Music Therapy with Adolescents in Psychiatric Treatment Who Have Histories of Loss: A Thematic Analysis of Session Content

By Jennifer M. Seley, MT-BC

A Thesis Submitted in Partial
Fulfillment of the Requirement
for the Master of Arts Degree

Master of Arts in Music Therapy Program
In the Departments of Graduate Studies
And Music and Theatre
Saint Mary-of-the-Woods College
Saint Mary-of-the-Woods, Indiana

December 4, 2014

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Abstract

Many adolescents with psychiatric disorders have experienced significant losses in their lives, yet there is limited literature describing this population. In the current study, six adolescents in residential psychiatric treatment who had histories of loss received individual music therapy sessions. Music experiences included singing, instrument play, and dancing to both pre-composed and improvised music, as well as composing original music. The researcher reviewed session videos, analyzed the content of the sessions, and identified six key themes. These themes suggest that loss, negative and positive relationship experiences, emotional pain, comfort, and resiliency are important issues to this population. The results of this study can shape the practice of clinicians working in adolescent psychiatry and form the basis of future research on this population.

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ACKNOWLEDGMENTS

First I would like to thank the academic team that supported me in writing this thesis. Warm thanks to my advisor Dr. Tracy Richardson for your ongoing guidance, patience, and sagely wisdom. Thank you to the other members of my thesis committee—Dr. Robert Krout and Dr. Alan Turry—for your wonderful feedback and thought-provoking comments. I would like to express additional gratitude to Dr. Alan Turry for teaching me the fundamentals of qualitative data analysis and for helping me to believe that I could actually do it.

I would also like to thank my colleagues at Cincinnati Children's Hospital Medical Center for their support in various aspects of the research process. Thank you to Stephanie Rowland, Melissa Harney, and Delvin Hector for assistance with consents. Thank you to Melissa Liddle for generously giving up so much time and expertise to do a remarkably thorough data check. Additionally, I am grateful to Brian Schreck for providing intercoder reliability and for consistently encouraging me when I ran into the many barriers that accompanied this study.

Thank you to my patients and clients, especially the six in this study, who have the courage to open up and share your inner world with me through your music. It is an honor to be a part of your creativity and growth.

Finally, thank you to David Seley. Your constant support, sacrifices, and love not only helped bring this thesis to fulfillment but also allow me to do the work that I do everyday. You are the rosin to my bow, the mallets to my marimba, and the breath in my melodica.

Introduction

The issues that lead to adolescent psychiatric treatment are like an iceberg. Above the water's surface, healthcare providers can see the tip of the iceberg, the overt behaviors (such as self-harming behaviors, suicide attempts, and aggression towards others) that are causing the adolescents or those around them distress. In psychiatric treatment, healthcare providers often metaphorically chip away at the tip of the ice, striving to eliminate those overt, maladaptive behaviors. But what about the deeper issues under the surface of the water that serve as the foundation for those behaviors at the tip of the iceberg?

Loss is one such under the surface issue that many adolescents in psychiatric treatment face. However, the topic of loss is frequently overlooked or avoided by healthcare providers during treatment (Cait, 2012; Cates, 1986; McFerran, 2010). Treatment modalities for these adolescents may include medication management; behavioral interventions; verbal counseling; adjunct therapies, such as speech therapy and occupational therapy; and expressive therapies, such as music therapy. Avoiding the topic of loss during these treatments does not eliminate adolescents' feeling the impact of their losses. Adolescents in psychiatric treatment often directly or indirectly bring up issues related to loss during symbolic modalities of treatment, such as music therapy (Frisch, 1990; Rolvsjord, 2001; Tervo, 2001).

While there is a significant amount of literature related to adolescents in psychiatric treatment (e.g., Geller & Biebel, 2006; Mathai & Bourne, 2009) and the impact of loss on adolescents (e.g., Balk, 2011; Kaczmarek & Backlund, 1991), the literature describing adolescents hospitalized or institutionalized for psychiatric treatment who have also histories of loss is limited. When loss is described in the adolescent psychiatric treatment

literature, the articles are generally small in scope, focusing on the impact of loss on a specific adolescent (e.g., Cait, 2012; Tomori, 2000). There is limited literature that takes a broader approach in looking at the interplay between loss and intensive psychiatric treatment (e.g., Cates, 1986; Wallis & Steele, 2001).

Within the music therapy literature, several authors have described how loss surfaces during treatment sessions with adolescents with psychiatric needs. This literature has consisted of case studies or descriptive narratives of loss within articles on other topics (e.g., Frisch, 1990; Rolvsjord, 2001; Tervo, 2001). There is a lack of literature that more broadly and systematically describes music therapy with adolescents in psychiatric treatment who have experienced loss.

Purpose of Study

Research that explores what occurs during music therapy sessions with adolescents receiving psychiatric treatment who have histories of loss could have an impact on future clinical practice with this population. Themes identified from music therapy sessions provide insight into what issues are important to these adolescents and what clinical needs they have. Therefore, the purpose of the current study was to use thematic analysis to identify the themes present during individual music therapy sessions with adolescents with histories of loss who are receiving treatment at a residential psychiatric treatment facility.

Definitions

For the purpose of this study, *music therapy* was defined as the use of music experiences implemented by a board-certified music therapist that promote attainment of individualized treatment goals and overall well being. *Adolescents* was defined as

individuals in the period of life that begins with the onset of puberty at approximately age 10 and ends with the onset of adult identity in the early 20s (Balk, 2011; Erikson, 1985; McFerran, 2010; Van Heeswyk, 1997 as cited in McFerran, 2010). *Loss* was defined as something or someone once valued being "taken away irrevocably" (Balk, 2011, p. 7). *Psychiatric treatment* was defined as interventions geared toward promoting the well being of individuals with diagnosed psychiatric disorders or severe emotional or behavioral disturbances. *Thematic analysis* was defined as a qualitative research design in which the researcher identifies and analyzes categories within the data (Braun & Clarke, 2006).

Literature Review

Adolescence

Adolescence is the period of life and development that begins with the onset of puberty and ends with the onset of adult identity (Balk, 2011; Erikson, 1985; Van Heeswyk, 1997 as cited in McFerran, 2010). It extends from approximately age 10 through the early 20s (Balk, 2011; McFerran, 2010). Adolescence is a time of transition and involves many changes in one's physical, cognitive, and psychosocial functioning and identity (Austin, 2007; Frisch, 1990; Erikson, 1985; Kaczmarek & Backlund, 1991; McFerran-Skewes, 2000). While this multitude of changes can make adolescence a stressful and vulnerable stage of life, adolescence is also considered the peak period of functioning in many domains and is often accompanied by an increase in creative drive (Austin, 2007; Epstein, 2007 as cited in McFerran, 2010; Frisch, 1990; Raz, 2006 as cited in McFerran, 2010).

Many of the changes in other domains of adolescents' lives are brought on by the physical changes occurring in their bodies. During puberty an influx of hormones are being released in the body (McFerran, 2010; McFerran et al., 2010). There is an increase in physical and sexual energy, as well as a rapid increase in physical growth (Erikson, 1985; Frisch, 1990). The peak of human physical performance occurs during adolescence (Epstein, 2007 as cited in McFerran, 2010).

Significant changes occur cognitively during adolescence. Adolescents are transitioning into what Piaget called the stage of *formal operational thinking*, which is characterized by the ability to understand and generate more abstract concepts (Inhelder & Piaget, 1958). During the transition into formal operational thinking, adolescents often oscillate between concrete and abstract thinking (McFerran, Roberts, & O'Grady, 2010;

McFerran-Skewes, 2000). Adolescents also tend to be egocentric in their thinking. Adolescent egocentric thinking often manifests in a sense of invulnerability, which can lead to increased risk-taking behaviors (Steinberg, 1985 as cited in Kaczmarek & Backlund, 1991; McFerran, 2012). Additionally, the peak of neurological capacity occurs during adolescence, as does the peak of many other cognitive functions, such as memory (Epstein, 2007 as cited in McFerran, 2010; Raz, 2006 as cited in McFerran, 2010).

Other changes occur in the emotional and social domains during adolescence. Due to the hormone changes in their bodies, adolescents often experience frequent mood changes (Kaczmarek & Backlund, 1991; McFerran et al., 2010). They experience emotions in a deeper, more intense manner than they did during childhood. This deepening of emotions leads to romantic love and the beginning of intimate relationships (Fleming & Adolph, 1986 as cited in Balk, 2011; McFerran-Skewes, 2000). During adolescence, relationships with peers become more important than relationships with family (Kaczmarek & Backlund, 1991). Adolescents often become sensitive to their peers' opinions and judgments of them and seek a sense of belonging within peer groups (Austin, 2007; Erikson, 1985; McFerran et al., 2010).

This sensitivity to peers' judgments and search for belonging stem from one of the main developmental tasks of adolescence: formation of identity. Adolescents turn to many external sources during their internal searches for identity. They may affiliate and sometimes overidentify with different peer groups (Erikson, 1985). They experiment with new behaviors and characteristics, often influenced by peers or idols (McFerran, 2010, 2012). These experiments and affiliations help adolescents develop a clearer sense of who they are and what their roles are (McFerran, 2010).

Adolescents in Psychiatric Treatment

When mental, emotional, or behavioral difficulties interrupt adolescents' typical development and functioning, they may need psychiatric treatment. When the impact on functioning is severe, adolescents may require intensive forms of treatment, such as inpatient psychiatric hospitalizations or care at long-term residential treatment centers. These intensive treatments are fairly common, with psychiatric disorders being the leading cause for hospitalization among children and adolescents ages 5 to 19 (Geller & Biebel, 2006).

Adolescents are generally admitted to intensive psychiatric treatment facilities when their symptoms cannot be managed in a less restrictive setting. Two common reasons for admission include adolescents' posing a significant risk of harm to themselves or to others (Geller & Biebel, 2006; Kaltiala-Heino, 2010; Mathai & Bourne, 2009). Adolescents may also be admitted for intensive treatment due to life-threatening eating disorders or severe manifestations of disorders such as obsessive-compulsive disorder, phobias, or schizophrenia that impede adolescents' abilities to function (Mathai & Bourne, 2009). In addition to those mentioned above, diagnoses for adolescents in psychiatric treatment may include depression, bipolar disorder, anxiety disorders, conduct disorder, and personality disorders (Kaltiala-Heino, 2010; Mathai & Bourne, 2009). Often adolescents have multiple diagnoses (Mathai & Bourne, 2009). Comorbidity between substance abuse and other psychiatric disorders is high in adolescents (Geller & Biebel, 2006).

