabant, Solati et al., 2017; Brabant, van de Ree, and Erkkilä, (2017). A study that explored the relationship between musical preferences and the use of music in everyday life for the modulation of emotions found that people with mental disorders used music for the reduction of negative emotions, especially those individuals who preferred reflective music (Gebhardt, Kunkel, & von Georgi, 2016). The interest of these studies have been on the response to musical processes and therapeutic impact, thus the consequences of music therapy. The interest of our study, instead, is on the verbal content that emerges in a course of individual music therapy and the association of such content with respectively music therapy methods and diagnosis. Our study thus examined qualitatively the emerging content that experientially precedes considerations of therapeutic process or therapeutic consequence, addressing inter alia the acknowledgement in the review mentioned above that limited research had been conducted on the connections between receptive and active music therapy methods and diagnosis (Gold et al., 2009).

Method

Participants

Within a qualitative case study design, participants were purposively sampled prior to the commencement of a structured course of music therapy during their hospitalisation for a major depressive disorder (MDD) or a schizophrenia-spectrum psychotic disorder (SSD). There were ten participants per diagnostic group, eight male and twelve female, with ages ranging between 18 and 57 years. They participated in a total of 131 individual music therapy sessions. The study was approved by the Faculty of Health Sciences Research Ethics Committee at the University of Pretoria. Permission to conduct the study was obtained from the Chief Executive Officer of the hospital.

Procedures and data collection

The data collection took place over a two year period at a public psychiatric hospital in South Africa. Participants, who had each granted written informed consent, underwent individual music therapy scheduled twice weekly for a total of eight sessions. The music therapy sessions were structured uniformly across participants, but were flexible enough to accommodate the nuances of each patient's unique process. In blended fashion (Mössler, Assmus, Heldal, Fuchs, & Gold, 2012), the

structuring provided for a range of techniques within active and receptive music therapy methods, being a) guided relaxation and music listening, b) structured drumming exercises, c) unstructured improvisations that were developed and extended during each session, d) movement exercises, e) vocal work, focusing on both structured songs as well as free improvisation, f) a range of music listening methods comprising a range of arts therapies modalities and g) song writing. The sessions were audio-video recorded for the purpose of in-depth analysis.

Data analysis

All 131 music therapy sessions were transcribed verbatim from the audio-video recordings. Guided by grounded theory (Holton, 2007; Urquhart, 2013), all of the verbatim accounts of participants were segmented into first level codes using open coding. These were then analysed inductively by constant and systematic comparisons, seeking for emerging concepts that capture stable patterns in the data. Higher level codes so derived were subjected to the same inductive process until no new properties emerged from the continued coding, and theoretical saturation was thus reached. A crucial drive that steered the analyses was that the higher order codes, subthemes and themes should remain an apt expression of the raw data, averting or "bracketing" the imposition of prior theory as far as possible (Matthews & Ross, 2010; Miles & Huberman, 1994). Emphasis was thus placed on honouring the given content, working with the 'whatness' of the very experience as distinct from the researcher's response to the experience (Finlay, 2011). The researchers' assumptions and understanding were bracketed to avert imposing a frame or view. Rather, contents were analysed descriptively and as true to the voice of the participants as possible. For this reason, the subthemes and themes were first identified without consideration of specific music therapy methods or diagnostic category. These considerations followed only during a subsequent phase of theoretical coding and analysis. To ensure optimal articulation and capturing of the meaning expressed by the raw data as guided by grounded theory, the analyses were undertaken as a conjoint activity, revisiting and revising prior articulations during a series of meetings. To ensure, further, that analysis of the large amount of data generated by the study be credible and transparent, the coding was systematically and comprehensively recorded using conceptual memoing through cycles of coding (Holton, 2007).

Findings

The thirteen themes that emerged verbally within the course of music therapy were i) not to feel; ii) to do or not to do; iii) grappling with the desired future; iv) hurt and fear of undesirable outcomes; v) sadness, brokenness and futility; vi) anger, trust and vulnerability; vii) desire for connection with and affection of others; viii) barricaded from being (in the) present; ix) tensing and un-tensing; x) personal relating to one's musical expression; xi) reflections on the music and music making in therapy, xii) resilience in courage and xiii) invigoration and liberation.

The salient aspects of each theme are presented below with examples prior to considering the respective contributions of the music therapy methods as well as the differentiation between the two diagnostic groups.

