The Psychodynamics of Music-centered Group Music Therapy with People on the Autistic Spectrum

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ABSTRACT

The aim of this qualitative study was to conduct a naturalistic examination of the process of a music therapy group with preverbal individuals on the autistic spectrum. The study involved a music therapy treatment process, based on music-centered music therapy and music psychotherapy, that occurred in 16 sessions over a period of approximately four months. The study investigated the nature of the clinical process, the elements that characterized the intrapersonal and interpersonal dynamics of the group, and the way participants engaged with and utilized the music in their intrapersonal and interpersonal dimensions.

The research design was one originally developed by Smeijsters and Storm (1996) in which the researcher functions in an ongoing consultative role to the therapists as the therapy process proceeds. The study investigated and discussed the advantages and disadvantages of Smeijsters and Storm's (1996) model. The analyses of the 16 sessions revealed that all the studied clients were able to operate, in terms of intra-relationship, according to Greenspan and Wieder's (2006) first developmental stage: they demonstrated interest, curiosity, and initiative. In terms of inter-relationship, they were able to operate according to Greenspan and Wieder's (2006) developmental second stage: they engaged and established relationship with others. It was concluded that music had a relevant role in the process of assessing, treating, and evaluating the individuals in the group.

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I made the choice to come to Temple with my pregnant wife to improve my journey as a music therapist. I knew I was starting an unique journey in my life but I did not know what to expect. Even now, after getting to this point in the process, I still think I am not totally aware of what happened and will happen to me. However, it is already clear that I became a totally different professional, and a totally different person. More importantly, it is palpable that I became a more mature human being. Thank you very much, Temple!

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Little Dado, my love, you became my biggest inspiration and motivation in life, man. As we say to each other every morning before I leave to work: “Te amo mais que tudo” (I love you more than everything).

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CHAPTER ONE

INTRODUCTION

Overview

This dissertation study is a qualitative, naturalistic examination of the process of a music therapy group consisting of people diagnosed with autism spectrum disorder (ASD). The study involved a music therapy treatment process that occurred in 16 sessions over a period of approximately four months. Data consisted of session recordings, researcher notes, and interviews with the therapists. The research design was one originally developed by Smeijsters and Storm (1996) in which the researcher functions in an ongoing consultative role to the therapists as the therapy process proceeds. This study was conceived and designed in accordance with the researcher's philosophy as a music therapist who has worked with people with ASD for 24 years: each human being with ASD should be treated as a whole person and not as a syndrome.

This chapter will provide an overview of ASD and briefly review the literature on music therapy for ASD and a rationale for the research topic and design will be discussed.

Autism Spectrum Disorder (ASD)

The word *autism* comes from the Greek word *autos* meaning *self*. The term was created in 1911 by the Swiss psychiatrist Eugene Bleuer (1950). The history of autism began with Leo Kanner's (1943) article called "The Nervous Child." Kanner studied 11 children, eight boys and three girls, from two to four years old. He saw common characteristics in all of them and concluded that these characteristics comprised a unique, rare syndrome that had not been previously reported.

ASD is diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association (APA), 2013). Its cause is still unknown but it is understood as a brain development disorder that manifests before three years of age and it is diagnosed four times more often in males than in females. Greenspan and Wieder (2006) state that many facts interact to cause the disorder. One of the early signs of core deficits of ASD is the lack of sustained attention to different sights or sounds (Greenspan & Wieder, 2006).

The frequencies for the disorder across U.S. and other countries have approached 1% of the population (APA, 2013). This data is controversial, though. It may reflect an expansion of the diagnostic criteria of the DSM-5 to include subthreshold cases, increased awareness, differences in study methodology, or a true increase in the frequency of autism spectrum disorder (APA, 2013). Some investigators attribute the higher rate to better investigation and diagnosis; however, many believe there has been an increase in autism and ASD (Greenspan & Wieder, 2006).

Characteristics of the disorder include persistent impairment in reciprocal social communication and social interaction, and restricted, repetitive patterns of behavior, interests, or activities. These symptoms are present from early childhood and limit or impair everyday functioning (APA, 2013). The DSM-5 requires that individuals with a diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified, should be given the diagnosis of autism spectrum disorder (APA, 2013).

It is important to differentiate ASD from other developmental disorders. A significant proportion of young girls with Rett syndrome, for example, have a presentation that meets diagnostic criteria for ASD (APA, 2013). The difference is that most individuals with Rett syndrome improve their social communication skills, and

autistic features are no longer a major area of concern. Another developmental disorder with similar characteristics to ASD is selective mutism. However, even in settings where the child is mute, social reciprocity is not impaired, and there are no restricted or repetitive patterns of behavior present (APA, 2013). In language disorders and social communication disorder the language symptom is not associated with subnormal nonverbal communication, nor with the presence of restricted, repetitive patterns of behavior, interests, or activities (APA, 2013). Some specific behaviors such as bodily spinning, lining up toys, or repeating words without apparent meaning or purpose arise from fundamental problems in relating, communicating, and thinking, but are not specific to autism (Greenspan & Wieder, 2006).

A diagnosis of ASD in an individual with intellectual disability is appropriate when social communication and interaction are significantly impaired relative to the developmental level of the individual's non-verbal skills (APA, 2013). A diagnosis of attention-deficit/hyperactivity disorder (ADHD) is given in individuals with ASD when attention difficulties or hyperactivity exceed what is typically seen in individuals of comparable age. Schizophrenia differs from ASD because its symptoms, such as hallucinations and delusions, are not features of ASD (APA, 2013). Finally, motor stereotypes are among the diagnostic characteristics of ASD, so an additional diagnosis of stereotypic movement disorder is not given when such repetitive behaviors are better explained by the presence of ASD (APA, 2013). One of the main reasons for the many misdiagnoses of ASD is that not enough time is spent watching the child interact with a parent of other caregiver (Greenspan & Wieder, 2006).

Discussion of ASD is prevalent in the Brazilian media. Furthermore, Brazilian president Dilma Rousseff recently approved a new law that guarantees the right for specialized treatment and obligates the state and private institutions to offer individuals

diagnosed with ASD access to education and employment (Lei Berenice Piana, 2012). Also, based on the new law, schools and health insurance companies cannot reject individuals diagnosed with ASD. Consequently, in the past few years, the scenario in Brazil has drastically changed so that parents of children with ASD are more willing to engage in treatment options.

Theory and research have demonstrated that individuals with ASD, through treatment, have the potential to learn how to enjoy and engage in relationships and meaningful communication (Greenspan & Wieder, 2006). However, more educational and therapeutic programs for individuals with this disorder are needed. One of the goals of this study was to examine and discuss how music therapy may be a beneficial treatment to individuals with ASD.

Music Therapy in the Treatment of People with ASD

Music therapy has been used as a treatment method with people with ASD since the 1960s, and several articles and studies have been published on its use (see Appendix A). Countries all over the world have been involved in clinical and research work on music being used to treat people with ASD. Articles and books on clinical cases and research have been published in the United States, Canada, Brazil, Argentina, Italy, and Korea.

The frequency of peer-reviewed publications on music therapy, for individuals with ASD has increased over the last 20 years. For example, the *Journal of Music Therapy* published only seven articles about the topic from 1964 until 1990. That is an average of only one article about the application of music with ASD published almost every four years. From 1991 until 2012, however, this average increased to one article published every two years.

In a recent survey that the present author conducted with Brazilian clinicians (Brandalise, 2012a), it was found that music therapy for autism is being widely practiced in Brazil (Figure 1). Participating therapists worked with individuals with ASD more than with any other group of people (*n*=16; 23,8%).

Figure 1. Populations Being Treated by Brazilian Music Therapy Clinicians

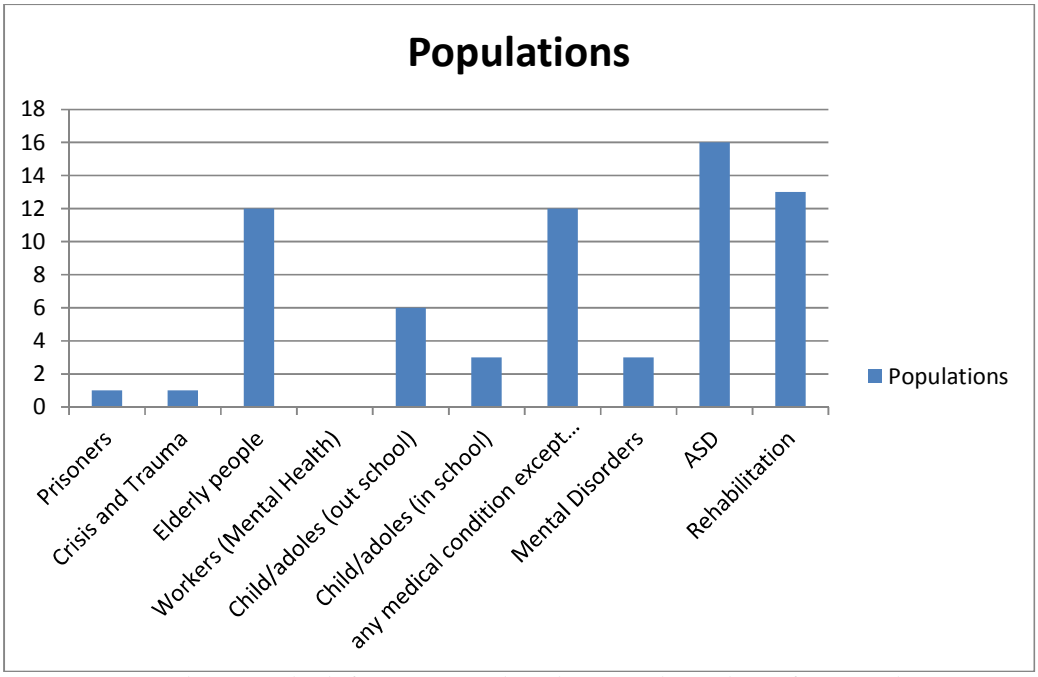

Figure 1. *Numbers on the left correspond to the actual number of respondents.*

The results of this survey demonstrate that music therapists most commonly work with people with ASD in Brazil. Yet, even though the country has a specialized journal in music therapy, publications on the topic are rare and more research is warranted.