In addition to the symptoms or behavioral manifestations that led to admission, adolescents in psychiatric treatment are often dealing with many other psychosocial issues.

Adolescents in psychiatric treatment often come from complex family situations, with many having a history of foster care placement (Geller & Biebel, 2006). Cates (1986) points out that admission to a residential treatment facility is often the culmination of many out-of-home placements. Many adolescents in psychiatric treatment come from poverty. There are high levels of correlation between adolescents with psychiatric disorders and adolescents who have had contact with the juvenile justice system (Geller & Biebel, 2006). School difficulties are common among adolescents in psychiatric treatment, and they often have diagnosed learning disabilities (Brooks, 1989; Geller & Biebel, 2006). Many have histories of being physically and/or sexually abused (Geller & Biebel, 2006). In addition, adolescents in psychiatric treatment have often experienced one or multiple significant losses (Cates, 1986; Wallis & Steele, 2001).

Loss

Loss is a phenomenon that can take many forms and have many facets. At its core, loss involves something or someone once valued being "taken away irrevocably" (Balk, 2011, p. 7). Loss is closely associated with grief, which is defined as the responses to a loss (Balk, 2011). Loss and grief are natural, normal experiences encountered universally by all people (Balk, 2011; McFerran, 2010).

There are many different kinds of losses that may be significant to an individual. One such loss is the death of a family member, friend, or pet (Balk, 2011; Bright, 2002; McFerran, 2010; Rudenberg & Royka, 1989). Another is loss of relationship, including divorce, breakups, termination of friendships, and termination of parental rights (Balk, 2011; Bright, 1999, 2002; Schwartz, 2010; Kaczmarek & Backlund, 1991; Lenhardt, 1997). Loss of home may occur via destruction of the home, such as the occurrence of a house fire,

or through one's removal from the home, such as via placement into foster care (Rudenberg & Royka, 1989; Schwartz, 2010). Loss of self can manifest through loss of limb after an amputation or loss of functioning following an illness or injury (Balk, 2011; Rudenberg & Royka, 1989). Loss of hopes and dreams can occur following the diagnosis of an illness, psychiatric disorder, or acquired disability (Bright, 1999, 2002; McFerran, 2010). Individuals who come from tumultuous home lives may grieve the loss of a normal childhood (McFerran, 2010). Other losses include loss of employment, loss of valued possessions, loss of cultural identity, and loss of control (Balk, 2011; Bright, 1999, 2002; McFerran, 2010).

Disenfranchised loss is a type of loss that is not socially acceptable to grieve but nevertheless has an impact an individual (Doka, 1989; Kaczmarek & Backlund, 1991; Lenhardt, 1997). Examples of disenfranchised losses include the death of a favorite celebrity, termination of an extramarital affair, and loss through abortion. Disenfranchised grief also includes losses that go unrecognized by society. These losses may go unrecognized because the griever is viewed as incapable of understanding the loss because of age or disability (Doka, 1989; Lenhardt, 1997).

Impact of Loss on Adolescents

These various types of losses can have a significant impact on the daily functioning of adolescents. Following a loss, some adolescents have reduced energy, changes in eating or sleeping habits, or somatic complaints. Some have difficulties focusing, and they may become preoccupied with thinking about the loss (Balk, 2011; Kaczmarek & Backlund, 1991). Adolescents who have experienced a loss tend to experience a wide range of emotions, including anxiety, anger, guilt, confusion, and depression (Austin, 2007; Balk,

2011). Some adolescents become withdrawn and isolate themselves. School performance often declines, and some adolescents neglect or withdraw from responsibilities at home or their place of employment (Kaczmarek & Backlund, 1991). Following a loss, adolescents may question meaning and other spiritual issues (Balk, 2011). To cope with loss, adolescents often alternate between periods of active grieving and distraction from their loss (McFerran et al., 2010).

Loss can have a unique impact on adolescents due to the characteristics and tasks of their developmental level. Because adolescence is already a time of emotional lability, dealing with a loss during adolescence can complicate an already overwhelmingly emotional time (Cates, 1986; McFerran-Skewes, 2000). Adolescence is a time of increased risk-taking, and some adolescents turn to risk-taking behaviors, such as drug and alcohol use, to attempt to cope with their losses (Kaczmarek & Backlund, 1991). Because adolescents are acutely aware of differences between themselves and peers, adolescents who are grieving may feel out of place in peer groups or may attempt to hide their grief in order to fit in with peers (Balk, 2011). Adolescents' identity formation can be impacted by loss, especially loss of relationship. When adolescents enter into romantic relationships, parts of their identities become defined by those affiliations. When those relationships end, the adolescents lose not only their partners but also parts of their identities (Kaczmarek & Backlund, 1991). Another developmental impact of loss is the re-grief phenomenon, the tendency of individuals to re-experience previous losses as they enter into different stages of life (Oltjenbruns, 2001). Therefore, adolescents who experienced significant losses earlier in their lives may re-experience the grief as they enter adolescence (Balk, 2011).

Qualitative researchers have interviewed adolescents with various types of losses to identify themes in how adolescents perceive and deal with loss. In her study with African American adolescents in foster care, Schwartz (2010) found that the theme of experiencing disruption in response to loss came up more frequently with adolescents who lived in non-kinship placements than with adolescents lived in placements with friends or relatives. Van Epps, Opie, and Goodwin (1997) analyzed themes during group discussions with adolescents living in poverty who had experienced the death of a loved one. The theme of stress and chaos came up during every discussion. In regards to emotional themes, anger and guilt were expressed frequently, as were feelings that were "intense and painful, and difficult for most to put into words" (p. 32). When discussing coping strategies, the themes of avoidance, isolation, and talking with others emerged. Other themes included confusion about circumstances related to the death, changes in life circumstances, continued connections with the deceased, and fear and despair about the future (Van Epps et al., 1997).

Loss and Adolescents in Psychiatric Treatment

Adolescents in foster care and adolescents living in poverty are only two of the many subgroups of the adolescent population that have experienced loss. One subgroup of adolescents that has received limited attention in the loss literature is adolescents in psychiatric treatment. This limited attention is interesting because the loss literature describes individuals with psychiatric disorders as more prone to pathological responses to loss (Bright, 1999, 2002). Additionally, Cates (1986) points out that adolescents in residential treatment settings have the potential for experiencing more losses than the average adolescent. Adolescents in residential treatment have often experienced frequent

changes in placement, caregivers, and peers, each of which can be considered a loss (Cates, 1986).

The literature that does exist on adolescents in psychiatric treatment with histories of loss describes these adolescents as having grief that is often blocked or not activated (Cates, 1986; Tomori, 2000; Wallis & Steele, 2001). Often this incomplete or inactive grief appears to stem from dysfunctional family relationships or family disruptions. For some of these adolescents, their families could not tolerate the painful emotions associated with loss, and the adolescents had to shut down their own grief responses (Cates, 1986; Tomori, 2000). Many of the losses experienced by adolescents in psychiatric treatment are disenfranchised and have never been recognized (Cates, 1986). Additionally, this population tends to have complex grief situations. Some may experience contradictory emotions around their loss, such as simultaneous relief and sorrow following the death of an abusive parent. Many have experienced other traumatic events in addition to their loss, and the effects of trauma can complicate the grieving process (Cates, 1986; Wallis & Steele, 2001).

Several authors have written about the tendency for healthcare professionals to overlook or avoid addressing grief with adolescents in psychiatric treatment. McFerran (2010) suggests that many healthcare professionals may avoid bringing up loss to avoid triggering depression. In her case study of a young adolescent male experiencing separation anxiety following several major losses, Cait (2012) points out that modern society tends to view grief as a time-limited process, meaning that others may not recognize the impact of the loss if it did not occur in the recent past. Cait also argues that avoiding loss in treatment may be a reflection of the healthcare professionals' own

discomfort with death. By focusing on other aspects of treatment, healthcare professionals get to circumvent the reality of death and avoid witnessing the pain associated with loss (Cait, 2012). Cates (1986) attributes the tendency to overlook loss in adolescent psychiatric treatment to the behavioral orientations of many treatment facilities. Because healthcare professionals who practice from a behavioral orientation tend to emphasize the present, they may not recognize or acknowledge a loss that occurred in the past. However, Cates points out that "the impact of an early or recent loss upon present emotional state and behavior is profound" (Cates, 1986, p. 150).

Loss Interventions

When the issue of loss is not overlooked, there are a number of options available to address loss and facilitate a healthy grieving process. Generally loss interventions can be divided into two categories: preventative interventions and psychotherapeutic interventions. Preventative interventions target individuals who have experienced loss but have not displayed difficulties functioning or symptoms of complicated grief. Their function is primarily supportive. Psychotherapeutic interventions are for individuals who have experienced difficulty coping with loss. These individuals often display symptoms of complicated grief (Rosner, Kruse, & Hagl, 2010; Schut, Stroebe, van den Bout, & Terheggen, 2001). Specific treatment formats include both individual and group sessions (Cates, 1986; Schut et al., 2001). Modalities used in treatment vary from counseling techniques, psychoeducation techniques, art therapy, play therapy, and music therapy (Rosner et al., 2010). In their meta-analysis of interventions used with children and adolescents who had experienced loss through death, Rosner et al. (2010) listed music therapy as a promising treatment model. They also recommended further exploration of the modality due to "the

enormous part music plays in contemporary youth culture… especially with adolescents" (Rosner et al., 2010, p. 130).

Adolescents and Music

Rosner and colleagues' comment sheds light on a phenomenon that many have addressed in the music therapy literature: the relationship between adolescents and music. Music is highly valued by adolescents and plays a key part in their lives (McFerran, 2010; Austin, 2007). Adolescents devote approximately two and a half hours of each day to listening to music (McFerran, 2010). Additionally, adolescents ranked music as their most preferred activity (Fitzgerald, Joseph, Hayes, & O'Regan, 1995).