To feel or not to feel

As summarised in Table 1, this theme concerns the indifference and apathy expressed by some, whilst others articulated being shut down or "dead" to feelings. Participants acknowledged awareness of suppressing unbearable feelings as well as being afraid to face feelings. For example, one participant spoke of a "whirlwind of emotions", but she was unable to verbally speak the feelings, stating that she was afraid to face these feelings. She agreed, however, to write them down. Some participants

Table 1
The theme “to feel or not to feel”.

Subthemes	Salient examples
Indifference	<i>It's dead, I don't feel like nothing, I'm not feeling anything right now</i>
Not feeling	<i>I don't like to feel emotions</i>
Suppression of the unbearable	<i>Look it squarely in the eye... Sadness, disappointment, regret ...just some of the emotions I keep, that I bottle up, so I want it to be out in the open and I want to stare it out</i>
The issue of feeling and facing emotions	

recognised the need to and difficulty in facing their feelings, especially as a way to move forward with their lives.

Active music therapy methods elicited responses reflecting ambivalent feelings about own participation in music making and indifference when reflecting upon music making, whereas receptive music therapy methods elicited responses concerning clients’ internal states of feeling that ranged from feelings of nothingness, the awareness of suppressing feelings and the need to face feelings.

When differentiating between the diagnostic groups, participants from both diagnostic groups expressed indifference. Both diagnostic groups were able to voice feelings, link past events with current feelings and use symbolic material to express feelings. Participants from the MDD-group more readily articulated specific inner states of feeling and displayed awareness of the suppression of emotions and the fear of facing feelings, whereas participants in the SSD-group experienced greater difficulty in being aware of feelings and finding the vocabulary to express and reflect upon feelings.

To do or not to do

This theme, summarised in Table 2, has to do with ‘doing’ and taking action within the context of musical participation and with respect to personal circumstances. The theme reflects the extent of musical ‘doing’ expressed by some participants through reticence to start or take initiative in music making, hesitancy and resistance to play or sing, lacking in self-confidence, being uncertain due to the novelty of music making, feeling stuck and difficulty accessing new musical ideas. Participants demonstrated increasing willingness to try and confidence to exercise choice and initiative in music making. Regarding taking action in their lives, participants expressed feeling stuck and trapped by circumstances. One participant expressed this as “it’s so dark I can’t rise up”. Participants referred to failed attempts at trying to change circumstances or seek help leaving them with a sense of paralysis. On the other hand, some participants demonstrated a willingness to venture towards breaking circumstantial and emotional inertia which is captured by the following statement: “forward I go, stronger, stronger and I will win”. Furthermore, participants referred to how mental illness had compromised their capacity for decision making, often with the power to make decisions taken out of their hands whilst, in contrast, there was recognition of the importance of making decisions towards an improved future: “at a crossroad in daily life. I need to make a decision”.

Both active and receptive music therapy methods contributed to the ‘not to do’ part of Theme 2 through revealing ‘stuckness’. In the case of active music therapy ‘stuckness’ was evident through perseverative musical expression and difficulty in varying aspects of musical material,

Table 2
The theme “to do or not to do”.

Subthemes	Salient examples
About who begins	<i>You can go all the time. I'll follow you</i>
Resisting doing	<i>I'm stuck</i>
Stuck	<i>I haven't got a cooking clue about music but I tried</i>
Failing, also in self-confidence	<i>Undecided, I'm confused, unsure, demotivated</i>
Willingness to venture	
Decision making is an issue	

whereas receptive music therapy methods elicited feelings of ‘stuckness’ concerning patients’ internal states and circumstances. Receptive music therapy, though, also elicited increased internal motivation and movement towards action.

Both diagnostic groups expressed feeling stuck within music making and were dismissive of their own musical ability. Participants from both diagnostic groups also expressed a loss of agency in making of decisions, but also expressed an intention to move forward. Not being able to move and being in darkness were expressed in the MDD-group whilst loss of interest, feelings of isolation, resistance and frustration were prevalent within the SSD-group.