The use of music with the person with ASD can promote the improvement of interpersonal relationships (Aigen, 1997; Carpente, 2009; Finnigan & Starr, 2010; Goldstein, 1964; Kern & Aldridge, 2006; Nordoff & Robbins, 1977; Stevens & Clark, 1969; Turry & Marcus, 2003), achievement of expressive freedom (Nordoff & Robbins, 1971), achievement of vocal improvement (Nordoff & Robbins, 1971), improvement in

communication (Carpente, 2009; Edgerton, 1994; Nordoff& Robbins, 1971; Saperston, 1973), achievement of vocal and verbal confidence (Nordoff & Robbins, 1977), mutuality (Aigen, 1998; Carpente, 2009; Turry & Marcus, 2003), musical experience (Aigen, 1998; Carpente, 2009; Turry & Marcus, 2003), musical skills (Abbamonte & Politi, 2007; Aigen, 1998; Boso, Emanuele, Minazzi, Abbamont & Politi, 2007), development of the self (Aigen, 1998; Turry & Marcus, 2003), achievement of higher forms of rhythmic order (Nordoff & Robbins, 1977), improvement in speech production (Hollander & Juhrs, 1974; Lim, 2010), decrease of tantrums (Goldstein, 1964) and improved participation in treatment (Goldstein, 1964).

The Therapeutic Use of Songs and Improvisation with People with ASD

Among the pioneer music therapists who have worked with people with ASD, improvisation has been the main clinical intervention of choice (Alvin & Warwick, 1978; Nordoff & Robbins, 1971, 1977; Saperston, 1973). It remains a common technique in the clinical work with this population (see Appendix A).

Another trend is the clinical use of song in treatment with this population (Aigen, 1995, 1998; Boso et al., 2007; Buday, 1995; Brandalise, 1998; Edgerton, 1994; Finnigan & Starr, 2010; Gattino, Riesgo, Longo, Leite, & Faccini, 2011; Goldstein, 1964; Kim et al., 2008; Lim, 2010a; Nordoff & Robbins, 1971, 1977; Mahlberg, 1973; Steven & Clark, 1969); the use of a variety of musical instruments (Aigen, 1995, 1998; Boso et al., 2007; Buday, 1995; Brandalise, 1998; Brownell, 2002; Edgerton, 1994; Finnigan & Starr, 2010; Gattino et al., 2011; Goldstein 1964; Hollander & Juhrs, 1974; Kim et al., 2008; Mahlberg, 1973; Nordoff & Robbins, 1971, 1977; Saperston, 1973; Steven & Clark, 1969, Turry & Marcus, 2003); the use of clapping (Mahlberg, 1973); the use of message tapes (Benenzon, 1987); the use of dance and body movement (Goldstein, 1964); the use of outdoor music (Kern & Aldridge, 2006); the use of the

Tomatis method (Corbett, Schikman & Ferrer, 2008); and the use of music videos (Lim, 2010b).

Psychotherapy in the Treatment of People with ASD

People with ASD can be supported and treated through a variety of systems of therapy. For the purpose of this research, the use of psychotherapy in the treatment of people with this diagnosis will be discussed. Corsini and Wedding (1995) propose that psychotherapy is

> a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that may be two or more people in each party, for the purpose of amelioration of distress in one of the two parties relative to any or all of the following areas of disability or malfunction: cognitive functions (disorders of thinking), affective functions (suffering or emotional discomforts), or behavioral functions (inadequacy of behavior), with the therapist having some theory of personality's origins, development, maintenance and change along with some method of treatment logically related to the theory and professional and legal approval to act as a therapist. (p. 1)

Theories and procedures vary significantly among psychotherapists. Corsini and Wedding (1995) describe a variety of different ways that psychotherapy can be understood and applied in order to treat psychological disorders. These methods include psychoanalytical, Adlerian, analytical, person-centered, cognitive and behavioral, existential, family, multimodal, and other psychotherapies.

Recent research on psychotherapy for people with ASD has focused on different objectives. These include increasing communication (Koegel, 2000), social interactions and social relationships among young children (McConnel, 2002), parent education

(Steiner, Koegel, Koegel, & Ence, 2011), validation of measures (Bolte, Westerwald, Holtmann, Freitag, & Poustka, 2011), evaluation of a theatrical intervention program (Corbett et al., 2011), development of speech (Sullivan, Sharda, Greenson, Dawson, & Singh, 2013), training of social skills (Freitag, et al., 2013; Solomon, Goodlin-Jones, & Anders, 2004), and evaluation of risks for bullying (Hebron & Humphrey, 2013; Zablotsky, Bradshaw, Anderson, & Law, 2013).

There is a tendency to focus research on cognitive-behavioral therapy (CBT) in the work with this population as a method to ameliorate destructive behavioral patterns, social communication deficits, and to treat anxiety, among other therapeutic goals (Chalfant, Rapee & Carroll, 2006; Freitag et al., 2013; Lerner, White, & McPartland, 2012; Storch et al., 2013). One of the main goals of CBT is to train individuals with life skills (e.g., social skills, playing skills). The emphasis on research using CBT may be because CBT methods are easier to standardize, replicate, and measure than treatments with a psychodynamic approach.

In contrast to CBT, models of dynamic psychotherapy recognize the primacy of relatedness and attachment and propose that the mind is built out of interactional configurations of the self in relation to others (Yalom & Leszcz, 2005). Muratori and Maestro (2007) have written about early intervention approaches with children with ASD. They concluded that the differences in behavior, emotion, and brain functions of a child with ASD are effects of impairments in primary or secondary inter-subjectivity. According to the authors, the lack of inter-subjective behaviors is the defining way to distinguish children with autism from those with typical development during the first year of life. They propose that more contingent behaviors happen when the caregiver approach is high in intensity and rich in non-verbal behaviors.

Muratori (personal communication, August 29th, 2013) confirmed that research on psychodynamic psychotherapy with people with ASD continues to be needed. Among the approaches to ASD involving a model based on disturbances of connections and expanding emotional interactions, Muratori and Maestro (2007) discussed the Developmental, Individual differences, Relationship (DIR; also called 'Floortime') approach (Greenspan & Tippy, 2011). The model is a well known developmental and relational based model developed by Stanley Greenspan (2006), who believed that a person with autism is unable to connect emotions or intent to motor planning and sequencing, therefore creating a lack of connection between emotion and action that leads to symptoms. Greenspan proposed a treatment that underlies the importance of identifying individual differences in the modality of sensory and motor information processing and the kind of interactions that the child establishes with others. The core of the treatment is the strengthening of vivid interactive modalities appropriate for the child's specific difficulties in information processing and the establishment of more two-way circuits of communication. According to Greenspan and Tippy (2011), the DIR model is effective because it has the ability to move kids from dependence on their memories into the rich world of abstraction.

In the music therapy literature, there are several examples of the use of psychotherapeutic approaches in the work with people with ASD (Aigen, 1997, 1998, 2002; Barcellos, 2004; Brandalise, 1998; Carpente, 2009; Craveiro, 2001; Gattino et al., 2011; Nordoff & Robbins, 1971, 1977). Carpente (2009) has conducted research on music therapy and DIR in the treatment of people with ASD integrating DIR into his philosophical, clinical and theoretical work.

The varying differences in treatment options for people with ASD raise a question: what is the most efficient way to intervene in the treatment with people with

this diagnosis? Timulak (2005) discussed the phenomenon of a client's and therapist's characteristics affecting the psychotherapeutic process. Timulak (2005) refers to Arnkoff, Glass and Shapiro (2002) who found that the relationship between the client's expectations regarding the effectiveness of the therapy he/she is about to undergo and the actual outcome has some predictive power. According to Yalom and Leszcz (2005), the history of psychotherapy abounds in healers who were effective, but not for the reasons they supposed. The authors added that clients may improve for entirely obscure reasons.

Timulak (2005) stated that no single study can resolve the question of whether therapy for a specific diagnosis works in all circumstances. Rogers and Vismara (2008), in their study about early intervention with people with ASD, stated that it is not possible to be certain about what kinds of interventions are the most efficacious in early autism. Therefore, there is a need for research on different psychotherapeutic approaches to treat ASD, including music psychotherapy, in order to provide comprehensive treatment options for this population.

Research Questions and Design

There were two primary questions explored within this study, each with two sub-questions:

1) What is the nature of the clinical process of a music psychotherapy group utilizing a music-centered approach with clients with ASD?

Sub-Question 1: What elements characterize the intrapersonal and interpersonal dynamics of the group?

Sub-Question 2: How do the clients engage with and utilize the music in the intrapersonal and interpersonal dimensions?

2) How effective is Smeijsters and Storm's (1996) research design in studying a music psychotherapy group with clients with ASD?

Sub-question 1: How useful is the design in understanding the process of therapy?

Sub-question 2: How useful is the design as a research method? What challenges and advantages emerged?

The qualitative design of this study allowed flexibility in terms of adding and/or reformulating these questions along the course of the research process in response to emerging findings. Although the guiding questions remained the same, new questions also emerged. For example: What were the relationship dynamics of the therapists? Furthermore, how did their dynamic influence the group dynamic?

In addition, at a certain point in the process, the clinical team and the consultant believed that it was important to integrate children with their parents in some of the sessions. This clinical intervention was motivated by the significant increase of aggressive behavior demonstrated by two group members, putting themselves, group peers, and therapists at physical risk. Therefore, some other questions emerged: How do the research participants react and interact in group music therapy with their parents? How do children and parents play together? What happens in clients whose behaviors were aggressive towards their parents?

In order for these general questions to be researched, naturalistic inquiry was applied, combined with the pioneering research design proposed by Smeijsters and Storm (1996). Naturalistic inquiry is based upon the belief that realities are multiple and that there is no possibility for time-and context-free generalizations. According to Lincoln and Guba (1985), through naturalistic inquiry, some level of understanding can be achieved but the researcher should not expect to achieve control and prediction. The goal of this research was not to establish general laws but to investigate each

individual's story as it developed within the group processes. These values are congruent with the values underlying the researcher's clinical belief and practice. In this way, there was an important consistency between the phenomena being studied and research design.