Music is more than recreation or leisure for adolescents. Adolescents frequently use music to regulate emotions, unconsciously choosing music that will help them feel better (Saarikallio & Erkkila, 2007). They use music to make meaning from past experiences (DeNora, 2000 as cited in McFerran et al., 2010). Adolescents also use music for self-expression, as a modality for communicating their emotions, values, and dreams (Frith, 1981 as cited in McFerran, 2010; McFerran, 2010). Closely related to the use of music for self-expression is adolescents' use of music in identity formation. Music preferences often serve as mirror, reflecting back who the adolescent is (Austin, 2007; McFerran et al., 2010). Adolescents use music to affiliate themselves with others with whom they wish to identify and as a barrier to keep out others (especially parents) with whom they do not wish to identify (Frith, 1981 as cited in McFerran, 2012; McFerran, 2010).

Music Therapy with Adolescents with Histories of Loss

Given the strong relationship adolescents have with music, music therapy is a natural choice of treatment for adolescents in need of therapeutic interventions. Many

music therapists have used music to address the therapeutic needs of adolescents who have experienced different kinds of loss. Music therapy literature contains examples of therapists working with adolescents who have experienced loss through the death of a loved one (Dalton & Krout, 2005, 2006; McFerran, 2010; McFerran, 2012; McFerran et al., 2010; McFerran-Skewes; Roberts, 2006), loss of control (Flower, 1993), losses related to being in foster care (Austin, 2007), and the various losses associated with substance abuse (McFerran, 2010). These sessions take a variety of formats, including individual, group, family, home-based, school-based, facility-based, and community-based therapy sessions (Austin, 2007; Dalton & Krout, 2005, 2006; Flower, 1993; McFerran, 2010, 2012; McFerran et al., 2010; McFerran-Skewes, 2000; Roberts, 2006).

Music therapists utilize a variety of music therapy experiences and have diverse therapeutic outcomes in their sessions with adolescents who have experienced loss. Many therapists working with adolescents who experienced loss through death of a loved one used songwriting to facilitate self-expression and to tell the story of their grief. Sometimes the adolescents engaged in recording their songs to have a tangible keepsake associated with their loved one and to have a reminder of therapeutic themes after the session was completed. Some adolescents verbally processed their lyrics to enhance understanding and expression. Others deflected therapists' attempts at verbal processing, and the music itself served as the sole form of expression (Dalton & Krout, 2005, 2006; McFerran, 2010, 2012; McFerran et al., 2010; McFerran-Skewes, 2000; Roberts, 2006). Some sessions with adolescents who experienced loss through death of a loved one included instrumental improvisation as a non-verbal outlet for self-expression (Dalton & Krout, 2005, 2006; McFerran, 2010; McFerran et al., 2010; McFerran-Skewes, 2000; Roberts, 2006). Some also

included group music sharing as a validation of emotions and identity, a method of expressing and communicating, and a means for connecting with other grievers (McFerran-Skewes, 2000).

Music therapists that addressed other losses used many of the same music experiences as those addressing loss through death; however, there are differences in therapeutic outcomes of these sessions. In using instrumental improvisation with adolescents who were experiencing loss of choice and control, Flowers (1993) describes adolescents who became musically dominant via controlling the tempo, dynamics, and other musical elements and at times even rejecting the therapist's attempts to join their music making. She also describes what appear to be musical re-enactments of past abuses in which the adolescents had no control, this time with the adolescents taking the roles of power. Austin (2007) used music improvisation, group music sharing, and therapeutic music lessons in her community music therapy program for adolescents in foster care. One of the outcomes was that this community program became a source of constancy and stability through the many losses the adolescents faced during their time in foster care.

Additionally, some authors have identified themes related to therapeutic sessions with adolescents who have experienced loss. Dalton and Krout (2005) analyzed lyrics of songs written by bereaved adolescents in music therapy sessions. They identified five themes related to the grief process: understanding the loss and grief, feeling a variety of emotions while grieving, remembering both positive and negative memories of the deceased, integrating and coping with the loss while continuing to live, and personal growth as a result of the loss. McFerran et al. (2010) used focus group interviews to analyze participants' experiences in an adolescent music therapy bereavement group. They

discovered the overarching theme of "having permission to grieve" (p. 555). Subthemes from this study include changes in grieving status, changes in loss-related feelings, improving daily experience of coping with grief, increased interpersonal connections, and increased sharing about their loss.

Music Therapy with Adolescents in Psychiatric Treatment

In addition to its use with adolescents experiencing loss, music therapy is also used with adolescents in psychiatric treatment. The music therapy experiences sometimes directly address the issues that led to hospitalization. Many adolescents are hospitalized for issues related to impulsivity, and highly structured music experiences provide opportunities for these individuals to develop and practice self-control (Frisch, 1990). Adolescents can transform their aggression into something constructive through music making (Tervo, 2001). Music paired with movement may increase body acceptance and decrease sexually acting-out behaviors (Brooks, 1989). Music may provide an alternative method for coping and relaxing for adolescents with histories of substance abuse (Brooks, 1989). Additionally, during receptive music therapy experiences, adolescents often choose songs that relate to their problems. Verbal processing related to these choices can provide insight into adolescents' perspectives of their problems (Frisch, 1990).

Other music therapy experiences with adolescents in psychiatric treatment focus more on growth and development (Frisch, 1990). Because many adolescents in psychiatric treatment have communication deficits, the non-verbal and symbolic nature of music provide an accessible media for communicating and expressing. Through their musical expressions and expression of music preferences, adolescents work toward identity formation (Brooks, 1989; Frisch, 1990). Identity work is important with adolescents in

psychiatric treatments because many of them lack the ability to cope with the stresses of this developmental task on their own (Frisch, 1990). Music may facilitate connecting with intense emotions and desires, including anger, shame, sadness, love, intimacy, and sexuality. Music can reach deep emotional levels that cannot adequately be described by words and has the potential to bring hidden pain to the surface. One of the painful emotions that may surface during music therapy work with adolescents in psychiatric treatment is grief (Frisch, 1990; Tervo, 2001).

Music Therapy with Adolescents in Psychiatric Treatment Who Have Histories of Loss

Grief and loss have received limited attention in the adolescent psychiatric music therapy literature, a reflection of this same trend in the general adolescent psychiatric literature. Frisch (1990) acknowledges that loss is a common theme in songs written by this population. She describes two case examples in which adolescent females who had been abandoned by their parents wrote songs with loss as a key lyrical theme. Frisch also suggests that the theme of loss may not be verbalized in other areas of their treatment until adolescents have had the opportunity to explore it symbolically through song lyrics or music that reflects the feelings associated with their loss.

Tervo (2001) describes grief manifesting during instrument play. The adolescent in the case example had lost his mother at age 5. During one period in his music therapy treatment course, the adolescent's guitar playing took on a new level of intensity and often had a weeping sound as he played. Shortly after the manifestation of his grief-laden playing, the adolescent began discussing his mother in his verbal psychotherapy sessions.

Rolvsjord's (2001) case study of "Sophie" describes the expression of loss through both instrument play and songwriting. Sophie had experienced multiple losses in her life, including the death of her best friend several years prior to her hospitalization, and she demonstrated high levels of resistance during verbal psychotherapy sessions. Sophie's music therapy sessions initially focused on using piano playing to promote meaningful activity during her hospitalization. As the sessions progressed, Rolvsjord sensed Sophie's choices of songs to play were significant. Rolvsjord began using the metaphors contained in the songs lyrics to communicate with Sophie. Sophie eventually verbalized the connection between these songs and the loss of her best friend. Using words chosen by Sophie, Rolvsjord composed an original song about the friend. Sophie learned to play this song on piano, and her practicing the song during her own time ensured the transfer of the grief themes from the therapy room to Sophie's everyday life.

These examples (Frisch, 1990; Rolvsjord, 2001; Tervo, 2001) provide evidence that loss manifests in music therapy sessions with adolescents in psychiatric treatment. However, all the literature on this topic is included in case studies or brief case descriptions within articles on other topics. The topic of music therapy with adolescents in psychiatric treatment who have a history of loss has not been systematically studied previously. The purpose of the current study is to identify themes that are present during music therapy sessions with adolescents in psychiatric treatment who have histories of loss.

Methods

Research Framework and Design

This research study has a qualitative framework. In qualitative research studies, the researcher traditionally serves as the primary instrument for collecting data. Qualitative research typically takes place in a naturalistic setting where the phenomenon being studied occurs or seeks to capture participants' natural thoughts or feelings about the phenomenon. Data analysis is inductive, moving from individual, specific pieces of data to broad, general themes. The interpretation of this data relies on the researcher's background and perspective, as well as the researcher's ability to discover patterns and commonalities in the data. Qualitative researchers operate from a holistic perspective, attempting to portray and understand many aspects of the phenomenon, as opposed to isolating individual variables (Creswell, 2009; Wheeler & Kenny, 2005).

The specific design for this study is thematic analysis. Thematic analysis is a systematic approach to identifying and analyzing patterns or categories within data. Although thematic analysis has traditionally been used as a tool within various qualitative methodologies, Braun and Clarke (2006) contend that thematic analysis can be a separate, autonomous research design. Within the music therapy literature, researchers have recently begun to follow Braun and Clarke's recommendation of using thematic analysis as a stand-alone approach (e.g., Baker & Krout, 2011; Kleiber & Adamek, 2013).

Thematic analysis is appropriate for the current study for several reasons. First, this is my first research study. Braun and Clarke (2006) suggest that thematic analysis is a foundational method and appropriate for new qualitative researchers. Thematic analysis is also appropriate for this study because it is exploratory. No other studies currently exist

that systematically describe music therapy with adolescents who are in psychiatric treatment and have histories of loss. Thematic analysis provides a methodical way of identifying general themes that can be used to increase the knowledge base for understanding this little-researched population.

The Researcher's Role

Because thematic analysis depends heavily on the researcher's interpretation, it is important that I as the researcher identify and disclose any personal values, experiences, or biases that could contribute to the outcome of the study. I am a music therapist at the research facility and had been practicing there for three years at the study's onset. Because I am a clinical staff member at the facility, I had access to participants' clinical records and information from treatment team members. Information from these sources likely influenced my interpretation of various participant responses.