Grappling with the desired future

Grappling with the desired future was a theme that emerged, relating events prior to hospitalisation and what participants would want in future (see Table 3). Some participants had either attempted or contemplated suicide prior to hospitalization. Participants spoke about wanting to end it all due to present and future reality being experienced as overwhelming, most strikingly expressed as “It’s sadness that pushes you to the edge and want you to escape to somewhere, where you will feel at peace, or end it all”. For some participants the future was contemplated with questions and feelings of doubt and skepticism. Participants expressed doubt about the possibility of an improved future or the prospect of healing and recovery. Other participants indicated experiencing impasse due to being dependent on others, yet articulating a desire for independence. For some participants the future was a desired, idealised state starkly contrasted from a perceived unmanageable reality: “It is a place I wanna be, no stress no pain, no suffering, not waking to a day when you feel it should never be”. The themes of escape, safety, being rescued and grandiose ideations are amongst these references. For some participants, references to an envisaged or desired future related more directly to statements of intention about taking practical steps towards the future: “so that I can get the skills on how to run financials and stuff like this”.

Receptive music therapy methods exclusively gave rise to this theme. The MDD-group made numerous references to suicide, whereas there was only one such reference in the SSD-group. The MDD-group expressed emotional impasse, doubts and cynicism. Both groups articulated feelings of being stuck in their dependency of others, yet also expressed the desire for personal and financial independence. Both groups articulate a desire to escape from reality, expressed as an idealised state in the MDD-group and in more grandiose terms in the SSD-group.

Hurt and fear of undesirable unknown

This theme expresses references to trauma and hurt as well as the disabling impact of past hurt or trauma on the future that was envisaged as ominous or undesirable (see Table 4). Participants experienced anticipated future outcomes as unpredictable and unstable: “I don’t really know what’s going to happen there, because it can change anytime”. Participants indicated the need to adopt caution regarding future endeavors or ideals owing to the perception of the ominous nature of the ever changing nature of their lives.

This theme also highlights current experiences of fear as well as

Table 3
The theme “Grappling with the desired future”.

Subtheme	Salient examples
Ending it through suicide	<i>It's sadness that pushes you to the edge and want you to escape to somewhere, where you will feel at peace, or end it all, there was a time when I wish I was,yes</i> <i>I feel angry in myself, I feel dependent, sometimes lonely and unhappy,</i> <i>It is a place I wanna be, no stress no pain, no suffering, not waking to a day when you feel it should never be. A sense where there is love laughter, a place where everybody would like to be</i> <i>I would like to support my mom more. Get a job, obviously to support her</i>
Doubt and skepticism about the future	
An impasse, with unwanted dependency	
Escaping from the realities of life to some ideal situation	
Envisaging a desired future	
Aspiring towards financial and occupational independence	

projected fear of future hurt and disappointment. References include the fear of venturing out, the fear of loss and the fear of being hurt. One participant articulated the fear of the strengthening process, moving forward and making future decisions, acknowledging “I’m a little bit scared”. References to fear also related to anxiety and the fear of feeling emotion.

Receptive music therapy methods elicited feelings, memories and symbolic material associated with trauma, fear and unpredictability. Active music therapy methods afforded musical expression and reflection, through clinical improvisation, of what was elicited during the music listening methods.

Both diagnostic groups articulated similar verbal responses through reference to past traumatic incidents and facing an unknown future, articulating feelings of fear and uncertainty and using metaphoric language to express these sentiments.

Sadness, brokenness and futility

As seen in Table 5, participants articulated feelings of sadness, low mood, depression, unhappiness and disappointment: “Sadness, it’s just you live with these anxieties, you don’t realise nature anymore...So much lost time”. For some these feelings were pervasive, whilst for others sadness, pain and brokenness were mentioned with reference to a particular incident or relationship. Imagery elicited by the music offered symbolic ways for participants to share aspects of struggle and difficulty with reference to unmanageable and inexpressible emotions: “this journey is very, very difficult”. Also expressed in this theme were feelings about self and circumstances that reflect hopelessness, helplessness, despondency and futility: “feel hopeless, on my knees, can’t stand up”, “I feel like I am useless”, “I am a loser”. These feelings impacted negatively on motivation to proactively initiate change.

As with the previous theme, receptive music therapy exclusively gave rise to this theme. Music listening methods elicited symbolic material, emotional responses and associations linked to feelings of sadness and futility. References to states such as sadness, helplessness and being heartbroken were prominent from the MDD-group, whereas the SSD-group referred less to feelings and more to own life circumstances, especially not being in control of circumstances. Both groups used symbolic metaphoric material to express this theme.

Anger, trust and vulnerability

Salient references to vulnerability, trust and anger are summarised in Table 6. These presented in a rather entangled way, hence we report these as a singular theme. Some referred to the qualities of sensitivity

Table 4
The theme “hurt and fear of undesirable outcomes”.