Smeijsters and Storm (1996) offered the basis for the research design utilized in this study. This pioneering design was developed in 1989, and it includes elements of action research. Applying an action research approach meant that the research process was intended to positively influence the outcome of treatment by means of the researcher's analysis and discussion with the therapy team. This model allows the researcher to be involved in the clinical process in a deliberate way and it thus contrasts with other research approaches in which the researcher is not supposed to influence the findings. Moreover, it allows for some distance because the researcher-consultant is not in the dual role of therapist and researcher. As a third team member, the researcher along with the two therapists adds perspectives, analysis, and ideas for the therapy.

Chapter Two will present and discuss the main theoretical background of the clinical work.

CHAPTER TWO

THEORETICAL FOUNDATIONS

This chapter describes the various theoretical components of the treatment method that was applied in the research. The method included group, psychotherapeutic, and music-centered therapy foundations that will be further described in detail. In addition, as it was previously stated, this study employed a naturalistic research design, which will also be discussed.

Psychotherapy in Group Work

This study employed a psychotherapeutic approach to group work, requiring a thorough discussion on psychotherapeutic group dynamics. Contemporary theories of group dynamics are comprised by four principal authors: Yalom, Lesczcz, Kottler, and Englar-Carlson. According to Yalom and Leszcz (2005), group therapy is a highly effective form of psychotherapy that is equal to individual therapy in its power to provide meaningful benefits. Mechanisms of change in group therapy involve interpersonal relationships, corrective emotional experiences, and how the group functions as a microcosm of the clients' lives.

Therapeutic Factors in Groups

Why individuals change due to group therapy is hypothesized to be due to eleven therapeutic factors in groups: 1) Instillation of hope; 2) Universality; 3) Imparting information; 4) Altruism; 5) The corrective recapitulation of the primary family group; 6) Development of socializing techniques; 7) Imitative behavior; 8) Interpersonal learning; 9) Group cohesiveness; 10) Catharsis, and 11) Existential factors (Yalom & Leszcz, 2005). These factors, and those of the other seminal group theorists, are described in more detail below.

Instillation of Hope. Proposed by Yalom and Leszcz (2005), the installation of hope is crucial in any psychotherapy. Hope not only keeps the client in therapy but also propels faith that the treatment mode can be therapeutically effective. According to Kottler and Englar-Carlson (2010), installation of hope is also relevant as part of what they call *support.* Hope generates possibilities for recovery, allowing members to believe that being in the group will enhance one's sense of well-being.

Sense of Belonging. According to Kottler and Englar-Carlson (2010), groups create a sense of cohesion and trust that makes it easier to feel safe and less isolated. The sense of cohesiveness that can be experienced in a group is often described as feeling an attraction to the group with a notion of identifying with the group or with the group members. This factor may be related to Yalom and Leszcz's (2005) sense of universality, where members recognize that they have peers experiencing similar phenomena.

Vicarious Learning of Modeling. Group members learn not just from direct experience but also from observation. According to Lanza (as cited in Kottler & Englar-Carlson, 2010), the leader models effective behavior, and in groups that are co-led, the leaders demonstrate effective ways to communicate and resolve conflicts with each other. Yalom and Leszcz (2005) theorized that members not only gain through receiving help, but also in giving it, as part of the reciprocal giving-receiving sequence. The authors call this factor *altruism*.

Family Reenactment. Kottler and Englar-Carlson (2010) cited that groups provide an interpersonal context that is reminiscent of a family, complete with parental figures, sibling rivalries, and struggles for power and control. This environment makes it possible for participants to work through family issues. Yalom and Leszcz (2005) call this factor the corrective recapitulation of the primary family group. They believe that

the great majority of group clients have a background of an unsatisfactory experience in their families and that therapy groups resemble family in many aspects: there are authority/parental figures, peer/siblings figures, strong emotions, and deep intimacy as well as hostile, competitive feelings.

Awareness. Group experiences help participants become more aware of their behavior and the impact it has on others. By observing others, members can become more motivated to grow and learn. In this sense Yalom and Leszcz's (2005) development of socializing techniques has to do with social learning and development of basic skills. According to the authors, this factor operates in all therapy groups, although the nature of the skills taught and the explicitness of the process vary greatly, depending on the type of group therapy. This factor is not dicussed by Kottler and Englar-Carlson.

Interpersonal Learning. This is a factor that Yalom and Leszcz (2005) considered especially relevant as a mediator of change. They discussed three concepts within interpersonal learning: a) the importance of interpersonal relationships, b) the corrective emotional experience, and, c) the group as social microcosm. The importance of interpersonal relationships and the group as a social microcosm are especially relevant to this dissertation research. Interpersonal learning considers the human being's need to belong, which is a powerful, fundamental, and pervasive motivation. Without interpersonal bonds and attachment, human beings would not survive. This concept establishes the principle of dynamic psychotherapy for which relatedness and attachment are fundamental. Poor communication of children's needs and of parental expectations generates feelings of personal helplessness and ineffectiveness in both children and parents.

The group as social microcosm discusses the idea that freely interactive groups with few structural restrictions can develop into social microcosms of the participants' lives. The more spontaneous interaction presents, the more rapid and authentic the development of the social microcosm. Clients display their maladaptive interpersonal behaviors in the therapy group and therapists observe them, their triggering events, and the responses of the members.

Finally, Yalom and Leszcz (2005) add transference as a concept in the theme of interpersonal learning. Transference is a specific form of interpersonal perceptual distortion. In both, individual and group therapy, the recognition and working through this distortion is important. Yalom and Leszcz (2005) consider that the range and variety of distortions to be greater in groups than in individual therapy. For the majority of clients, therapists become the personification of their images of parents, teachers, other authority figures, and established traditions and values.

Cohesion. This factor points to the understanding that the process of a group is not just the sum of its parts but instead it has properties of its own. It supports the idea that what forms a therapeutic factor of a group is not individual members but the connection among them. According to Joyce, Piper, and Ogrodniczuk (as cited in Kotller & Englar-Carlson, 2010), cohesion speaks to all of the relationships in a group, and it tends to be one of the most predictive variables in terms of good outcome. For Yalom and Leszcz (2005), group cohesiveness is one of the most important factors in group dynamics and is analogous to the therapeutic relationship in individual therapy. In all individual psychotherapy, a good therapist-client relationship involving trust, warmth, empathy, understanding, and acceptance is essential for a positive outcome.

Yalom and Leszcz (2005) defined cohesiveness as the attractiveness of a group for its members and consider it necessary for other group therapeutic factors to operate.

Group members are differentially attracted to the group and cohesiveness fluctuates during the course of the therapeutic process. Group cohesiveness operates as a therapeutic factor first by creating group support and acceptance and later through its role in interpersonal learning.

Magic. Kottler and Englar-Carlson (2010) state that amazing things happen in groups, some of which defy description and explanation. The feeling of camaraderie and caring become intrinsically healing. In a way, this idea could be represented by Yalom and Leszcz's (2005) statement that there is no consensus about the reasons clients improve.

Stages of Group Evolution

In addition to the therapeutic factors of groups, Kottler and Englar-Carlson (2010) described four stages of group evolution that also contribute to an individual's treatment process: Induction, experimental engagement, cohesive engagement, and disengagement.

Induction. Group members require orientation in the beginning of the process (Kottler & Englar-Carlson, 2010). The induction stage has to do with the necessity that members may depend on leaders for guidance. Members may experience confusion, curiosity, and personal protectiveness.

Experimental Engagement. This is the stage of the group when members want to stretch themselves (Kottler & Englar-Carlson, 2010). Members may want to test the group to determine how it responds to bids for power and deeper levels of self-disclosure. Members will push the limits of what the group can do and hold. At this stage, group members are competing to establish their place in the group.

Cohesive Engagement. This is described as the "working stage" where trust and accommodation has been reached such that productive activities take place (Kottler &

Englar-Carlson, 2010). Group members start to identify with each other and form a sense of cooperation and collaboration as well as hope and positive expectations for the process. Some conditions are required for this stage to happen: Time, stable settings to help members to feel safe, an atmosphere in the group that is conducive to individual self-expression, and a democratic rather than authoritarian leadership to prevent dependency and destructive coalitions.

Disengagement. In the stage of disengagement, people may experience a feeling of loss. Kottler and Englar-Carlson (2010) stated that it is rare for any of us to feel part of a group that feels endlessly safe and secure. It is not uncommon to experience resistance from group members during this stage. One of the challenges for the leaders in this stage is to keep people engaged in the process.

Music Psychotherapy

In this study, a music-centered music therapy approach was combined with music psychotherapy theories. Bruscia (1998) proposed the following definition for music psychotherapy:

> Psychotherapy is essentially concerned with helping a person make those psychological changes deemed necessary or desirable to achieve well-being. Characteristic goals are greater self-awareness, resolution of inner conflicts, emotional release, self-expression, changes in emotions and attitudes, improved interpersonal skills, resolution of interpersonal problems, development of healthy relationships, healing of emotional traumas, deeper insight, reality orientation, cognitive restructuring, behavior change, greater meaning and fulfillment in life, or spiritual development. Psychotherapy is essentially an interpersonal process. Treatment takes place within and through the client-therapist relationship.