Because of my dual role of therapist and researcher, my philosophy of music therapy impacted both my choices during the study sessions and my interpretation of responses during data analysis. As a music therapist I operate from an approach influenced by person-centered, Gestalt, strength-based, and music-centered philosophies. The person-centered influence indicates a strong emphasis on unconditional positive regard and a warm, authentic therapeutic relationship. Under this approach, I encourage clients to guide the session, trusting that they know their own needs. However, I do provide guidance and limitations when clinically appropriate. The Gestalt influence means that I believe that the issues that clients become aware of and that become figural during a session reflect clients' most prominent needs. I also value the Gestalt principle of holism, which emphasizes the importance of understanding the whole individual, not just isolated behaviors, feelings, or

verbalizations. Because the strength-based approach influences my practice, I believe that it is important to connect with and amplify one's healthy components to promote healing. Music-centered philosophies contribute to my view of music within the session. To me, music is not simply a means for achieving a non-musical goal. The process of engaging in a music experience is therapeutic in and of itself. I also believe that the elements of music created during a session can provide insight about clients' inner worlds.

These philosophical influences shape what makes a "typical" music therapy session with me. My sessions typically begin either with what organically unfolds as clients enter the music environment or with a verbal check-in about where the clients want to start. The majority of the music therapy experiences that I facilitate during sessions involve clients' actively making or composing music; I only occasionally use receptive experiences. I favor the use of live music, but if there is a clinical reason to use recorded music, there is still a live musical element added over the recording. Throughout sessions, I frequently point out the positive behaviors, music skills, and interactions that clients display to help them recognize and take ownership of their healthy attributes. I encourage verbal reflection on the music created during the session but also try to be sensitive of times when it feels like the music is more meaningful standing on its own without a verbal interpretation. I tend to take a role as co-creator in the music with clients. However, if clients need to assert their independence or explore autonomy, I instead actively listen and serve as a witness to their music creation. When co-creating music with clients, my musical choices are initially shaped by what musical elements will support, compliment, reflect, and validate the clients' musical choices. As the therapeutic relationships grow, I begin introducing musical

elements that nudge clients out of their comfort zones and help them connect with different aspects of their personalities.

In addition to my approach to therapy, my personal experiences with loss likely influenced my interpretations during the study. My childhood experiences with caregivers who displayed limited emotional nurturance have led me to explore the concepts of attachment and disenfranchised losses in my adult life. I have noticed that since beginning this exploration, I have been more apt to recognize insecure attachment styles and symbolic representations of loss during sessions with my clients. I also experienced a significant loss during my adolescence—the death of Josh, my best friend's younger brother who was also a peer in my high school band. Following Josh's death, I saw how our small community became more tightly knit and bonded together through our shared grief. This helped me to develop a belief that positive meaning can come from painful losses. Another significant loss in my life was the death of my cousin's husband. After his death, I moved in with my recently widowed cousin and her three young children. Living with them for four months immersed me in the world of youth who were trying to heal and move forward from a life-altering loss.

My beliefs about loss also shaped my actions and interpretations during the study. I view loss as a normal part of life, not as a pathological phenomenon. However, I believe that unresolved grief can play a significant role in the development, manifestation, or magnification of psychopathology. I believe that the resolution of loss is not time-limited and that loss can continue to affect individuals for long periods of time after the loss initially occurs. I believe that loss is frequently unidentified, overlooked, or ignored in

psychiatric treatment. However, in my clinical work I frequently notice adolescents bringing up loss in various manners during their music therapy sessions.

These personal experiences and values mean that I brought certain biases to the study. To promote objectivity, I established various verification procedures (see "Verification" below). Nevertheless, my biases may have impacted the study's results.

Participants

Participants for this study were recruited from the residential psychiatric treatment facility at which I work. Adolescents were eligible for the study if they were between the ages of 11 and 17, receiving individual music therapy services from me as part of their psychiatric treatment, and had a history of loss. History of loss in this study is defined as having experienced the death of a friend, family member, or significant person in one's life; loss of family due to foster care or other out-of-home placement (excluding the current residential facility); or loss of a parent or caregiver due to divorce, abandonment, or caregiver incarceration. Exclusion criteria included actively experiencing psychosis at the time of the study intervention.

At the onset of the study, the exact number of participants was unknown, as is common in qualitative research. Many forms of qualitative research alternate data collection procedures with data analysis procedures. The exact participants chosen and the number of participants chosen are dictated by the findings of each preliminary data analysis (Abrams, 2010; Strauss & Corbin, 1990). The purpose behind this type of sampling is to recruit participants that are likely to provide data that will progress the study toward the point of saturation. Data saturation is the point in the study at which no new codes or themes are generated and at which data collection becomes redundant (Strauss & Corbin,

1990). When I created my research proposal, I set a nine-week data collection period and set out to collect data from a minimum of six participants during this time frame. The proposal allowed for data collection from additional participants if (a) there were participant withdraws and/or (b) the data was not saturated after six participants and there was time remaining in the allotted nine-week data collection period. The nine-week time frame was chosen as a balance between the four-week time frame recommended to all graduate-level music therapy students by my university and the indefinite time frame until data saturation recommended by the Institutional Review Board at the hospital co-supporting my research.

Selection and enrollment was initially determined by what Strauss and Corbin (1990) refer to as "open sampling." This means that the first two participants were selected solely on the basis of meeting inclusion criteria and their willingness to participate in the study. After the preliminary data analyses, I recruited based on purposive sampling principles, recruiting participants that were likely to provide new and differing perspectives for the data analysis. I based these selections on my knowledge of the adolescents from their previous music therapy sessions with me. For example, I recruited the participant Jayla (pseudonym) because she (a) tended to utilize modalities (improvisation and instrument play) not frequently used by previous participants, (b) historically appeared more motivated by the in-the-moment expression and interaction compared to previous participants who had at times appeared more motivated by the musical product, and (c) represented an ethnic group and age bracket not represented by previous participants.

Six participants completed the study intervention. These participants were all female, ages 11-16. None of the six participants were in the custody of their biological parents at the time of the study. One participant was in the custody of another family member, and the remaining five participants were in the foster care system. In addition to the loss of support from their biological parents, most participants had also experienced other losses, including the death of family members. All participants had multiple psychiatric diagnoses. These included post-traumatic stress disorder, reactive attachment disorder, mood disorder, disruptive behavior disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, fetal alcohol spectrum disorder, mild intellectual disability, and various language impairments. One participant's diagnoses included psychotic disorder not otherwise specified, but her psychotic symptoms were well controlled at the time of the study. Some of the participants' strengths (as identified by me) included friendliness, outgoingness, sense of humor, attention to detail, knowledge of popular culture, and passion for creative expression. All participants had received multiple music therapy sessions prior to the study and had well-established therapeutic relationships with me. Data did not reach saturation after six participants, but no additional participants were recruited due to time constraints.

Procedure

Each of the participants engaged in an individual music therapy session with me. All sessions occurred at the residential treatment facility in treatment rooms near the participants' units. Participants were familiar with these rooms from previous treatment sessions. Session length varied slightly based on participant clinical need and attention span, but all sessions lasted between 40 and 60 minutes.

As suggested by the person-centered approach, the participants chose the focus of their sessions, including the types of music experiences and specific musical pieces or styles used. This means there was no standard set of procedures followed during data collection. Information on the procedures and music used in individual sessions is delineated in Table 1.

Therapeutic Relationship

An important element of the sessions not reflected in Table 1 was the therapeutic relationship. Because topics related to relationships recurred throughout the sessions (see "Themes" in Chapter Three, Results, below), it is important to have an understanding of the context in which these relationship-based themes occurred. Additionally, part of the therapeutic relationship was my musical countertransference. Dillard (2006) defined musical countertransference as "a musical reply in response to feelings, thoughts, images, and physical reactions evoked by the client" (p. 208). This countertransference was a bias and impacted my actions during the sessions and during data analysis. Transparency about my countertransference was an important validity measure (see "Verification" below).

Much of my work with Bernard involved helping her maintain a feeling of connection with her loved ones from whom she was separated, a goal she chose at the beginning of her treatment. Because she was working to maintain attachment with people who would be involved in her life long after my treatment with her was finished, I did not focus on creating a deep attachment between Bernard and myself. I instead worked to develop a basic therapeutic relationship that helped her feel safe enough to explore and express her feelings toward her loved ones. At times, I sensed that Bernard felt insecure in her musical expressions, and in response I often added supportive backing vocal lines as

Table 1
Content of Study Sessions

Participant[a]	Pre-Established Treatment Goal	Music Experiences
Bernard	Coping with separation from loved ones	Use of GarageBand software to record herself singing with recordings of pop songs that she verbally identified as being meaningful to her; expressed intention to give these recordings to a family member
Jayla	Safe self-expression	Improvisation with voice and open-tuned acoustic guitar as therapist played a second acoustic guitar Singing and rapping pop songs as therapist provided acoustic guitar accompaniment and vocal support
Maya	Increasing self-confidence	Vocal improvisation with therapist accompanying on keyboard Use of GarageBand to record herself singing hooks of familiar rap songs as therapist rapped verses and provided acoustic guitar accompaniment
Michelle	Safe self-expression	Use of musical loops in GarageBand to create an accompaniment for an original song written prior to session Recording spoken vocal line on top of accompaniment using GarageBand and vocoder
Princess	Safe self-expression	Singing and dancing to pre-composed gospel, r & b, and pop songs as therapist played acoustic guitar Improvisation with voice and electric guitar as therapist provided acoustic guitar accompaniment and sang
Veronica	Building healthy relationship skills	Singing a pre-composed pop rock song as therapist sang and provided acoustic guitar accompaniment; practiced the same song throughout session, emphasizing collaboration and mutual support through the joint singing

[a]Names are pseudonyms chosen by participants.

she created songs for her loved ones. Outside of this, my role with her was more verbal, and I was aware of little musical countertransference.

In contrast, my relationship with Jayla was almost entirely music-based. We talked minimally during her sessions, and when we did, it was almost always directly connected to the music we were about to create. Jayla was very connected with the music and appeared at ease with my presence as a co-creator within it. Jayla was an extremely talented, creative, and spontaneous individual, and I often felt my own creativity and spontaneity heightened when I was with her. My music during her sessions frequently reflected these feelings.