Subthemes	Salient examples
Disabling impact of trauma	<i>It just hurts so much more because I was a child</i> <i>I don't really know what's going to happen there, because it can change anytime</i> <i>I feel scared and lonely</i>
Ominous anticipation of the unknown	
Fear of hurt and the unknown	

Table 5
The theme “sadness, brokenness and futility”.

Subthemes	Salient examples
Telling about sadness	<i>My heart was very sore, very red inside, I know I'm heartbroken</i> <i>Something broke me – from there it went down</i> <i>The worst journey to be endured</i> <i>Feel hopeless, on my knees, can't stand up</i>
Brokenness	
Hardship and struggle	
Feelings of futility	

Table 6
The theme “anger, trust and vulnerability”.

Subthemes	Salient examples
Intimate vulnerability	<i>To tell you the truth I'm so scared of being hurt, the stage I am I'm vulnerable</i> <i>I'm feeling very angry, I'm still angry</i> <i>Don't trust anyone</i>
Anger at others and self	
Difficulty in trusting others	

and vulnerability as being desirable more than the destructive parts of self. This theme also expresses anger towards others and self: “I just feel angry and aggressive”, “would like to break something”, “I feel angry in myself”. There were inferences to trust difficulties of the medical system, significant others, the possibility of recovery or the prospect of future opportunities. Trust difficulties also seemed to be linked to the other themes, expressed as anticipation of an ominous unknown, hurt and fear of the unknown, feelings of futility and doubt and skepticism about the future.

Receptive music therapy methods elicited a range of feelings including anger, vulnerability, self-hate and aggression, traumatic memories and awareness regarding trust difficulties. Active music therapy was appropriated to reflect internal conflict and release anger through improvisation, whilst awareness of the need to trust was elicited through mirror image movement techniques: “Following somebody’s direction, and trusting that person that they cannot mislead you”.

Both diagnostic groups articulated difficulties with trust, expressed through engagement with and reflection on symbolic material. Among the MDD-group specific reference was made to accessing emotions and (unconscious) issues that they had not been aware of before.

Desire for connection and affection of others

A prominent theme salient to all participants across both diagnostic groups were references to being alone, lonely, isolated, missing family,

Table 7
The theme “desire for connection and affection of others”.

Subthemes	Salient examples
Loneliness and isolation	<i>I feel like I'm alone now, no one is there for me, I can't, cause I'm all alone</i>
Loss of self and others	<i>I am alone with my problems</i>
Need for social connection	<i>I have this longing to be loved again</i>
Desire for intimacy and love	

loss of relationship and the need for social connection, support and love – see Table 7. This theme is expressed through four sub-themes: a) Loneliness and isolation: “I am alone with my problems”, “I feel scared and lonely”; b) Loss of others which is expressed through references to loss of aspects of life, relationships and feelings of grief connected to being away from, longing for or missing family, friends or romantic partners: “lost a lot of years”, “This one remind me of my mom. She used to share everything, she was there for me; c) the need for social connection which was articulated as the need for social support and social interaction, affection for and responsibility towards family members, caring for others and an expressed desire for healthy relationships and d) desire for intimacy/love which refers to longing for intimacy and romantic partnership, the loss of romantic love, desire for marriage and family life. Other references linked to this subtheme included feelings of freedom, peace and love through imagery of nature, feelings of restfulness and love and references to spiritual love.

Receptive music therapy elicited feelings of the loss of significant others, missing family, being alone, the loss of romantic love as well as the expressed desire to see family members, the need for social connection and romantic love. Active music therapy, using songwriting and improvisation provided the means through which to express love and feelings regarding family members. Common to both diagnostic groups were the experiences of feeling and being alone, loss of social connection, being away from family and other forms of social support and expressing the desire for love, intimacy and social connection.

Barricaded from being (in the) present

Expressed through this theme were references to the difficulties participants experienced being in the present moment during music therapy sessions – see Table 8. Examples include difficulties with concentration and focus, particularly in the context of active music making: “It’s sort of blank, because of all this trauma” “something’s going on with my mind” and “my concentration levels haven’t been so great”. Difficulties relating to memory loss and remembering aspects of music therapy work in previous sessions are also embedded in this theme: “all the songs have gone out of my head”, for some participants fluctuating between forgetting and remembering the therapist’s name or life events: “I cannot remember anymore because I was a child. Many years ago”. In contrast, participants referred to the manner in which active participation in music assists with concentration and focus: “teach me to be in my mind” and “good to concentrate. And think”.