> Music psychotherapy is defined by the use of music experiences in addition to or in lieu of the traditional types of verbal discourse. Music psychotherapy is the use of music experiences to facilitate the interpersonal process of therapist and client as well as the therapeutic change process itself. (p. 2)

In his definition, Bruscia (1998) did not refer to the necessity of verbal interpretation in order for treatment to be considered music psychotherapy. Rather, the key factor is that therapeutic change requires a facilitation of interpersonal relationships through the use of music. Bruscia described four approaches in music psychotherapy with a decreasing emphasis on music: (1) music as psychotherapy; (2) music-centered psychotherapy; (3) music in psychotherapy; and, (4) verbal psychotherapy with music. Music *as* psychotherapy describes a process when the therapeutic issue is accessed, worked through, and resolved through creating or listening to music, with no need for or use of verbal discourse (Bruscia, 1998). Music-centered psychotherapy occurs when the therapeutic issue is accessed, worked through, and resolved through creating or listening to music. In this method, however, verbal discourse is used to guide, interpret, or enhance the music experience and its relevance to the client and therapeutic process. Music *in* psychotherapy is utilized when the therapeutic issue is accessed, worked through, and resolved through both musical and verbal experiences, occurring either alternately or simultaneously (Bruscia, 1998). Music is used for its specific and unique qualities and is germane to the therapeutic issue and its treatment, and words are used to identify and consolidate insights gained during the process. Finally, verbal psychotherapy with music is a process where the therapeutic issues are accessed, worked through, and resolved primarily through verbal discourse (Bruscia, 1998). Music experiences may be used in tandem, to facilitate or enrich the discussion, but are

not considered germane to the therapeutic issue or treatment of it. In this research, music-centered psychotherapy was characterized when music was applied *as* therapy and words were only used to guide the group dynamics.

Analysis of Group Dynamics in Music Therapy

In a review of the literature of group work in music therapy (Brandalise, 2012a), a tendency for clinicians to use groups to support individuals' processes and growth without intentions of describing all the elements involved in group dynamics was identified. Clinicians often lack a clear description of the group as an organism in and of itself that needs to be taken care of to be healthy, to offer support, and to be a safe place for individuals to develop and grow.

In the literature on group music therapy, group cohesion was the most discussed phenomenon. On one hand, this is surprising, because many important and previously discussed characteristics are involved in group dynamics, such as rules, norms, and stages of group development. These dynamics are not well discussed in the literature. On the other hand, focusing solely on group cohesion can be expected, because this outcome is common and the need to research all the remaining details of the group dynamics is relatively new to the field.

Arnason (1998) provided details about group dynamics in her study of a group music therapy process with professional music therapists. The author mentioned common feelings experienced by members in the beginning of the group process, such as uneasiness, discomfort, and ambiguity. Both Arnason (1998) and Skewes (2001) described common characteristics in music therapy groups, such as the themes introduced by the group (e.g., what is supposed to happen in this group?), group norms (e.g., when to start and stop an improvisation?), working towards unity and cohesiveness. Lecourt (1993) theorized that a group needs to be considered not as a sum

of individuals but as a whole, as an entity in which the dynamic rests on a so-called "force field" made by tensions, movements of cohesion or destruction, and a search for balance. In addition, the group can be considered a transitional space providing transitions from psychic reality to social reality.

Although clinicians are using a variety of music therapy methods, approaches, and instruments, there is a lack of research analyzing the musical component of the experience with groups. Aigen (1997) studied a year-long music therapy group comprised of four adolescents at the Nordoff-Robbins Center in New York. The author found several elements of group dynamics to be present, such as trust, norms, roles, group structure, musical themes, members' interactions (among themselves and with the music), and cohesiveness. Aigen's research is one of the few studies about the musical material that resulted from the group dynamics. Musical scores were analyzed as data (including compositions using tonal patterns in the keys of Bb, Cm, G, C, and Em). Chord inversions were used, as well as many harmonic strategies for providing tension to support the content provided by the lyrics (use of primary dominants, secondary dominants, Neapolitan progressions, and diminished fifths). Although Aigen discussed the clinical intention behind his musical interventions, he did not report harmonic or melodic analysis. Due to this limitation, it is difficult to connect the music's structures and parameters with the clinical intentions that were mentioned.

Music-Centered Music Therapy

Music-centered music therapy implies the use of music *as* therapy. According to Bruscia (1998), music being used in therapy means that it is used "not only for its own healing properties but also to enhance the effects of the therapist-client relationship or other treatment modalities" (p. 39). Turry and Marcus (2003) described the Nordoff-

Robbins approach as being one example of a model that uses music as therapy, meaning that the musical activity that happens between client and music is the therapy.

Historical Context of Music-centered Music therapy

It is not possible to discuss music-centered music therapy without reflecting on part of the music therapy history. Modern music therapy practice started in the mid-1940s and, at the beginning, theoretical foundations had to be imported from other professions and theories such as medicine and psychology. Music therapists had to adjust what they were observing in their practices into other fields' pre-existing theories. However, as Garred (2001) observed, ready-made theories from neighboring professions do not necessarily fit music therapy. Nonetheless, from these early foundations, some music therapy models emerged.

For example, analytical music therapy (Priestley, 1994), the Benenzon model (Benenzon, 1985) and behavioral music therapy (Madsen, Cotter & Madsen, 1968) are music therapy models that were based on theories externals to music therapy. Yet, at the same time, in the late 1950s and early 1960s, music therapy pioneers such as Paul Nordoff, Clive Robbins, and Helen Bonny were concentrating their efforts in trying to better understand the power of music in the therapeutic processes they were experiencing with their clients. According to Aigen (2005a), in 1965, Paul Nordoff and Clive Robbins first coined the term "the art of music as therapy." In the 1980s, the term "music-centered" became a descriptor of theory and practice in music therapy at the *The Bonny Foundation: An Institute for Music-Centered Therapies,* founded by Helen Bonny, Barbara Hesser, and Carolyn Kenny.

Therefore, in the 1980s, even as questions developed about the uniqueness of music therapy and its adaptation in the scientific world, questions also emerged about

the role of music in therapy. What was unique in the experience with music that would make it, therapeutically speaking, relevant? In the words of Bonny (1982),

> our profession has just gone through a long and tedious process of trying to be accepted by being "scientific." I can speak from experience having studied my craft in the 1960s, and then worked for seven years in a research center. I came out of those years of experience with the conviction that making music therapy fit into the scientific model is like trying to stuff a size 10 foot into a size 6 shoe! It just won't fit; and if we do get the foot into the shoe, it is far from comfortable. (p. 2)

The 1982 Symposium and indigenous music therapy research. In 1982, Barbara Hesser from New York University (NYU), along with the Musicians Emergency Fund, hosted the conference entitled "Music in the Life of Man." This event became a turning point in the profession's history. Thirty-one influential music therapists from fourteen different countries were involved including Ruth Bright (Australia), Lia Rejane Barcellos (Brazil), Edith Lecourt (France), Rachel Verney (England), Chava Sekeles (Israel), Even Ruud (Norway), Carolyn Kenny (Canada), Helen Bonny, Clive Robbins, Kenneth Bruscia, Charles Eagle, Clifford Madsen, Barbara Wheeler, and Carol Robbins (USA). The main goal of the event was to develop principles on what is inherent in the experience of music that makes it unique in therapy.

Kenny (personal communication, September 27th, 2015) stated:

> Thirty-one music therapists and scholars in related disciplines gathered for five intensive days and nights of dialogue on the campus of NYU. Though this gathering represented the seeds of what we know as Music Therapy Theory in contemporary times, very little has been written about

> this historical event. Conversations were intense, full of appreciation for the power of music and our shared passion for the work, and debate. A new book titled *The 1982 Symposium on "Music in the Life of Man:" The Beginnings of Music Therapy Theory (Barcelona Publishers, 2015 forthcoming).* How did this gathering influence future thoughts about theory for music therapy? What were the enduring collegial friendships forged during those five days? This book documents the legacy of the 1982 Symposium regarding these questions.

Barbara Hesser (1996) stated that

> it is the experience of music in our lives and the lives of people with whom we work that is the essence and heart of music therapy. By keeping this experience as the center of our professional activities (e.g., clinical practice, theory and research) we will naturally recognize the important principles as they emerge. (p. 16)

Hesser's (1996) vision was pointing to the future, encouraging the creation of native theories that could, according to her, emerge from the music therapy's clinical practice. Furthermore, Hesser believed that

> in order to strengthen our discipline, we need now to move beyond the development of new techniques and begin to articulate whole clinical models. We have few of these models available at this time. A model would contain a strong theoretical framework and a rationale for the techniques used as well as a body research that demonstrates the effectiveness of the work. (p. 18)

Hesser (1996) quoted Bonny, who stated that

> the carefully researched and discrete paradigms underlying medical science daily practiced and accepted by our society are not truth per se but one of a number of explanations. Like the adventurer who searches the world for treasure and finds it in his own backyard, we may find the diamonds we seek in own house. (p. 19)

All of these quotations reflect the importance of the aforementioned 1982 Symposium. Among the event's reporters was one of NYU's master's students, Kenneth Aigen, who in 1991 wrote his doctoral dissertation called "The Roots of Music Therapy: Towards an Indigenous Research Paradigm." In his dissertation, Aigen (1991) expressed his belief that there was a necessity for music therapy to develop its own theoretical body, what he called "the necessity of an indigenous paradigm" (p. 95). He referred to the work of the historian Thomas Kuhn in observing that

> our activity as music therapy researchers includes the creation of hypotheses guided by our important research problems. In effect, Kuhn says that by definition, a paradigm which transforms a field into one that exhibits scientific progress is an indigenous one. (Aigen, 1991, p. 99)

Nordoff-Robbins music therapy. The Nordoff-Robbins Center for Music Therapy at NYU is a highly regarded music therapy center that uses music improvisation to work with people with ASD. Nordoff-Robbins music therapy originated in 1959 by the pianist Paul Nordoff and the special education teacher Clive Robbins. The model of Nordoff-Robbins was originally named 'Creative Music Therapy,' and became known as the exemplary model of music-centered music therapy.

According to Nordoff and Robbins (1971), music is a world in which everyone lives. The music therapist is actually a "musician" therapist who could activate his/her

musicality in order to create creative melodies, harmonies and rhythms. One of the most influential authors to Nordoff was the music philosopher Victor Zuckerkandl (1973). In fact, in Nordoff's (as cited in Robbins & Robbins, 1998) clinical philosophy, it is possible to find a clear connection with Zuckerkandl's (1973) ideas (Table 1).