Maya and I had a positive, congenial rapport with each other, but I often felt like I was on a roller coaster during her sessions. Maya's mood shifted often, and her moods often manifested in extremes. Because of her labile mood, I frequently felt like I was walking on eggshells with Maya and gravitated toward musical elements that created a sense of grounding that would help us both feel more stable. Maya also had extremely low self-esteem and frequently verbalized that she did not feel capable of any task presented during sessions. I often felt like a cheerleader during her sessions and found myself musically taking stronger, more directive roles than I generally take due to her insecurities.

My relationship with Michelle was pleasant but distant. Michelle tended to be very focused on musical product and appeared to view me as a means to an end. As a result, she rarely gave space for me to be a co-creator in her music, and when I tried to join her, she often dismissed my attempts. I instead took more of a witnessing role, listening to and validating the messages she expressed through her music creation. Michelle did appear to respect me and was receptive to my feedback and ideas of how to enhance her music. The

most vibrant aspect of my relationship with Michelle was our shared connection with humor, which we often incorporated into our sessions.

Princess and I had a relationship that was warm and trusting. Playful banter was an important part of our relationship, but we had many serious moments together as well. She initiated using the music in our sessions to explore her feelings about the death of a family member, a topic she had demonstrated resistance to in other areas of her treatment. Princess was very connected with her spirituality, and I frequently had the sense of a divine presence during our sessions. As a result, my music during her sessions often had a grander feel.

Forming a reciprocal relationship with Veronica was difficult. She had difficulty accepting my ideas and input, and it sometimes felt as if she were creating a barrier to keep me out even though I could tell she deeply wanted to have a meaningful relationship. I had to work hard to maintain unconditional positive regard and to tolerate her need to control all musical elements during our co-creation. Eventually, she trusted me enough to intermittently reveal vulnerable pieces of herself. After she exposed these vulnerabilities, I found that my music with her often took on a more nurturing tone.

Data Collection

To capture the therapeutic relationships and musical interactions during the study sessions, I video recorded each session using the built-in video camera on a facility-owned MacBook Pro laptop. I frequently use this laptop during individual music therapy sessions and chose to use it as the recording device for the study, believing it would be minimally intrusive to the participants due to their previous exposure and familiarity with it.

Participants were able to use other programs on the laptop (such as GarageBand) during the video recording process.

Data Analysis

Data analysis was intertwined with participant selection and data collection. The initial first level analysis for the first two participants occurred before subsequent participants were identified. This alternating of participant selection, data collection, and data analysis repeated for every two subsequent participants.

Braun and Clarke's (2006) phases of thematic analysis served as the basis for analysis in the study. The steps included:

1. Familiarizing myself with the data

   I immersed myself in the spoken elements of the session by watching the session video and transcribing all the verbal components. I then immersed myself in the music from the session, listening to each piece on the video multiple times. Next, I completed a music description chart (see Appendix A) for each piece to ensure I had fully considered all its musical elements. After completing this chart, I made a list of the components of the music that seem most significant to the essence of the music and the in-the-moment musical experience. The list for each piece served as the basis for subsequent data analysis.

2. Generating initial codes

   I inductively categorized each individual piece of data to describe its essence. During this step I also begin comparing and contrasting codes associated with different participants and identifying new participants who might provide differing information for analysis.

3. Selecting and collecting data from new participants
4. Searching for themes
5. Reviewing themes

   I ensured that each theme is applicable to every piece of coded data associated with it.
6. Refining themes
7. Producing the final report

Verification

I utilized the following procedures as suggested in Creswell (2009) to promote reliability during the study:

1. Checking verbal transcripts to eliminate errors
2. Reviewing music data lists to ensure accuracy
3. Writing out definitions of each code and verifying that subsequent data coded does not change the meaning of the code
4. Cross-checking codes for the first two sessions by another board-certified music therapist familiar with adolescents in psychiatric treatment to obtain intercoder agreement

I utilized the following strategies as suggested in Creswell (2009) to promote validity during the study:

1. Revealing personal biases in both the research proposal and the final write-up of the study
2. Spending prolonged time in the field

3. Using an external auditor unaffiliated with the study to review the research upon completion of the data analysis. See Appendix B for the review checklist I developed for this study.

Ethical Considerations

To protect the participants, I ensured that the legal guardians of all participants understood and signed a parental permission form. Additionally, all participants signed informed assent forms written in language geared toward their developmental levels. I provided verbal clarification to participants to ensure they understand the purpose, risks, and potential benefits of participation. I also offered copies of the session recordings and study results to participants and their guardians. Several participants and guardians requested and were provided with a DVD of their session's recording. To further protect participants, I did not implement any aspects of the study until receiving approval from the Institutional Review Boards at both the residential treatment facility and the university supporting my research.

To protect confidentiality, the recordings of all study sessions were saved directly onto a secured, hospital network drive reserved specifically for the proposed study. Only the individuals providing verification measures and I have access to this password-protected drive and the files it contains. Electronic data will be saved for three years following completion of the study. After three years, electronic data will be destroyed. Participants' names were replaced by pseudonyms in data analysis and the final report, and any other personal identifiers were changed or removed during the transcription process.

Results

Themes

The music and verbalizations from the six sessions generated a large amount of data. Even after removing data and codes that appeared irrelevant to the research question, there were 243 codes remaining. After I grouped similar codes together to form preliminary themes, it became evident that I had more themes than were practical to include in a report. As I result, I decided to focus on what Braun and Clarke (2006) call *key themes*, the themes that appear most relevant to the research question and most significant in portraying the essence of what occurred during the sessions. Ultimately, I identified six key themes:

- loss and endings;
- negative relationship experiences and detachment;
- positive relationship experiences and attachment;
- emotional pain, distress, and self-doubt;
- seeking stability and comfort; and
- positive, confident, and resilient aspects of self.

A summary of the results is located in Table 2.

I developed these keys themes from the song lyrics that were sung in the sessions, my interpretation of non-verbal musical elements within the music experiences, and the therapeutic conversations that occurred between the music making. In the following excerpts from the sessions, the participant's name and type of data (song lyric, music analysis note, or therapeutic conversation) are in italics below each excerpt. If

Table 2
Summary of Results

Theme	Sample Excerpt	Type of Excerpt
Loss and endings	You're the one that I love And I'm saying goodbye (Axel, Vaccarino, & Campbell, 2011)	*Lyric from pre-composed song in Bernard's session*
	Vocal melody ends on the fourth, which gives an unsettled or unfinished feeing to the end of the song	*Music analysis note from Princess's session*
Negative relationship experiences and detachment	Trying to forgive you for abandoning me (Hissink, Jordan, Maraj, Rotem, & Rishad, 2010)	*Lyric from pre-composed song in Maya's session*
	Ee, there's some boys, um, tried to hurt the girl, severely…Starts with an *r*…I think you know what I'm talking about…Um, and that's what the part that she can't talk about.	*Statement from Michelle during therapeutic conversation*
Positive relationship experiences and attachment	You're a great friend And a great supporter And you helped me through everything I love the way you speak to me And I think about it everyday I walk through the streets	*Improvised song lyric by Jayla*
	A tenderness present in our version of the song that is not present in the original; appears reflective of the therapeutic relationship	*Music analysis note from Veronica's session*
Emotional pain, distress, and self-doubt	Cry my eyes out for days upon days Such a heavy burden placed upon me (Hissink et al., 2010)	*Lyric from pre-composed song in Maya's session*
	I feel like I suck at singing.	*Statement from Bernard during therapeutic conversation*
Seeking stability and comfort	I wanna be free from these chains A bird once small, be free of pain I'm calling out to you now Please hear me someway, somehow (Miner, 2010)	*Lyric from pre-composed song in Princess's session*
	Almost a lullaby-like feel to the song—plucked and resonant acoustic guitar, softer vocal tones, and V's rocking throughout	*Music analysis note from Veronica's session*
Positive, confident, and resilient aspects of self	Lots of moments of softness, tenderness, and soothing tones in Jayla's vocals	*Music analysis note from Jayla's session*
	You're beautiful in so many ways Don't let them bring you down Beautiful you	*Lyric from original song composed by Michelle*

the excerpt is a lyric from a pre-composed song, the original songwriter(s) are cited in parentheses.

Theme 1: Loss and Endings

The music the participants created often reflected issues and feelings associated with loss, endings, and separation. When given the option to create whatever music they found meaningful, several of the participants chose to sing breakup songs with lyrics related to the loss and ending of relationships:

> You're the one that I love
>
> And I'm saying goodbye (Axel et al., 2011)
>
> *Bernard- lyric from pre-composed song*

> I loved you with a fire red,
>
> Now it's turning blue (Tedder, 2006)
>
> *Veronica- lyric from pre-composed song*

Some participants explored loss through lyrics directly about grief and bereavement:

> Think I'll miss you forever
>
> Like the stars miss the sun in the morning sky (Del Ray & Nowels, 2012)
>
> *Bernard- lyric from pre-composed song*

Others expressed their losses indirectly. In the following extract from an improvised song, the participant sang about the time she used to spend with a loved one. The implication is that she now separated from that individual.

> I remember the times
>
> When we used to love

I remember the days

We were together

Jayla- improvised song lyric

Not only is the theme of loss and endings reflected verbally through the participants' lyrics, it is also reflected nonverbally through other musical elements. The endings of many of the pre-composed songs they chose to sing appeared notable to me for ending in non-traditional or unexpected ways. For example, several of the songs ended on unexpected pitches and chords:

Vocal melody ends on the fourth, which gives an unsettled or unfinished feeling to the end of the song

Music analysis note from Princess's session

Does not end on tonic; appears to reflect the contemplative, unsure nature of the lyrical content

Music analysis note from Maya's session

During several of the sessions, participants chose to continue playing or singing beyond what felt like the ending cadences:

Although Jayla verbalizes that she is done singing, she quickly chooses to extend the song and up the energy level

Music analysis note from Jayla's session

These extensions changed the natural endings of the music. During some of these extensions, participants explored the previous musical material in new ways. During other extensions, they repeated previous musical material with no changes.