Active music therapy methods elicited both an awareness of concentration difficulties as well as promoted opportunities for focus, concentration and interpersonal awareness. Concern about memory loss was articulated in relation to both receptive and active music therapy methods but difficulty accessing long term memory emerged during receptive methods.

Both diagnostic groups referred to difficulties with concentration. In

Table 8
The theme “barricaded from being (in the) present”.

Subthemes	Salient examples
Difficulty being here, now in music making Forgetting and remembering	<i>I can't think too much. If I think too much and concentrate hard I get a headache I can't remember. Is it with music or without music</i>

the MDD-group, references were made to music eliciting difficult thoughts, the cognitive impact of trauma, and concern about memory loss. In the SSD-group, memory difficulty was experienced primarily with regard to the ‘here and now’, difficulties with remembering the therapist’s name, music from previous sessions and what was required musically within specific components of the sessions. Participants from the SSD-group articulated that active participation in music making assisted with concentration.

Tensing and un-tensing

The relaxation and movement activity at the beginning of every session resulted in references to bodily experiences, pain, tiredness, stress and tension, e.g. “I’m tense, I can feel it”, and “my head is burning”. Numerous references were made to feelings of stress, nervousness and anxiety: “alone, angry, isolated, disconnected, anxious, tense and that is why I am frustrated”, “It’s just you live with these anxieties”. There were references to the music eliciting anxiety on one hand, whilst offering anxiety and stress release through, for example, drumming on the other (Table 9).

Participants acknowledged the need for and benefit of physical exercise: “though the muscles are stiff I get the flow”, “I like the soothing music, and then to do that you can feel your body responding to the music” and remarked on the fact that there is not enough opportunity for physical exercise in their daily hospital routine. Participants also reported experiences of relaxation and calming through various music therapy methods.

Active music therapy methods elicited awareness of physical ailments, tiredness and challenges such as anxiety and stress, yet affording experiences of relaxation and calming, stress and anxiety relief and feelings of wellness. Receptive music therapy methods elicited feelings of anxiety and being drained, references to emotional tiredness and past feelings of stress, yet affording experiences of relaxation and calming through music-evoked imagery.

The two groups contributed similarly to this theme, but the MDD-group displayed greater awareness of physiological and emotional states with reference to physical ailments, tremor, frozen speech, stiffness, emotional tiredness and feeling drained.

Relating to one’s musical expression

This theme emerged exclusively from active music therapy methods – see Table 10. Participants related to music making in different ways, considering their own relationship with and past experiences of music listening and making. Almost everyone did not have prior musical training, except for participating music making at school, but some had never participated in any form of music making. This theme accordingly expressed i) non-acquaintance and novelty of music making where for many participants this was their first experience of actively participating in music making; ii) reconnecting with previous musical experience where some participants had previously been involved in some form of active musical participation; iii) personal identification with music preferences was expressed through distinct musical preference through which participants brought cultural, spiritual and linguistic identification to the music relationship; iv) exercising choice in music making; and v) discomfort with their own voice in singing.

The two diagnostic groups were similar with respect to previous musical experience, music making as a first time experience, indicating

Table 9
The theme “tensing and un-tensing”.

Subthemes	Salient examples
References to physical bodily distress and ease	<i>Yes, but more on my neck and shoulders and in my back, a little bit tiring in the back but it's ok,</i>
Tiredness	<i>That feeling of being drained</i>
Telling about being stressed and tensed	<i>I'm feeling stressed, that's why I came to hospital, I was very stressed when I came here</i>
Calming	<i>Horrible, like I have no control in that space, it affects my speech</i> <i>I'm feeling more calm</i>

preferred genre and instruments of choice, initiating music in own language and awareness of singing voice. Differences were apparent with the MDD-participants expressing discomfort using their voice to sing, whereas the SSD-participants expressed their enjoyment thereof. Among the MDD-participants, reference was made to a specific genre of music evoking difficult associations. In the SSD-group, a participant declined to play an instrument on spiritual grounds.