Table 1

Comparison of some of Zuckerkandl and Nordoff's Concepts

Victor Zuckerkandl (1973)	Paul Nordoff (IN: Robbins & Robbins, 1998)
Tones have dynamic qualities (p. 20)	The scale is stating its presence, its potentiality, its creative self (p. 3)
The dynamic quality of a tone, we said, is a statement of its incompleteness, its will to completion (p. 136)	Intervals have experiential dynamics (p. 66)
Successions of tones are motion not in respect to an order based on pitches but in respect to an order based on the forces in tones (p. 95)	Talking about chord inversions – we are not working with "just chords." We are working with dynamic forces (p. 52)

All of the above ideas are complex. They represent Nordoff's (as cited in Robbins & Robbins, 1998) and Zuckerkandl's (1973) philosophies of how music is experienced by people. It is possible to adopt this perspective without making esoteric or metaphysical assumptions about music. According to Zuckerkandl (1973),

> music is not a phenomenon of the inner world, nor it is something projected from the inner world to the outer world; it is a phenomenon of the outer world. It is not felt, it is not imagined, it is not willed. It is perceived. (p. 144)

A distinguishing feature of Nordoff and Robbins (1971) music therapy is their co-therapist model of treatment. The primary music therapist is the pianist whose main goal is to engage the child musically in a developmentally effective way while the role of the co-therapist is to support the pianist's work and to supplement it resourcefully in whatever way the situation calls for. According to Turry and Marcus's 2005 study on the teamwork suggested in Nordoff-Robbins' frame, however, the pioneers did not define in detail the various aspects of the team members' roles in relation to each other.

Not all music-centered music therapy models use the same principles. Music-centered practitioners apply music using different methods and techniques. Nordoff-Robbins music therapy primarily uses improvisation (Robbins & Robbins, 1998). This is defined as music being created in the here-and-now according to the way music therapists perceive clients' needs in the moment. Therefore, while the Nordoff-Robbins model of music therapy pioneered the music-centered approach, contemporary music-centered music therapy significantly varies and will be further reviewed in more detail.

Music-centered Perspectives

Zuckerkandl (1956) has influenced several music-centered music therapists (Aigen, 2005; Ansdell, 1995; Bonny, 1978a; Brandalise, 2001; Nordoff & Robbins, 1977). This is significant because Zuckerkandl (1956) provided one of the most important philosophical backgrounds for music-centered theorists: music can be seen as an entity that has inner qualities. In the therapeutic dynamic of music therapy, some music-centered theorists have illustrated this idea, as a triangle illustrating a music-centered therapeutic dynamic where therapist, client, and music have the same importance (Brandalise, 2001; Garred, 2001).

Music-centered music therapy is theorized and practiced in a variety of ways by music therapists in different parts of the world. The search for an indigenous theory for

music therapy can be considered one of the central common characteristics of contemporary music-centered music therapists: the need to find answers for the practice through music therapy's own tools. This has become one of the main challenges for all music-centered authors and practitioners (Aigen, 2005; Ansdell, 1995; Bonny, 1978a; Brandalise, 2001; Garred, 2001; Lee, 1996; Nordoff & Robbins, 1971, 1977; Turry & Marcus, 2003; Verney & Ansdell, 2010). Theorizing music therapy dynamics without having to import other fields' concepts and theories could create what was proposed by Aigen in 1991: indigenous theories based on music therapy practices and for music therapy.

Music Therapy Theory

One of the central efforts of all music-centered theorists is to identify in the uniqueness of music what is unique in music therapy (Aigen, 2005a; Ansdell, 1995; Bonny, 1978a; Brandalise, 2001; Nordoff & Robbins, 1971, 1977; Lee, 1996; Garred, 2001; Turry & Marcus, 2003; Verney & Ansdell, 2010). They all indicate that music has a fundamental and central role in the music therapy dynamic.

Aigen (2005a) believes that to be a music-centered music therapist means to place ideas about music at the core of music therapy theory. A music-centered music therapist understands that musical goals are clinical goals. Bonny (1978b) identified music as movement, symbol, and a language of emotion and meaning. For Ansdell (1995), music has a central role to the treatment and the therapeutic work occurs in and with music.

Music as a Self-contained Experience

The creative experience itself can facilitate therapeutic change without the necessity for a translation of the experience to any other media. This is another important essential aspect of music-centered music therapy: to practice what Bruscia

(1998) called ‘transformative music psychotherapy.’ Lee (1996), music-centered clinician, says:

> My experiences confirm that verbal explorations in music therapy are secondary to musical explorations. In my work, improvisation is not considered as a channel towards words, but as the source of its own unique experiences and processes. (p. 24)

Music as a medium implies an experience where the reason for it is contained within the doing of it. Thus, music is not a means to an extrinsic goal. The reason to make music in music therapy is to experience what music uniquely provides, not to achieve some nonmusical goal. This concept has been widely discussed by several authors. It is a central aspect in Aigen’s (2005a) book, influenced by the aesthetic philosophy of John Dewey, which engages the use of music as a medium or as a means in therapy. According to Aigen (2005a), “human activities can be separated into those that are media and those that are means” (p. 57). Turry and Marcus (2003) also demonstrated that change occurs in and through musical processes, which then transfer into the life of the client outside the therapy room. Moreover, Verney and Ansdell (2010) identified that the key to transformation is the fact that what the therapist hears is music. Although the client can be screaming or expressing rage, music-centered music therapists interpret these sounds as music, which is intrinsically beautiful.

Epp (2001) also investigated the role of self-expression in music-centered music therapy, and found that a theory of self-expression for a music-centered practice cannot detach expressive content from the lived performance of music.

Discussions on Therapeutic Music Production

Music and its production in therapy is another essential characteristic of music-centered theorists. In the music therapy literature, some authors have included audio

recordings of the music therapy discussed in their books (Aigen, 1998; Ansdell, 1995; Brandalise, 2001; Lee, 1996; Nordoff & Robbins, 1977). These authors have maintained that the importance of listening to the music produced by clients and therapists. In short, for these music-centered music therapists, music is the central therapeutic content through which stories of clients are developed in therapy. It is not possible for a reader, interested in music-centered music therapy, to detach music from his/her reading. Furthermore, these authors use music analysis and transcribed session scores as important tools to perceive clients' needs, monitor clients in their processes, and recognize possible development and growth through the musical creative experience.

Commonalities and Differences Between Music-Centered Music Therapy and Music Psychotherapy

Although it seems central to contemporary music-centered practitioners and theorists that musical experience is valued as an end objective in and of itself, how does an insight gained in music differ from a psychotherapeutic insight? It should be possible for a psychotherapeutic insight to happen in and with the music.

All music-centered models, despite their differences, present characteristics that could be included in a psychotherapeutic perspective. However, some music-centered music therapists argue that music-centered practice and psychotherapy are two different approaches (Ansdell, 1995). Ansdell has stated that in music psychotherapy, the use of music is a facilitator of words.

The search for an understanding about meaning appears to be common among some music-centered theorists and practitioners. Ansdell (1995) wrote about meaning being gained without the necessity of translation into words; instead, meaning has to do with something making sense in itself, connecting two minds and two bodies in the same experience. Aigen (2005a), influenced by Dewey's (1934) aesthetic theory as well

as Lakoff and Johnson's (1980) Schema theory, identifies that music can be preserved as it is experienced without necessity for verbal translation. Moreover, meaning can be achieved through the so-called image schemata, which are foundations for metaphoric thinking, organizing mental representations.

There are also differences in the ways theorists think about the therapeutic relationship. For example, according to Aigen (2005a), it is not contradictory for a music-centered practitioner to use the therapeutic relationship as an important vehicle in therapy; however, he does not consider it required. Garred (2001) proposed the metaphor of a triangle, explaining his understanding of the therapeutic dynamic: the client-therapist and music make a triad. Music is defined as therapy as well as a 'mediating space,' which stimulates the client to enter into dialogue. Further defining 'music as means', Garred (2001) observed that

> in music therapy music is clearly not an object to be valued and considered solely for its own inherent qualities. Music in this instance clearly serves some purpose. One suggestion, close at hand, might be that music here instead of being an autonomous art object is to be applied as a means towards a predefined end. The therapist applies music as a means for the betterment of the client. (p. 3)

But Garred (2001) also noted that

> for the client in music therapy the primary motivation for doing music is the music activity itself, and if it was not, one could hardly expect any improvement of functions following from this activity. Using music *solely* as a means for improving non-musical functions will tend to overlook this crucial intentional aspect of doing music. (p. 4)

Thus far, this chapter has discussed theoretical foundations and literature on group theory, psychotherapeutic music therapy, and music-centered music therapy. The remainder of this chapter will focus on the research design implemented in the present dissertation study.

Naturalistic Inquiry Applied to Music Therapy

In his analysis of qualitative research in music therapy, Aigen (2008) found that phenomenology was the most commonly used research method, as it was found in 16 out of 61 studies . This method was followed by grounded theory (11 studies), naturalistic inquiry (7 studies), qualitative/social descriptive research (6 studies), qualitative case study research (3), content analysis (3), musicological methods (3), and one occurrence of each of the following methods: action research, biographical, ethnographic, ethnomusicological, heuristic, identity structure modeling, narrative inquiry, personal construct theory, phenomenography, self-inquiry, philosophical inquiry, and collaborative research.

However, only some of the studies utilizing naturalistic inquiry studied actual clinical process. Aigen (2005b) quoted Norman Denzin in defining naturalistic inquiry

> as the studied commitment to actively enter the worlds of native people, and to render those worlds understandable from the standpoint of a theory that is grounded in the *behaviors, languages, definitions, attitudes* and *feelings* of those studied. Naturalistic behaviorism attempts a wedding of the covert, private features of the social act with its public, behaviorally observable counterparts…The naturalist is thus obliged to enter people's minds, if only through retrospective accounts of past actions. (p. 352)

Arnason (1998) studied the experiences of professional music therapists in an improvisational music therapy group. She combined naturalistic inquiry with musical analysis of improvisations and used the natural setting in which she was the participant-researcher. The author employed techniques for trustworthiness by checking her interpretations with the group members (participant checking) and being a member of an ongoing research support group. The support group was used as a form of peer debriefing that functioned similarly to a clinical supervision group for therapists. Members of the group shared their data, interpretations, and personal struggles, and they offered each other support in addition to challenging the researcher's interpretations of the data.