Theme 2: Negative Relationship Experiences and Detachment

Like many adolescents in residential psychiatric treatment, these participants had experience with abuse, bullying, and other types of relational trauma. During their music therapy sessions, they appeared to be processing and trying to make sense of their previous negative relationship experiences. Their lyrics at times explored issues and feelings related to relational trauma, including exploitation and abandonment:

I'm holding on your rope

Got me ten feet off the ground

And I'm hearin' what you say

But I just can't make a sound

You tell me that you need me

Then you go and cut me down (Tedder, 2006)

Veronica- lyric from pre-composed song

Trying to forgive you for abandoning me (Hissink et al., 2010)

Maya- lyric from pre-composed song

I gave you my love to borrow

But you just gave it away (Levine et al., 2012)

Jayla- lyric from pre-composed song

Some of the participants' lyrics reflected a sense of trying to detach and separate from individuals with whom they had had negative relationship experiences:

I'm so over you

Go get lost (Cole, Camper, Wilson, & Banks, 2012)

Princess- lyric from pre-composed song

The music within the therapy sessions sometimes served as a springboard for participants' verbally exploring issues related to negative relationship experiences. One participant verbally described the music video that she envisioned accompanying the original song she recorded during the session. Although the lyrics of the song had been about bullying, she appeared to be processing a different relational trauma (sexual abuse) in her description of the video:

> Ee, there's some boys, um, tried to hurt the girl, severely…Starts with an *r*…I think you know what I'm talking about…Um, and that's what the part that she can't talk about.
>
> *Michelle- therapeutic conversation*

Theme 3: Positive Relationship Experiences and Attachment

In addition to processing their negative relationship experiences, the participants also created music about positive relationship experiences they have had. The lyrics from the following two improvisations describe the impact such positive relationships have had on the participants:

> You're a great friend
>
> And a great supporter
>
> And you helped me through everything
>
> I love the way you speak to me
>
> And I think about it everyday I walk through the streets
>
> *Jayla- improvised song lyric*

You make me smile

You mean the world to me

And I appreciate you

You love me and I know

But I will survive

You's make me survive

I will love you

You are the one

Love me

Because you really make me smile

Maya- improvised song lyric

The participants also explored and practiced various elements of positive relationships through their musical interactions with me. Improvisations and joint singing especially appeared to foster a sense of closeness and trust:

An intimacy present in the joint vocal "oo"s

Music analysis note from Jayla's session

A tenderness present in our version of the song that is not present in the original; appears reflective of the therapeutic relationship

Music analysis note from Veronica's session

Through their music, the participants maintained a sense of connection and attachment with significant people in their lives. One participant recorded herself singing

songs with the intention of sending the recordings to a family member. She used the music as a way to stay emotionally connected with the relative that she was physically separated from:

> Um, I mean, the next song, uh, "Say Something…" I want to sing that for [her family member]
>
> *Bernard- therapeutic conversation*

Another participant used the music to maintain a sense of connection with a deceased family member. She verbalized choosing one song specifically because it reminded her of this family member. Her connection with this relative appeared to extend beyond the notes and lyrics that she sang to become a visceral experience:

> Holding arms close to chest on "Hold me close" line give a feeling of closeness, holding on to [her family member], craving nearness to him
>
> *Music analysis note from Princess's session*

During an improvisation later in the same session, she appeared to be affirming her attachment to this family member. Although she did not verbalize that the improvisation was about her relative, I had the strong sense that it was, and the lyrics were congruent with previous statements she had made about this family member:

> *Princess:* You'll always be here with me
>
> 'Cause together we make one team
>
> Because I love you
>
> *Jenn:* And I keep you close to me
>
> 'Cause we're a team
>
> *Lyrics from joint improvisation between Princess and me*

The above lyrics appeared to describe not only Princess's relationship with her deceased loved one but also the therapeutic relationship. Although this was not a conscious decision that I made as we created the song, the lyrics reflected the intimacy and collaboration between us. Perhaps our therapeutic relationship served as positive relationship experience for Princess as she came to terms with the loss and change of other relationships in her life.

Theme 4: Emotional Pain, Distress, and Self-Doubt

The participants appeared to be experiencing significant amounts of emotional pain, distress, and self-doubt, as many of their musical selections reflected these difficult emotions. Their lyrics expressed feelings that were often quite intense:

Cry my eyes out for days upon days

Such a heavy burden placed upon me (Hissink et al., 2010)

Maya- lyric from pre-composed song

Truth is I'm weak

No strength to fly

No tears to cry

Even if I tried (Franklin, 2012)

Princess- lyric from pre-composed song

They did things you can't talk about

Michelle- lyric from original song

The participants' pain and distress surfaced in the other elements of their music besides their lyrics. The words *melancholy, somber, sadness, disappointed,* and *hurt* recur throughout my music analysis notes in reference to the overall feel of individual pieces of music. Although the tone of each piece was set and influenced by different factors throughout the sessions (including recordings of pre-composed songs that played during the sessions, a computerized accompaniment composed by a participant, improvisations initiated by participants, and live re-creations of pre-composed songs in which the therapist determined the tone based on lyrical content and participants' affects), the pain and distress was recurrent. The participants' vocal tones and the timbre of the instruments they played often reflected difficult emotions:

> Although P's vocals are softer in tone, her electric guitar playing is often heavier and off-rhythm—almost as if she is using the guitar to release nervous energy while she addresses the difficult topic of singing about [her deceased family member]
>
> *Music analysis note from Princess's session*

> Vocal delivery frequently has a slightly distant feel, almost as if she is not quite ready to connect with the content of the lyrics [about relational trauma]
>
> *Music analysis note from Michelle's session*

This distant vocal delivery sounded to me as if Michelle was not fully emotionally present in her music. This could have been a protective function because truly feeling and connecting with the pain associated with trauma could have been too difficult for her to handle.

One of the difficult emotions that surfaced in almost every session was self-doubt. Five of the six participants verbalized insecurities or doubts about their musical abilities at least once during their sessions:

I feel like I suck at singing.

Bernard- therapeutic conversation

I'll probably mess up though.

Jayla- therapeutic conversation

I think when people let me wanna listen to it they gonna say I have a horrible voice.

Maya- therapeutic conversation

I'm not good at this.

Princess- therapeutic conversation

Like I don't really feel confident anytime you let me sing by myself.

Veronica- therapeutic conversation

Not only did they express insecurities in regards to their musical abilities, but at times their lyrics also reflected feelings of inadequacy:

And I am feeling so small

It was over my head

I know nothing at all (Axel et al., 2011)

Bernard- lyric from pre-composed song

Additionally, their musical delivery also reflected their insecurities:

> V's voice often sharp…wavering at times, frequently not strong in tone
>
> *Music analysis note from Veronica's session*

Although it is possible that Veronica's vocal tone could have been from a lack of singing proficiency, I believe that it was more likely a reflection of her anxiety and insecurities. During her treatment history with me, her voice was more consistently on pitch and stronger when she was at ease.

Theme 5: Seeking Stability and Comfort

The participants appeared to actively seek relief from their pain and distress, as the theme of seeking stability and comfort recurred throughout their music. In their lyrics, they at times explicitly pleaded for someone to provide ease:

> I wanna be free from these chains
>
> A bird once small, be free of pain
>
> I'm calling out to you now
>
> Please hear me someway, somehow (Miner, 2010)
>
> *Princess- lyric from pre-composed song*

At other times, their lyrics stated their desire for comfort:

> I wish today it would rain all day
>
> Maybe that would kinda make the pain go away (Hissink et al., 2010)
>
> *Maya- lyric from pre-composed song*

Some of their lyrics expressed taking action to obtain their sources of comfort:

> Oh, no rules, no religion
>
> I've made my decision

To run to You,

The healer that I need

Take me to the King (Franklin, 2012)

Princess- lyric from pre-composed song

The elements of music that the participants created and chose during the sessions also reflect their search for comfort and stability. Four of the songs had a prominent triple feel. Triple meters are often used in lullabies and relaxation-based music to evoke feelings of swaying or a comforting rocking. One participant's song, although not in a triple meter, evoked similar feelings of comfort through other musical elements:

Almost a lullaby-like feel to the song—plucked and resonant acoustic guitar, softer vocal tones, and V's rocking throughout

Music analysis note from Veronica's session

Theme 6: Positive, Confident, and Resilient Aspects of Self

In spite of the significant amounts of pain and self-doubt that the participants seemed to be experiencing, they were still able to connect with positive aspects of themselves through music therapy. One participant utilized a bold, energetic vocal tone as she sang lyrics about enlivenment:

High heels off, I'm feeling alive

Oh, my God, I feel it in the air

Telephone wires above are sizzling like a snare

Honey I'm on fire, I feel it everywhere (Del Rey & Nowels, 2012)

Bernard- lyric from pre-composed song

Several participants connected with their inner child and their playful side through the music:

> Playful, whimsical carefree at the end with almost an explosion of excitement in the last "wooooo!"
>
> *Music analysis note from Maya's session*

> Some playfulness in the vocal delivery, especially through use of accent
>
> *Music analysis note from Bernard's session*

> *Jayla*: I'm done. I think the show is over. Oh my God. Is it? *(Guitar stops.)* Is it?
>
> *Jenn*: Is it?
>
> *Jayla (whispered):* I don't hear the crowd.
>
> *(Jayla starts roaring crowd sound effect, then Jenn quickly joins)*
>
> *Jayla (whispered into microphone)*: Come on. Encore! Encore! What?
>
> *Jenn:* Woo! Encore! Encore!
>
> *Jayla:* I hear an encore, ladies and gentlemen!
>
> *Jenn:* Woo!
>
> *Jayla:* And we go… *[Returns to singing chorus of song]*
>
> *Therapeutic conversation from Jayla's session*

Some participants connected with positive yet softer aspects of themselves, including their own warmth, gentleness, and beauty. These softer characteristics manifested in both the participants' music and their lyrics.

> Guitar loop adds a slightly warmer feel during the more hopeful lyrics of the chorus

Music analysis note from Michelle's session

Lots of moments of softness, tenderness, and soothing tones in Jayla's vocals *Music analysis note from Jayla's session*

You're beautiful in so many ways

Don't let them bring you down

Beautiful you

Michelle- lyric from original song

During their music therapy sessions, the participants had moments of overcoming their self-doubts about their musical abilities. Some of the participants were able to verbally recognize and even celebrate these moments of success and increased confidence:

It took us a while, but we finally got it.