Reflections on the music and music making in the therapy

Participants reflected on active and receptive music therapy processes (see Table 11) through i) spontaneous commenting on music making through offering musical ideas, taking the initiative, exercising choice and requesting specific music within sessions, ii) heightened awareness and appreciation of the music through indicating recognition of familiar music and awareness of the nuance of musical elements and instrumentation; iii) recalling significant life-event memories as brought about by imagery and concrete associations elicited through music listening and iv) metaphorical reflections on affordances brought about by the music therapy. Here participants reflected on how the music had impacted on them personally at a more general level: “music changes on the inside”, “music opens doors” as well as indicating new insights gained through working with symbol, metaphor and association. For example, one participant worked with the symbol of a barrier line that represented her depression. Through active and receptive music processes she symbolically ventured towards “breaking the barrier”.

Both active and receptive music therapy methods have revealed unconscious material and brought to light awareness of different aspects of self. A heightened experience of the music was indicated in both methods but, in contrast, participants expressed less awareness of the music during receptive work and instead related evoked feelings, personal story and life event memories. Active music therapy methods afforded symbolic representation through musical expression, increased motivation, and agency. Receptive music therapy methods afforded the expression of emotion and elicited feelings of wellness.

Both diagnostic groups indicated a heightened awareness of the music, initiated musical ideas and linked music with specific memories. Reference to symbols and metaphor in musical processes were common to both groups. The SSD-group indicated limited awareness of the nuances of the music. The MDD-group referred to music revealing unconscious material and referred back to symbolic material elicited during the music therapy process. The SSD-group referred to music assisting with the expression of emotions and articulated feelings of wellness and being inspired and motivated.

Table 10
The theme “relating to one’s musical expression”.

Subthemes	Salient examples
Non - acquaintance and novelty of music making	<i>Stupid' with music</i>
Reconnecting with previous musical experience	<i>Something new, easier but still a new experience, something new for me</i>
Personal identification with music preferences and familiarity with musical expression	<i>I love it, out of practice, good to play again, my fingers don't work so well</i>
Exercising choice in music making	<i>I don't like jazz, because it makes me think, think, think,</i>
Discomfort with own voice in singing	<i>No. I hate it, I'm actually scared of my voice. Don't know why?</i>

Resilience in courage

Profoundly depressed, skeptical about the possibility of recovery, and wishing to escape from her stark reality one participant stated her intention for therapy as music assisting to “gently untie” her pain. This theme captures the “untying” which took place for many participants, facilitating courage, motivation and the possibilities of resilience and change– see Table 12. This theme was expressed as i) accepting circumstances and events, often against the backdrop of complex, difficult life circumstances; ii) change for the better that was experienced through active music therapy as stimulation, awakening, gain, feeling better and shifts in musical expressions and through receptive music therapy as a change in mindset, help, healing and recovery and music shifting mood; iii) strength and courage was accessed through musical processes affording participants the capacity to confront difficulty, discovery of inner resources, expressions of resilience, empowerment, survival and strength; iv) growing motivation and goal setting was expressed through the translation of sentiments evoked by images and reflections into practical application to everyday life wherever possible; v) persisting forward encompasses the struggle for most participants to access motivation and inner resourcefulness through statements reflecting the determination and persistence required to carry on or move forward: “I had to go on no matter how tired I am”, “Going back means giving up” and vi) attributing personal virtues refers to new insights gained about the self which may not have previously been considered, or which were reawakened. Such insights or attributes included expectations of the self, new experiences of self, feelings of significance, self-belief and confidence.

Active music therapy was experienced as an emotional awakening, offering an alternate active experience and alleviating boredom. Both music therapy methods elicited a shift in feeling states and experiences of inner strengthening. Receptive music therapy elicited responses linked to feelings of motivation, contentment and acceptance. Altered self-perceptions, movement towards recovery and practical applications indicating desire to change, were elicited in association with receptive music therapy methods.

Both diagnostic groups referred to music therapy shifting their feelings, accessing inner strength, renewing motivation to persist, looking to the future and altering self-perception. Both groups reported feeling better and experiencing feelings of self-significance. The SSD-group indicated music alleviating their boredom, wanting to survive, and the need to hold on. The MDD-group articulated feelings of hope, emotional awakening and increased motivation. References to specific steps towards recovery, intention to deal with pain, articulated future goals, desire to access one’s inner voice and inner resources, as well as steps taken during the music therapy process, were unique to the MDD-

Table 11
The theme “reflections on the music and music making in therapy”.