Additional research has utilized naturalistic inquiry. Aigen (1997) studied a music therapy process of a group of adolescents at the Nordoff-Robbins Center for Music Therapy for one year and it exemplified some of the primary aspects of naturalistic inquiry. He also utilized the natural setting. The group was filmed at the Nordoff-Robbins Center. Purposive sampling was illustrated by his selection criteria for the studied group. He studied older individuals with verbal skills, understanding that they could provide more sources of information about the process. Prolonged engagement and persistent observation were characterized by that fact that Aigen observed the group for an entire year and viewed the videos repeatedly. Interaction between knower and known could be seen in terms of the different levels of engagement he had in the phenomena under study. He was the camera operator and therefore had the control to choose what he thought were the most relevant moments of the session. The characteristic of emergent design can be seen in two aspects of the study. First, Aigen participated in the therapists' indexing. At a midpoint, he decided that it would be more

interesting to see the clinical events through the eyes of the therapists as they watched the tape and discussed the events.

Another music therapy researcher who has utilized naturalistic research design in multiple music therapy studies is Henk Smeijsters. A naturalistic single-case research design was used to study a music therapy process with a client suffering from musicogenic epilepsy (Smeijsters & Storm, 1995). In another study, Smeijsters and Cleven (2006) published the process and results of a naturalistic inquiry conducted with art therapists working in 12 institutions in the Netherlands and Germany. The aim of the study was to investigate the treatment of aggression through the use of arts therapies in forensic psychiatry. The researchers involved the participants through the use of questionnaires, interviews and focus groups. Furthermore, Smeijsters, Kurstjens, Welten, and Willemars (2011) researched arts therapies applied in the treatment of young offenders. Practice-based evidence was generated through the use of what the authors called naturalistic/constructivist research methodology in combination with grounded theory methodology.

The research conducted by Smeijsters and Storm (1996) deserves more attention since the applied design served as one of the main supports for the design of this dissertation research. Smeijsters and Storm's method included transcripts from self-reports, live and taped observation reports, interviews and team discussions as the ground data for analysis. Through this method, they were able to investigate the clinical treatment they proposed for a young girl with enuresis experiencing communication problems with her mother. Trustworthiness of the research was achieved through the application of member checking, analytical memos, categorization, development of multiple perspectives, and triangulation. Peer debriefing was employed as the research

conclusions were presented to neurologists and psychotherapists whose role it was to challenge the conclusions of the research and clinical team.

However, despite the promising music therapy research conducted using naturalistic inquiry, a review of the literature found a lack of naturalistic research of group music therapy processes with individuals with ASD. The present study met the need for this research utilizing Smeijsters and Storm's (1996) research design and the naturalistic inquiry proposed by Lincoln and Guba (1985).

CHAPTER THREE

METHOD

Study Design

This research investigated group dynamics that occurred in music-centered psychotherapy treatment with preverbal children with autism spectrum disorder (ASD). This study employed a naturalistic study design. Lincoln and Guba (1985) stated that the main goal of inquiry is to develop a body of knowledge in the form of working hypotheses. The authors described the 14 characteristics of the naturalistic paradigm, some of which were utilized in this research. One such aspect was that the research was carried out in a natural setting of a private specialized center where clients were familiar with their surroundings. The reason for naturalistic inquiry was to generate findings that were more applicable to actual clinical practice, because the study involved clinical practice rather than tasks in an unnatural environment such as a laboratory.

Setting

Although the researcher is the director of a music therapy center, it was determined that ethically the research would be conducted in a different facility with different clients. Data for this study was gathered at the specialized private center Centro de Atendimento e Profissionalização Criativa (CAP Criativa) in the city of Porto Alegre, Southern Brazil. This center was chosen because it was already set up with rooms that would be appropriate for music therapy groups. Additionally, this center had high enrollment of ASD clients.

This CAP Criativa center provides morning and afternoon clinical services to individuals with ASD. The types of treatment and education provided include services such as occupational therapy, school education, physical education, physical therapy,

and parental support groups. The music therapy treatment was offered as part of the research process in addition to the standard clinical services offered by the center.

Participants

Participants for this study included children with ASD. The researcher and the therapists had no prior interaction with the children and their families prior to the study.

Participants with ASD

Six participants with ASD were recruited for this study: four boys (Donald, 8 years old; Louie, 8 years old; Joshua, 10 years old; and, Gustavo, 14 years old) and two girls (Sonia, 9 years old and Valeria, 12 years old). There were no restrictions regarding gender, verbal skills, previous interest in music, or previous experience in music therapy. There were no exclusions for aggressive behavior or any type of functioning. Based on the clients served by the study site, all potential participants were between the ages of eight and 15 years old. There were initially no restrictions on participant age, however as initial participants were enrolled in the study, subsequent participants were limited to those whose age and functioning level were similar to the initial participants. This restriction was put in place in order to form a homogeneous group. Exclusion criteria included self-injurious behavior, difficulty following simple commands, and an inability to stay seated when necessary.

Upon admission to the CAP Criativa center, each client was evaluated by a variety of professionals to determine the best treatment plan. The director of the center is actively involved in the evaluation process, and therefore is knowledgeable about each client. In order to recruit for this research study, the

director contacted the selected families to inform them about the study. It was explained that music therapy would have no additional cost to the families. All of the six contacted families were interested in participating in the project, at which point the director scheduled a meeting of the families with the researcher. Meetings occurred with each family in order for the researcher to explain the study and gain informed consent. All families agreed to have their sons and daughters participate in the research, and consent forms were signed.

Therapist Participants

In addition to the participants with ASD in the music therapy groups, two therapist-participants were enrolled in this study. The therapist-participants for this study were employees of the researcher, and like the researcher had no prior knowledge of these participants.

Therapist-participants satisfied the following inclusion criteria:

1) The person in the primary role of therapist was a trained music therapist with eight years of clinical experience working with people with ASD.
2) The person in the primary role of co-therapist did not necessarily need to be a trained music therapist but needed to have at least three years of experience working with people with ASD.

All participants signed informed consent to participate in the research study. All information about the participants was kept in the strictest confidence. Pseudonyms were used to identify the data and will be used in all publications. Videos of the sessions were uploaded and stored on the researcher's personal computer. All data were stored on secure computers that were password protected.

As the research progressed, parents were invited to participate in Sessions 12, 14, and 15. The reasons for including the parents were multifold. Firstly, the team believed that the children's behaviors in the group were examples of the way they interacted with their parents in their home environments. Secondly, two of the group members had significantly increased their aggressive behaviors putting themselves, their peers, and the therapists at physical risk. The team and the director of the program felt it would be beneficial to include the parents of these clients in order to verify the connection between parents and kids, and facilitate new emotional experiences among them. Third, the research team underwent a process of supervision by a psychoanalyst who was hired by the research cite, which is owned by the researcher-consultant. In supervision, the topic of integrating parents and children was discussed. Although this research project was not discussed in supervision process due to methodological and privacy issues, the team was nevertheless influenced to pay greater attention to the parent-child dynamic. Finally, parents were invited to participate because of the emerging philosophy that healthy child development requires healthy parental relationship.

Study Protocol

Recruitment of participants took place from the end of January until the end of February 2014. Data collection took place from March 2014 to June 2014 over a total of 16 sessions. All sessions utilized music-centered music therapy interventions and different types of music according to the needs and interests of the group, as determined by the therapists who worked with them. Types of music varied in terms of styles (i.e., Samba, Bossa Nova, Capoeira, Choro, Reggae, Maracatu, Rock'n roll, R & B, House, Rap, Country, etc.), keys, arrangement (i.e., instrumental music, vocal music, classical music, etc.), and forms (classical music pieces, song, improvised music). Clients were

stimulated to interact in several ways (i.e., with music, musical instruments, group peers, and therapists).

Data Sources

There were four sources of data in this study: (1) video recordings; (2) description of sessions; (3) therapists' observations; and (4) meetings with the therapists.

Video Recordings

The researcher video recorded every research session then watched and analyzed these recordings.

Written Description of Sessions

After every session, the video recording was transcribed to a log containing line numbers in order to facilitate analysis. In this process, all the events were described in details. These events included verbal, physical, and musical events. Musical intervals, rhythmical patterns, melodies, and songs that were considered relevant were musically transcribed on a score and included as a data source in the descriptive log.

Therapists' Observations of the Video Recordings

The therapists-participants reviewed and analyzed the video recordings of each session and made their own observations and impressions. These reports were then orally transmitted to the researcher during the team meetings and consisted as another source of data.

Meetings with the Therapists

After every three sessions the researcher-consultant met with the therapists. During each meeting, the therapists gave their observation from the research sessions, and the researcher shared the results of the ongoing analysis. In this way, all clinical impressions were considered, thus providing continuity in treatment approaches. These meetings were recorded and transcribed, and were an additional source of data.

According to Lincoln and Guba (1985), this intra-team communication is important to keep all members moving together in the research project.

Data Analysis

After every session, the transcription of the video recording was analyzed and coded. According to Charmaz's (2006) concept of grounded theory data analysis, coding is the attachment of labels to segments of data that explain what that segment is about. The researcher used (a) initial coding; and, (b) incident to incident coding aiming to develop the research sessions into categories (see Appendix G). Through initial coding, the researcher tried to see action in each segment of data. Through incident to incident coding, the researcher conducted a comparative study of the incidents to identify properties of emerging concepts.

After every three sessions, the researcher wrote analytic memos based on the grounded theory method (see Appendix H). According to Charmaz (2006), this procedure is crucial because it prompts the researcher to analyze data early in the research process. Through memo-writing, the researcher reviewed the created codes and the contents of the previous sessions, summarized emerging themes, identified patterns, documented treatment ideas to be shared with the therapy team, and recorded speculations on the meaning of the musical and verbal interactions in the sessions. Categories, themes, and metaphors were used in order to illustrate the analysis. Categories were characterized by the main emotions evoked by the clients and therapists during different situations presented by the group dynamic and by the musical creation (i.e, significant intervals, melodies, phrases, songs, etc.). Themes were related to main thoughts, musical phrases (from pre-composed or composed materials) that had to do with different phases of the process. The use of sounds and music were explained and

understood relating to how they were used to support, offer relief, and offer insights to members and therapists.