Veronica- therapeutic conversation

I think I'm getting good with guitars.

Princess- therapeutic conversation

I don't give up once!

Maya- therapeutic conversation

Not only did the participants acknowledge their ability to overcome difficulties within the session, but their lyrics at times also reflected a grander sense of triumph, optimism, and resiliency:

I came to win,

To survive,

To conquer, to thrive

I came to win

To survive

To prosper, to rise

To fly (adapted from Hissink et al., 2010)

Maya- variation on lyric from pre-composed song

But still my soul

Refuses to die (Franklin, 2012)

Princess- lyric from pre-composed song

Jayla: Ain't about how fast I get there

'Cause I am Jayla Makayla Jackson

Oh

I can climb

Jenn: Walked down a lot of rocky roads

(Jayla laughs)

Jenn: But somehow

You just keep climbin'

Jayla: Oh yeah

Oh yeah

Oh yeah

Oh yeah

‘Cause I’m a leader

And I’m gonna make it to the top (improvisation based on Alexander & Mabe, 2009)

Lyric from pre-composed song that transformed into a joint improvisation between Jayla and me

Conclusions

Discussion

The purpose of this study was to identify themes that are present during music therapy sessions with adolescents in psychiatric treatment who have histories of loss. The participants were given freedom to explore whatever music and topics they found meaningful. They were not asked to concentrate on their losses, relationship experiences, connections with loved ones, pain, desire for comfort, or resiliency. These six key themes arose organically, providing support that these issues and emotions are important to them and prominent in their lives.

When the participants consented to the study, I informed them that one of the inclusion criteria was having a history of loss. As a result, it is possible that this information could have influenced their choice to explore issues related to loss and endings during their sessions. However, I had experienced multiple sessions with each participant prior to the study, and the content of every study session was representative of typical session content for each participant. It seems unlikely that the exploration of loss in their sessions was influenced by the consent form information alone.

Instead, it seems as if loss and endings are of genuine concern to these adolescents. As stated in previous literature on this population, adolescents in psychiatric care often have unresolved grief (Cates, 1986; Tomori, 2000; Wallis & Steele, 2001), and the participants' music seemed to reflect that phenomenon. I noted that the endings of many pieces seemed significant due to ending in unexpected ways. One interpretation of these song endings is that they may be musical reflections of the participants' experience with endings in other areas of their lives. Songs that ended on chords other than the tonic often

felt unresolved and lacking a sense of finality; this could be reflective of the participants' having unresolved grief and lacking closure. Several of the participants extended songs beyond what seemed like the natural ending cadences. This could reflect a fear of endings or their difficulty adequately weathering endings and transitions. It could also indicate that they are still trying to make sense of losses in their lives and are looking for extra space to explore issues related to endings.

The participants in this study had experienced not only significant losses in their lives, but they had also experienced relational trauma. Both of these occurrences are common in adolescents in psychiatric treatment (Cates, 1986; Wallis & Steele, 2001). Loss and negative relationship experiences are often inter-related for adolescents in psychiatric treatment. For example, some adolescents are placed into foster care and lose contact with their biological families due to allegations of abuse within the family system. Both loss and relational trauma can have a significant impact on the emotional wellbeing of individuals. Because many adolescents use music to make meaning from past experiences (DeNora, 2000 as cited in McFerran et al., 2010), it does not seem unusual that both loss and negative relationship experiences were themes in this study.

Perhaps it was the participants' experiences with loss and relational trauma that led to their exploring positive relationships and attachments during the sessions. The loss of people significant to them and the destruction of healthy relationships in their lives may have changed their perspective on the loved ones and healthy relationships they still have. From one perspective, these negative experiences could have helped participants better appreciate the people and relationships in their lives that have not been lost or damaged. From another perspective, their losses and trauma could have evoked a sense of fear about

potentially losing what they have left, causing them to cling to their remaining attachments. For participants whose losses and trauma left them with limited meaningful interpersonal connections, the therapeutic relationship may have served as a place for them to explore and experience the attachment that they were missing in other areas of their lives.

Regardless of the motivation behind the attachment, it seems important to these adolescents to maintain a sense of connection with significant individuals. Of particular interest to me was the participants' use of music to stay connected with individuals from whom they were separated. The participants created music for both living and deceased loved ones. One participant appeared to use the music to maintain a metaphysical bond with her deceased loved one; she appeared to be singing to and holding her loved one during her music. This is congruent with findings from the Van Epps et al. (1997) study. The adolescents in that study maintained connections with their deceased relatives, at times talking out loud to them and feeling their presence in dreams (Van Epps et al., 1997).

The music in the current study provided a safe place for participants to not only maintain connections with loved ones whom they missed but also to express emotional pain, distress, and self-doubt. These emotions are consistent with themes from previous literature on adolescents who had experienced loss. Van Epps et al. (1997) noted that the adolescents in their study frequently expressed anger, guilt, and hurt. Additionally, Frisch (1990) and Tervo (2001) noted that adolescents in psychiatric treatment often express painful emotions during their music therapy sessions.

Because loss and negative relationship experiences are often associated with difficult and painful emotions, it is reasonable that all three themes were identified together within the current study. It also makes sense that the theme of seeking stability

and comfort was identified in conjunction with the previous themes. When individuals have had life experiences that cause significant distress and pain, it is a natural human instinct to want relief.

This desire for relief could have been the reason the participants connected with positive, confident, and resilient aspects of themselves during their sessions. Their lyrics reflected finding meaning in difficult life experiences, which is congruent with Dalton and Krout's (2005) finding that adolescents can experience personal growth in the aftermath of loss. The participants in the current study frequently created music with a sense of hope and optimism for the future. This finding differed from previous literature; the adolescents in Van Epps et al. (1997) study expressed fear and despair about their futures. This difference in findings brings up an important question: Do the participants in the study not experience fear and despair when they think about the future, or does music therapy help them focus on the brighter elements of their futures? If these adolescents do experience despair about the future but are able to connect with hope and resiliency through music therapy, this could have important treatment implications. Additionally, did the strength-based approach I used during sessions have an impact on participants' connecting with hope and resiliency? If so, what specifically from the approach influenced this positive outcome?

The contrast between the painful emotions and the positive, resilient aspects of self reflects an oscillation that occurred musically within the sessions. Participants often alternated between creating music with heavy, painful feelings and music with lighter emotions, and oscillation was in fact one of the codes I used in data analysis. McFerran et al. (2010) noted that adolescents who have experienced loss tend to oscillate between

grieving and distraction from their loss, and this may account for the contrasting themes present in the current study: expressing emotional pain yet still connecting with positive, confident, and resilient aspects of themselves; processing negative relationship experiences yet reflecting on positive interpersonal attachments; creating music about loss and endings yet maintaining connections with individuals who are still in their lives.

While the themes present in the current study reflect general trends among the majority of the participants, one participant was a deviant case in several ways. This participant was the only participant who had no data connected to the loss and endings theme. She also did not verbalize insecurities related to musical abilities, a common trend among the other participants in the study. Of note, this participant was also the only participant who was in the custody of a family member. Schwartz (2010) found that adolescents in foster care who were in kinship placements expressed disruption in response to loss less frequently than adolescents in non-kinship placements. This participant's data support Schwartz's finding.

Clinical Implications

The findings of the current study have several implications for clinical practice with adolescents in psychiatric treatment who have histories of loss. The first is that clinicians need to recognize that loss may be an important therapeutic issue for these adolescents. The participants in the current study brought up topics related to loss in their music, providing support to the idea that their losses have a significant impact on them. Clinicians working with this population can proactively address grief and loss in their treatment sessions. A number of psychotherapeutic modalities exist to support grief and loss in the general adolescent population. (See "Loss Interventions" in Literature Review.) These

modalities and interventions can be adapted to meet the needs of adolescents in psychiatric treatment who are dealing with loss.

The results of the current study have implications for music therapists working with this population. In their sessions, the participants explored many issues that may be the focus of verbal psychotherapy sessions, such as loss and relational trauma. This indicates a need for music therapists to work in close collaboration with the social workers, counselors, or psychologists providing the verbal psychotherapy to these adolescents. As Frisch (1990) points out, adolescents in psychiatric treatment may need to explore difficult treatment issues through symbolic modalities like music therapy before they are comfortable talking about these issues directly. If music therapists work closely with clinicians providing verbal psychotherapy, this allows for better continuity and consistency of care. Conversely, this finding could support the idea that music therapists need to have strong verbal psychotherapy skills and be able to provide this treatment themselves when clinically appropriate.

The emotional pain that the participants expressed, paired with their actively seeking comfort and relief through music, suggests that music may be an appropriate therapeutic tool for self-soothing and self-regulation. However, given that adolescents in psychiatric treatment have historically turned to unhealthy coping and self-regulation strategies (Brooks, 1989; Mathai & Bourne, 2009), music therapists may need to provide these individuals with psychoeducation on healthy uses of music for self-soothing. This could include working with individuals to build self-awareness around their music listening habits. Music therapists may need to help these adolescents determine what

music brings them comfort, what music detrimentally intensifies difficult emotions, and how to appropriately assess their emotional responses to music.

Another clinical implication of the current study relates to the therapeutic relationship. Because the participants in this study explored and practiced positive relationships and attachment during their sessions, clinicians working with this population need to have an acute awareness of the therapeutic relationship during their sessions with this population. When adolescents have had limited experiences to form healthy attachments to adult figures (as is the case with many adolescents in psychiatric treatment who have experienced extensive relational trauma or frequent losses and changes in caregivers), the therapeutic relationship may be one of the first relationships in which they are able to experience trust, acceptance, and security. It is important that clinicians provide opportunities for these adolescents to experience and practice elements of positive, healthy relationships. If clinicians are coming from philosophical backgrounds that place less prominence on the therapeutic relationship, such as behavioral or cognitive behavioral approaches, they may need to adapt their approach to include a stronger emphasis on the therapeutic relationship.

Clinicians also need to recognize the self-doubt frequently expressed by the participants in this study. The adolescents' low self-confidence indicates that they may benefit from success-oriented experiences to build up their confidence and provide them with a sense of achievement. Clinicians working with this population should carefully consider the therapeutic interventions they introduce, ensuring that the challenge provided by the interventions does not overwhelm the adolescents' limited sense of confidence. This includes pacing sessions and treatment at a speed that promotes growth

in an attainable way. Clinicians may also need to provide extra support to promote success, as the adolescents' low self-esteem may indicate that they lack the internal resources to cope with difficulties or failure.