Subthemes	Salient examples
Spontaneous commenting on music making Heightened awareness and appreciation of music Recalling significant life-event memories Metaphorical reflections on affordances and connections brought about by the music therapy	<i>Should be very slow..something soft</i> <i>I will start with this just to hear what you are playing</i> <i>Misty. Yes of course. Beautiful, I love it</i> <i>I remember that day, I will not forget it</i> <i>I'm telling you something very personal</i> <i>The mamma fish and the baby, I have to be exposed to other things that are difficult and I have to be strong, yes, like a mamma fish</i>

Table 12
The theme “resilience in courage”.

Subthemes	Salient examples
Accepting circumstance and events Change for the better Strength and courage Growing motivation in goal setting Persisting forward Attributing personal virtues	<i>To accept what happened</i> <i>When we accept there come tears of joy again</i> <i>I remember the first day and thinking how is it going to help me? Yes I was so negative. But I said to myself let me give it a try. I woke up emotionally.</i> <i>It made me very strong, yes I'm strong. I can face everything</i> <i>Even though I will fall, I will stand up and move on</i> <i>I have to break the barrier piece by piece</i>

group.

Invigoration and liberation

Whilst earlier themes indicated the challenges for some participants with regard to, inter alia, the feeling and expression of emotion, motivation to act and accessing inner resources, this theme articulates capacity to experience and express pleasure, joy, liberation and heightened energy levels – see Table 13. References to enjoyment of musical processes, feelings of excitement and happiness, statements indicating spontaneous participation and liberation in active music making, and references to feeling “alive” and “very, very energetic” demonstrate the shift in energy levels and affect. For some these were transient moments, and for others a gradual shift over the course of the music therapy process.

Common to both active and receptive music therapy methods were associations with feelings of joy, happiness, and freedom. Active music therapy afforded new ways of self-expression, experiences of fun and pleasure, the opportunity for spontaneous creative expression, stress release through music making and experiences of liberation and humour. Receptive music therapy elicited imagery associated with joy, happiness and freedom, articulating most strikingly the desire for happiness, freedom and growth.

Both diagnostic groups experienced music as pleasurable and energising, improvisation as being fun, and associated imagery as positive feelings. The SSD-group associated imagery with feelings of happiness, growth and freedom and a desire for living. The MDD-group articulated the desire for happiness, freedom and spontaneity, enjoyment, shifting perspective, and experiences of stress release and liberation.

Table 13
The theme “invigoration and liberation”.

Subthemes	Salient examples
Experiencing music as pleasurable Expressions of joy Liberation Energising to life	<i>Wow, this is so nice. Brings it out in such a subtle, calm way</i> <i>It puts you in a different space which is absolutely fun, which I haven't had for a long time</i> <i>I experience that I become, I take a deep breath, feel release</i> <i>I feel alive</i> <i>I don't know what tomorrow is having for me. I don't want to think about tomorrow. As long as I got life</i>

Discussion

The findings of our study indicated that within the music therapy relationship clients’ verbal expression of issues concerned feeling and doing; connection with and affection of others; the reclamation of vigour and resilience; and various emotions of fear, anxiety, anger, sadness, desires, being stuck, and trust. These themes constitute the working material that presents centrally in music therapy sessions at the heart of the interpersonal encounter of individual music therapy as experienced by patients, informing the mutual understanding that is crucial in therapy.

Previous studies, in contrast, have focused on musical processes and their therapeutic effects. An exception is the group study by Grocke et al. (2013) which revealed themes similar to those revealed in our study. Its aim was to determine whether group music therapy improved quality of life, social enrichment, self-esteem, spirituality and psychiatric symptoms of participants with severe mental illness (Grocke et al., 2013). Themes emerging from their study included i) motivation, encouragement and hope, ii) being alone/isolated, lost, iii) appreciation of positive relationships, iv) dreaming and imagining the future, v) instructions and advice to self and others, vi) longing, vii) leaving and changing and viii) descriptions of nature reflecting hope. The significant outcomes of the study indicate that quality of life and self-esteem improved, that group music therapy created opportunities for fostering social connections and that music therapy should be considered as a component of holistic care in mental health (Grocke et al., 2013).

Our study, furthermore, showed similarities and differences of qualitative affordance between active and receptive music therapy methods. Similarly, similarities and differences were found between participants with MDD versus SSD. Although these findings are context dependent, music therapist may draw on these in the planning and strengthening of a music therapy intervention to have optimal reach and engagement with clients, structured around the needs of the individual and/or diagnostic group, and deploying the most suitable music therapy method.