Evaluation Criteria and Procedures

In qualitative research, findings cannot be generalized beyond the context in which they are discovered (Wheeler, 2005). Hence, the researcher's obligation was to provide enough information about the phenomena to allow the reader to make determinations about which findings are applicable in particular context. One criterion that this study tried to achieve was that of "thick description," the details of which are needed to help readers determine into what contexts they can apply the findings. The goal of the study was to provide a rich, multi-layered description of the process from multiple perspectives.

The researcher must acknowledge that the therapist-participants were the researcher's employees. Therefore, there was a natural, unavoidable power imbalance. Acknowledgement of this power imbalance does not mean it did not affect the research. Literature presents a similar dynamic in Aigen's (1997) naturalistic research at the Nordoff-Robbins Center. Aigen researched group dynamics at the center, where he worked as an employee. As part of his research, he studied two co-workers with whom he shared an office, and he discussed the unequal relationship in his findings. The goal was not to necessarily be equal but to be open and honest about all of the influences that were present.

Therefore, several steps based on Lincoln and Guba's (1985) suggestions were taken to establish trustworthiness and credibility: prolonged engagement, persistent observation, triangulation, and member checking.

Prolonged Engagement

According to Lincoln and Guba (1985), prolonged engagement helps to understand the context, minimize distortions, and build trust. Prolonged engagement is about the investment of sufficient time to achieve objectives such as learning the culture, testing for misinformation introduced by distortions either of the self or of the respondents, and building trust. In the current study, it was assumed that 16 sessions provided enough time for the researcher to know the "culture" of the participants, learn the context, and detect possible distortions, therefore long enough to reveal group process and dynamics.

Persistent Observation

Lincoln and Guba (1985) state that the objective of persistent observation is to identify characteristics that are most relevant to the problem being studied and focusing on them in detail. Observation in this study was conducted across different levels**.** First, the researcher observed and filmed the sessions. Then, in order to analyze the session and extract the moments whose characteristics and elements in the situation were most relevant to the problem or issue being pursued, the researcher repeatedly observed the videos. One video recording was created consisting of a selection of therapeutic moments the researcher-consultant considered the most relevant regarding group dynamics, music, and verbal production. The therapists also observed the session recordings and wrote their thoughts about the process in clinical reports. Finally, after every three sessions, a team meeting was conducted where all members shared their opinions about the process.

Triangulation

According to Lincoln and Guba (1985), triangulation is crucial in naturalistic studies in order to increase the probability that findings and interpretations will be found

credible. For this research, different data collection modes were used such as analytic memos, filming, observation, researcher and therapist clinical reports, and musical scores. In addition, there was triangulation during the data analysis by using different methods: qualitative analysis, musical analysis, and analysis of the team meetings.

Member Checking

Lincoln and Guba (1985) identified member checking to be the most important technique for establishing credibility. In the current study, the researcher interviewed the two therapists to gain their perspectives on: (a) the themes and other interpretations that were made of the clinical events and inferences about the meaning of the group process for the participants; and, (b) the effectiveness of the utilized clinical-research design. According to Lincoln and Guba (1985), the purposes for doing interviews such as those utilized in this study include obtaining *here-and-now* of persons, events, activities, organizations, feelings, motivations, claims, concerns, and other entities. The intention of this dynamic was to have therapists' perspectives influencing the researcher's point of view and vice versa. This is known as triangulation, a process in data collection where member checking enhances the construction of meaning (Lincoln & Guba, 1985).

Researcher Subjectivity

The presence of video recording may have influenced client participation in the therapy process and therefore it may have affected group dynamics. Additionally, the presence of a consultant-researcher offering ongoing guidance as the therapy process proceeds also undoubtedly influenced the process. Thus, such a form of data collection had two important aspects that are considered possible limitations: a) the researcher was the video operator; and, b) he was physically present in the music therapy room with the camera.

The first condition is delicate because the phenomenon was being analyzed as the researcher was collecting the data. This was demonstrated by the decisions made by the researcher himself (i.e., where and why to zoom in and zoom out to focus on individual and/or to capture the entire group, and angles to better operate). This process is another way of being present, as a kind of participant. Furthermore, editing is a way of interpreting what is going on in the process. However, even if there was a stationary camera that was not operated by anyone, certain things would be visible and other things not visible. In the way this research was designed, the researcher was able to explain the reasons for the focus on particular phenomena, whereas with a stationary camera the considerations that determine the limitations of the recording would simply be because of the camera position. It is not possible to have a video recording where everything is visible all the time, so when a person operates the camera, it allows for some flexibility.

In the qualitative research process where Aigen (1997) was the filmer, he realized that the video is an artifact that preserves a particular perspective on a series of events. However, as Lincoln and Guba (1985) proposed, as one axiom of naturalistic inquiry, a relationship of knower and known is inevitable. By saying "knower" and "known" Lincoln and Guba are not necessarily just referring to the researcher and the participants but to the researcher and the phenomena that the researcher wants to learn about. In the case of this study, it is the researcher's relationship to the topic of "group music therapy process with people with ASD" that the word "known" refers to.

Ethical Considerations

This study involved investigating human beings. It was conducted in Brazil, with Brazilian participants, but it was analyzed by North American ethics standards. Therefore, it was conducted in accordance with the Temple University Institutional

Review Board (IRB), the American Music Therapy Association Code of Ethics, and the Brazilian Code of Ethics. Furthermore, the study was approved by the Temple University IRB.

The researcher established a clear agreement with research subjects' guardians prior to their participation in the study. Informed consent was obtained detailing the responsibilities and rights of all parties. The researcher explained all aspects of the research that might have influenced the subject's willingness to participate, including all possible risks and benefits. Participation in the research was voluntary. The participant or legal guardian was free to refuse to participate or to withdraw from the research at any time without penalty or loss of services. The researcher was responsible for protecting the welfare of all the research participants, both during and after the study. To avoid adverse effects, all precautions to avoid injurious psychological, physical, or social effects to the subjects were taken. The researcher and the therapists stored research data in secure locations accessible only to the researcher and therapists. All research data will be shredded and erased after five years.

The researcher made a commitment to be competent in his research efforts, being cognizant of his limits and presenting his findings without distortion and in a manner that was not misleading.

In terms of relationships with the research subjects, the researcher protected the rights of the individuals with whom he worked. These rights included the right to safety, right to dignity, legal and civil rights, right to treatment, right to respect, and the right to participate in treatment decisions.

There was one ethical dimension to the study that was important to discuss. Part of the study's focus was to examine the termination process, so the intent was for the study group to end when the research ended after 16 sessions. It was decided before the

study began that if an extra session or two was needed to achieve a satisfactory clinical termination, those sessions would be provided. After the group terminated, if the researcher believed that continued group or individual treatment in music therapy was warranted, a recommendation to the center and to the parents/guardians of the client-participants was made.

The following chapter will describe the clinical story and outcomes of the research study.

CHAPTER FOUR

THE CLINICAL STORY

Introduction

As described in detail in Chapter 2, the music therapy process of this group was based on music-centered psychotherapy. The research clinicians, Carly and Chad (pseudonyms), aimed to access, work through, and resolve therapeutic issues through active and receptive group musical experiences. Words were used in song lyrics and also in nonmusical interventions, to guide, interpret, and enhance the music experience and its relevance to the clients and therapeutic process. Thus, through a music-centered perspective, music was not only fundamental to facilitate relationships but became one of the key agents of change. The music helped create a cohesive, free, and healthy group where everyone was able to experience safety and strength for creativity and growth.

A timeline of the research (see Appendix B) presents the main events of the process. Ten main songs/themes were produced (see Appendix C) during the 16-session process of the group. During analysis, it was noticed that each song captured an important essence, not only of a specific moment in the session, but also: (a) providing empowering support for the therapists to keep moving towards their therapeutic goals; (b) providing empowering support for the clients; (c) as a metaphor and a way to understand the dynamic and the goals being addressed; and, (d) as an indication of new intervention possibilities.

The main goal of the utilized music therapy approach, which focused on the therapeutic relationship and mutual music making, was to provide musical experiences that relate to and engage with a client's inherent musicality. This can also be called the process of relationship in music therapy. When clients allow this creative connection to happen, it indicates a feeling of safety and confidence in their musical processes. They

indicate that they are available for the musical-therapeutic relationship to unfold while expressing their willingness to explore themselves in a different way.

As reviewed in Chapter 2, in this music therapy approach, musicality is understood as an innate human ability (Zuckerkandl, 1973). The music therapist stimulates and facilitates the engagement of people through their musicality and creativity. Through those musical abilities, potentials for better health may emerge and clients achieve a different perspective about themselves. Clients may gain awareness of their inner strengths, challenges, and potential for well-being.

> Musicality is not the property of individuals but an essential attribute of the human species. The implication is not that some men are musical while others are not (…). Man is a being predisposed to music and in need of music, a being that for its full realization must express itself in tones and owes it to itself and to the world to produce music. (Zuckerkandl, 1973, p. 8)

The music therapists entered the music therapy process with the firm belief that the six individuals were about to initiate their creative and transformative music therapeutic process, despite the limitations imposed by their pathologies. The philosophy maintained that these participants had inner musicality and potential that could be intra and inter-personally developed for growth.