The findings in the current study also provide implications for the use of music therapy to promote resiliency. Many of the themes, such as loss and negative relationship experiences, suggest that the participants have had many difficult life experiences. However, these adolescents were still able to express hope and resiliency through their music. Although further research is needed to better understand this phenomenon, the presence of the resiliency theme provides preliminary support that music therapy may be effective for this population to connect with a sense of hope and feel confident in their ability to overcome difficult life circumstances. As a result, psychiatric treatment teams may want to consider music therapy referrals for adolescents with histories of loss who are dealing with suicidal ideation or a sense of hopelessness. Music therapists working with this population may wish to encourage the use of music that allows the adolescents to harness and explore their own innate resiliency.

Limitations

There were several sample limitations in the present study. The first is that the participants were all female. I did try to recruit males and had one male consent to the study. He was unable to complete the study session before an unanticipated discharge from the facility. The overrepresentation of females in the study is not a result of selection bias alone. Recruitment for the study occurred during a time frame where the research facility had a significantly higher number of females admitted for treatment.

The study sample had several other limitations. The six participants had limited cultural variances. While these participants are representative of the cultural variances in the geographical setting of the research facility, they are not representative of areas that have greater cultural diversity. All of the participants in the study had experienced the loss of their biological parents and were in alternative custody placements. There were no participants that had experienced loss while still living in the home of a biological parent. Additionally, all the participants in the study expressed themselves with verbal-heavy music experiences, such as singing and songwriting. There were no participants who expressed themselves primarily through non-verbal music experiences, such as instrument play without singing.

There were several limitations in the methodology. One limitation is that several participants mentioned the fact that they were being video recorded during their sessions. This awareness of the recording process may have changed the responses that they chose to give. Although I had explained to each participant multiple times before the sessions that we should behave as if the video camera was not there, some of the participants (especially the younger ones) appeared to be musically performing for the camera when it was first turned on. Two participants even asked for the video to be restarted when they felt like they had made mistakes in their music. Within the first few minutes of several sessions, I had to re-explain the purpose of the camera and remind them that we were trying to focus on having a normal music therapy session, not performing. Participants who had initially appeared focused on performing for the camera did appear to forget about the camera after several minutes and generally displayed behaviors that were congruent with those displayed in previous music therapy sessions.

Another limitation is the large timeframe for data collection. Although I had allotted nine weeks for data collection in the original study proposal, data collection actually took over a year due to difficulties recruiting participants. This timeframe coincided with a pivotal point in my development as a music therapist, influenced by my graduate level coursework. While my approach for all participants was influenced by person-centered, Gestalt, music-centered, and strength-based philosophies, I operated from a matured therapeutic approach for the latter participants. My shift to a more refined approach could have influenced my role during sessions and influenced these participants to give different responses than earlier participants.

Other methodological limitations relate to the scope of the study. Coding both the conversational and musical portions of the sessions made the scope quite broad. For a more focused study, I could have defined the clinical question more precisely. A question such as "What do adolescents in psychiatric treatment with histories of loss express through their music?" could have significantly narrowed the focus and scope of the study. The data in the present study never reached saturation, and I contribute that in part to the study's broad scope. If the clinical question had been more focused, this may have increased the likelihood of reaching data saturation.

Future Research

Given the limitations in the current study, replicating it with modifications would give a fuller, more reliable representation of the thoughts and feelings of the population. One modification is to use participants who represent a wider range of demographics, including males. Focusing the research question on the participants' music—as opposed to including verbal portions of sessions—would promote a more manageable data set.

Replications of this study could also continue until the point of data saturation. A final modification would be to make replications of the study more longitudinally based. The present study captured snapshots of single sessions. Although my clinical experience with the participants verified that the content of each session was typical, collecting data over the course of several sessions (or even their entire treatment) could promote a fuller understanding of the population.

While the current study provided preliminary data about adolescents in psychiatric treatment who have histories of loss, additional research is needed. Future studies could focus on identifying themes from music therapy sessions with adolescents in psychiatric care who do not have histories of loss. Comparing those results with those of the present study could help differentiate what themes are specific to individuals who have histories of loss and which themes are important to adolescents in psychiatric care as a whole. Phenomenological or narrative studies would also provide more insight into the impact loss has on this population. These studies could be music therapy studies in which participants are asked to create music specifically based on their experiences with loss. These studies could also be interview-based, asking the participants questions about the impact loss has had on them. Themes from the present study could serve as the basis for some of the interview questions.

Future studies could also focus on learning more about the topic of loss within adolescent psychiatric treatment. Results of the current study provide support that loss is an important topic to this population. However, the lack of literature on loss in adolescent psychiatric treatment settings makes me question whether or not loss is consistently addressed in therapy with this population. Cait (2012), Cates (1986), and McFerran (2010),

all suggest that healthcare professionals often overlook or avoid the topic of loss with adolescents in psychiatric care. Survey research on loss-related treatment services offered in adolescent psychiatric facilities would clarify whether or not loss is being addressed. It is possible that treatment facilities are providing loss-related interventions but are not publishing about them.

One important question left by the results of the study relates to the relationship between music therapy and resiliency in this population. One of the keys themes in the study was that the participants were able to connect with positive emotions, confidence, and resiliency during music therapy in spite of the many difficult and painful emotions they expressed. Future research that better clarifies the exact relationship between music therapy and resiliency in this population is needed. Studies that identify how to proactively promote resiliency during music therapy sessions with this population could be especially beneficial.

Personal Reflection

I approached this study excited and with an open mind about what I could potentially find, but in the end, none of the results seemed groundbreaking to me. All of the sessions in the study were typical sessions for the participants; I was accustomed to the topics and themes they addressed. In the end, what made the research meaningful to me was not discovering something new but having a systematic way to document what I see in this population everyday. It was empowering and validating to capture the topics that are important to these adolescents and share them with the academic community.

It was challenging at times to separate my clinical thought process from my research thought process. When listening to excerpts and reading transcripts, my

inclination was to interpret data through a clinical lens. To get myself more consistently viewing the data through a researcher lens, one of my research mentors encouraged me to ask the question "What surprises me about this?" I came back to this question a lot over the course of data analysis. I was glad to have the verification measures in place, especially the check for intercoder reliability and the overarching data check by the external auditor. Both individuals asked questions and pointed out alternative interpretations that helped me look at the data more from a more research-oriented perspective. I am a novice researcher, and I am still working to distinguish my research thought process from my clinical thought process. This is an area in which I hope to continue growing in future studies.

Performing the detailed data analysis during this study gave me a greater appreciation for all the intricacies of a music therapy session. I did not give full attention to many of the details during the in-the-moment music making and conversations. However, during data analysis, I was able to listen to improvised pieces from the session on repeat, break down and identify specific musical elements for all musical pieces, and pause session video to study participants' momentary affect changes. Doing so helped me see the interplay between so many small pieces and how they came together to affect the whole therapeutic process. It made me take greater pride in the work that I do when I realized how truly complex this process was and how smooth it often looked on video.

Carrying out this study gave me a greater understanding of the qualitative research process. I was especially surprised to learn how much of oneself goes into qualitative research. Over the course of the study, I came to understand that my personal interpretations and reflections were not only appropriate in this type of research but also

necessary to create a transparent, reliable study. Tangentially related to understanding my role in the research process was further understanding my role in the therapeutic process. Analyzing the session content and writing about the therapeutic relationship in the final report helped me to take more ownership of my personal role as a conduit of support and change.

Throughout the study, I was especially grateful for the session videos. They gave me a greater appreciation for the struggles and difficult emotions that the participants encountered. Because I watched these videos multiple times and immersed myself in the music and verbal transcripts, I essentially re-experienced each of their difficulties multiple times. At times it was uncomfortable to once again be in the moment of pain or anxiety, but in the end, I came away with greater insight of what it might feel to experience these emotions as frequently as these adolescents do, as well as a greater sense of empathy. However, the videos helped me to re-experience not only the participants' struggles but also their successes. I was grateful for the opportunity to relive the key therapeutic moments, to savor the aesthetic beauty of improvisations that would have otherwise only lived in the moment, and to re-experience the hope and exhilaration of their music.

Closing Remarks

The purpose of this study was to learn more about adolescents in psychiatric treatment who also have histories of loss. The study specifically focused on what these adolescents choose to express during music therapy sessions. Themes present in their sessions included: loss and endings; negative relationship experiences and detachment; positive relationship experiences and attachment; emotional pain, distress, and self-doubt; seeking stability and comfort; and positive, confident, and resilient aspects of self. This

exploratory study provided preliminary evidence about the strengths, needs, emotions, and values of this population. It is a starting point for future studies on this under-researched population.

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Appendix A:

Music Description Chart

Descriptor	Piece 1
Title, Original Artist/Composer	
Style	
Form	
Texture	
Meter	
Rhythm & Articulation	
Tempo	
Tonal Features	
Melody	
Harmony	
Timbre	
Dynamics	
Mood	
Other	

Note. Adapted from "Structural Model for Music Analysis" (Grocke, 1999)

Appendix B:

Thematic Analysis Review Checklist

Thematic Analysis Review Checklist	
Verbal transcriptions are accurate.	☐
Music analysis reflects significant aspects of the music and music experience.	☐
All data was given equal attention in the coding process.	☐
Themes contain internal homogeneity. *(Codes within each theme cohere in a meaningful way.)*	☐
Themes contain external heterogeneity. *(Differences between each theme are clear.)*	☐
Units of data that contain codes related to key themes accurately support those themes.	☐
Themes reflect an actual analysis (interpretation) of the data, not just a summary or paraphrase.	☐
Themes reflect the entire data set. *(Themes reflect patterns among participants; individual themes are not an analysis of a single participant's data.)*	☐
Codes not utilized in the key themes appear less significant to the research question than the codes grouped into the key themes.	☐
Results have substantive significance. *(Themes are meaningful, useful, and add value to the literature on the topic).*	☐

Note. Adapted from Braun & Clarke, 2006 and Patton, 2003