These findings concur with Nolan (2002) understanding of the role of verbal processing as eliciting a verbal response relevant to the music experience, establishing or increasing awareness about the music that includes one’s emotional response to the music as well as the aesthetic qualities of the music; to increase awareness of one’s own musical behaviour, the interpersonal process and the inner process, to experience shifts in thinking and feeling and to return to a more defended state.

The contributions of the specific music therapy methods resonate

with the work of Ansdell (2014) that suggests music offers i) a social experience in the form of musical togetherness; ii) generosity through welcoming a client in, and creatively working to meet the client in every present moment; iii) belonging as acquired 'through musical engagement and attunement, which opens up new spaces for an intimate communication supporting culturally based personal styles of 'being together in time' (see also Gratier & Apter-Danon, 2009); iv) experiences of interactive ritual that transforms personal and social experiences; v) moments of epiphany through which access to what may seem inaccessible is made possible; vi) musical thresholds that call for a crossing over or through to new territory. At the point of threshold, ambivalence or impasse may be present with choices as to whether 'we enter, retreat, hesitate, linger or dance'; vii) musical hope that helps us to think of the relationship between past, present and future. Ansdell (2014) suggests that musical time challenges the notion of human time and alternatively provides an audible understanding of the possibilities of human time as being "alive, connected, habitable, purposeful and transcendent"; and vii) musical flourishing whereby, through music, experiences of wellness and wellbeing can be experienced within illness and difficulty. Our findings demonstrate, as reflected through the themes, how music therapy provides a space for the full extent of human expression and concurs with the sentiment expressed by Shuman, Kennedy, DeWitt, Edelblute, and Wamboldt, (2016) that the goal of music therapy is not necessarily to improve negative mood or decrease symptoms, but rather to provide a space in which emotional state recognition, expression and self-exploration is possible.

In a study on participants' reflections on music therapy, participants referred to the rich sound world of music, the humanity of music therapy and the strengths enhancing opportunities experienced through music therapy (McCaffrey & Edwards, 2016). The emerging affordances from our research study resonate with these findings in that the rich sound world of music holds the extent of client experience with its complexity. The humanity of music therapy was reflected through the voice of clients through the speaking and sounding of their stories. Strength enhancing opportunities were appropriated through musical processes that afforded experiences of emotional expression, self-exploration, grappling with difficulty, inner strengthening and resilience.

The qualitative case study design of our study comes with the limitation that our findings are context specific and may only be extrapolated as potentially similar in similar contexts (Matthews & Ross, 2010). Further research will be required to examine dissimilar contexts. Our findings are thus contextual qualified as originating from a public psychiatric hospital setting in South Africa. Moreover, they originated during and not after a course of eight individual music therapy sessions, which means the contents yielded in our study may be different from contents that would emerge in a study after the completion of a music therapy course. Future studies may show how therapeutically relevant our findings are after completion of a music therapy course for patients similar to our study's.

The clinical intervention in our study was limited to eight sessions, which gave ample opportunity for engagement through receptive and active music therapy methods, but one may anticipate that more sessions might have provided for further development and depth in the therapeutic encounter including further richness of content. Therapy over a longer term period may reveal additional content, and future studies may reveal, but such would then also be more likely to reflect therapeutic changes over time rather than being affordances attributed to specifically the music therapy methods (as was the focus of this study).

In a qualitative case study design with its contextual limitations to a generalisation of its findings, the depth of exploration and engagement with each participant is considered more important than the sample size (Matthews & Ross, 2010). Our study analysed 131 therapy sessions, a number that may be considered a strength for the depth and engagement so afforded. The sample size of 20, by qualitative standards,

are generally considered reasonable for yielding relevant and trustworthy content for the particular setting. Saturation of data was attained suitably to support the identified themes, but the possibility of further themes emerging had other patients also been enrolled in the study and course of music therapy, has to be acknowledged.

Our study was further limited to the verbal affordance of receptive and active music therapy methods. Further studies may explore other kinds of qualitative affordances during music therapy, such as relationship qualities, processes of change, and musical expressions during conjoint music-making. Regarding the latter, a sensible research question is which qualitative contents are revealed in the language of music making (rather than words and sentences) during a course of individual active music therapy. Musical expressions may reveal more than was captured verbally in our study. It can be anticipated, nonetheless, that affordances in terms of musical expression would also reflect the verbal affordances found in our study, being responses that express inter- and intra-personal connection, self-exploration, grappling with difficulty, emotional expression, increased motivation, and the reclamation of energy, spontaneity and resilience.

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