It is also expected that, through *musicing*, music will emerge. Musicing, which is a verb defined as 'playing music,' is a particular form of intentional human action, consisting of activities that order and strengthen the self (Elliot as cited in Aigen, 2005a, p. 65). According to Aigen (2005), it supports a music-centered notion of clinical practice where the musical experience is a legitimate clinical goal. Some music may not be considered significant while other music may have a strong impact on clients and

therapists. Those more powerful musical themes will be referred to as 'clinical themes' (Brandalise, 2012b). The researcher had his first contact with the term in 1997, during his internship at the Nordoff-Robbins Center at New York University (NYU). Although there was no published definition of the term 'clinical theme,' the exploration and understanding of it came into fruition after discussions the researcher had with Drs. Kenneth Aigen, Alan Turry, and Clive Robbins. A 'clinical theme' is a particular recurring musical idea that has become or is becoming prominent in the session-to-session flow of a course of therapy because:

(1) it provides the client and therapist with a particular mode of co-activity that results in significant developments;

(2) it is of particular importance to the client and provides him/her with a clinically significant source of security in the therapy process;

(3) it carries important associations for the client which may help resolve a clinical impasse and;

(4) the client identifies positively with the content and/or purpose of the co-activity that the theme supports.

This chapter will detail the clinical story of the research process. Important interpersonal and intrapersonal dynamics, as well as other behaviors, musical themes, and general observations were noted, discussed, and included in the presentation of findings below.

Group Stage One: Induction

Meeting the Participants

The process started on March 7th, 2014. The group was comprised of six people with autism spectrum disorder (ASD), four boys and two girls: Donald and Louie (8

years old), Sonia (9 years old), Joshua (10 years old), Valeria (12 years old), and Gustavo (14 years old). In order to ensure confidentiality of all participants, pseudonyms were used. Only Joshua and Louie had participated in music therapy before, when they were much younger. None of the participants in the study presented with the ability to verbally communicate.

Carly and Chad were the therapist-participants in the research. Carly's main instrument is the voice and Chad's main instrument is the keyboard. Both are experienced clinicians who work with people with ASD. Chad has 16 years of experience and Carly has eight years of experience. In models where therapists work as a team such as in Nordoff-Robbins music therapy, one therapist is responsible for the music and the other therapist supports the musical direction, and, in a group context, leads group activities. In the present study, the therapists' roles varied according to the participants' needs. For example, if participants needed an intervention supported by the piano, Chad took the role of the primary therapist and was responsible for the supportive music. However, if Chad was required to manage the group in a particular moment, such as by verbally establishing leadership and managing behavior, Carly played the music. If vocal improvisation was the desired intervention, Carly led the improvisation while Chad facilitated the participants' engagement in the therapeutic and creative experience.

Session 1: Moments of Chaos, Moments of Balance, and Response to it Through the Composition of the First Clinical Theme

Before the first session started, Carly and Chad set up the music therapy room so that the clients sat in a semi-circle format with three clients on each of two benches in front of both therapists. Therapists offered a variety of instruments such as guitar, keyboard, Brazilian tambourine, bongo, ripinique (medium size Brazilian drum), afoxé

(type of Brazilian shaker), drum sticks, and clavas (small percussive instruments). The figure below illustrates the way Carly and Chad organized the room, indicating clients' benches, researcher and therapists' positions.

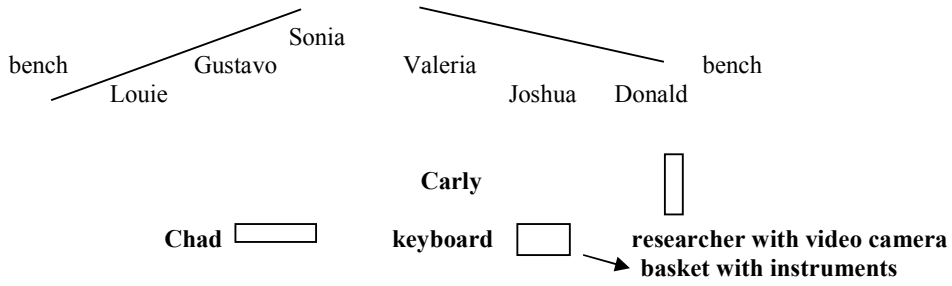

Figure 2. Room Organization

In the first session, participants started entering the music therapy room and Chad prematurely closed the door, accidentally leaving two clients outside the room. Therefore, at the start of the session, there were two clients in the semi-circle, two outside the semi-circle, and two outside the room. This action, coming from a therapist who was supposed to be focused on engagement and inclusion as two fundamental therapeutic goals, brought up a new question: can therapists be responsible for actions of exclusion? This observation and question will be discussed in more depth.

The initial dynamic of the room was chaotic and tense. Donald was not able to wait to play the guitar. Louie was running around the room without any purpose and trying to hit Sonia, who was reacting with fear. The therapists were trying to verbally establish leadership and group norms by alternating silence and physical contact. The challenge was to deal with a chaotic dynamic while also having to define each of their roles in the here-and-now of the session. It was not pre-established that Chad would be the one in charge of instilling leadership and norms. Thus, the initial dynamic among the therapists was confusing and also added to the chaotic group dynamic because guidance was not clear.

Approximately five minutes into the session, the therapists responded to the chaos through musical improvisation. Chad led the first improvisation using a song in a 4/4 meter and established a strong beat. Through this strong first beat, Chad was providing leadership and structure. The first clear response came from Sonia who demonstrated a happy facial expression. Louie responded by interacting physically with the therapist. The entire group started demonstrating more organization and calm during this improvisational experience. However, approximately five minutes into the improvisation, the dynamic reverted to a more chaotic atmosphere. Valeria, Donald, and Louie were not connected with therapists and peers. Group interactions remained poor for several minutes. The therapists eventually helped clients to reestablish internal organization, but Donald and Valeria started walking around the room demonstrating lack of interpersonal connection and meaning through their actions.

Then, Donald took his sneakers off. Carly intervened by helping him to put them back on, but Chad said: "Vamos sentar" (we will sit down). At this point, it was clear that Chad was the one in charge of giving structure in the group dynamic. The room became silent and group organization was back. From this silence, a strong rhythmical pattern emerged (see Figure 3). Carly perceived it coming from Gustavo, who was producing it with his feet, and called Chad's attention.

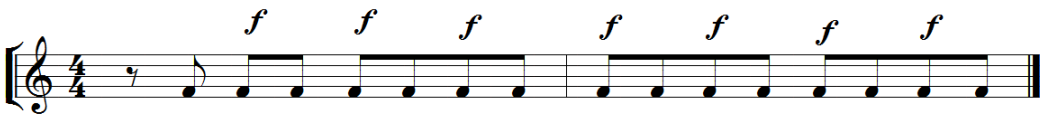

Figure 3. Gustavo's Rhythmic Pattern in Session 1

Almost 20 minutes into the session, a descending major second was sung by Gustavo. Carly responded by repeating it. The therapists then initiated an intervention using the produced rhythmical pattern and interval, creating a strong sense of

connection in the group for the first time. The chaos was gradually being transformed through music making. Figure 4 shows the interval produced by Gustavo.

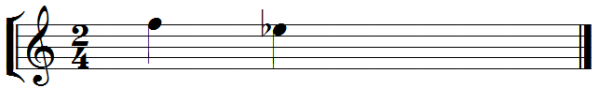

Figure 4. Gustavo's Interval in Session 1

Chad played a blues in the key of Ab having Ab/Db/Ab/Eb-Db/Ab/Eb as the harmonic progression. Valeria smiled, looking at him. At that point, Chad was paying more attention to Valeria, Carly, Louie, Sonia, and Donald. Gustavo and Joshua were left alone. The group was broken into these three subgroups. Exclusion actions were again presented in the dynamic (i.e., clients were left outside the room; Gustavo and Joshua were not assisted as mentioned above) and will be discussed in depth in the following section.

Louie was able to interact with Chad through his body. When Valeria left the semi circle again, Carly asked her to sit down and said, "Aqui na música, tu tens que te sentar" (here in the music you have to sit down). Chad was trying to establish norms through a rigid manner, which Carly reinforced. Chad was playing the keyboard (his primary instrument) and Carly was stimulating contact with the clients by offering them the tambourine. Through the lyrics, therapists improvised: "Here in the music you have to sit down." Therapists were clearly trying to establish the norms and leadership through the rigid norm of "you have to sit down."

The group became chaotic again, with participants standing up and walking around the room without any purpose. Then, Chad said to Carly: "Eu assumo" (I get this). He was focused and energetic, reinforcing his leadership. Carly moved to the keyboard and Chad went to the guitar, positioning himself in front of the clients. The

therapists added more volume to the improvisation and their voices were also firm. The loud volume and the firm vocal attacks were two components that gave guidance and organization to the chaos. Improvisation, then, became the first clinical theme (CT) of the session (see Figure 5).

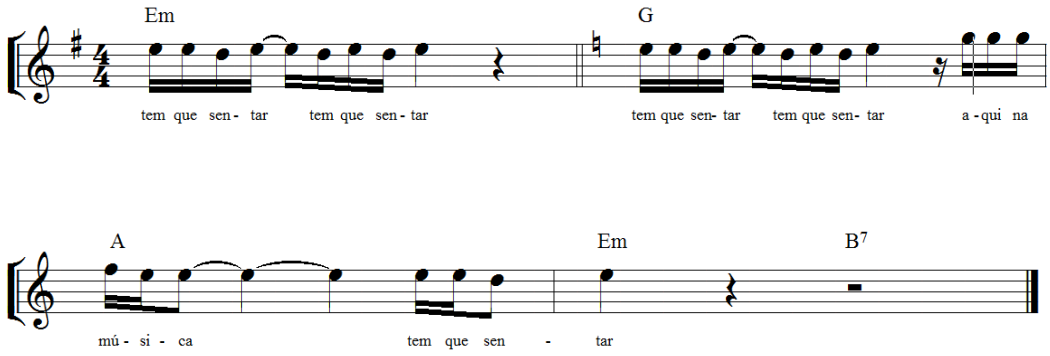

Figure 5. Song 1: Tem Que se Sentar (You have to sit down)

Although the song "Tem que se sentar" (You have to sit down) contains musical pauses, they are not significant in terms of giving spaces for participants to respond. Instead, the rests are a part of the composition, which has characteristics of a march. The way the structure of the theme was built allowed the therapists to musically intervene with strong vocals and rhythm. The song was built to sound rigid in order to reinforce the intervention of asking clients to sit down when chaotic moments emerged. The harmonic progression was circular and predictable: Em/G/A/Em/B7. Through interacting with this song, Sonia and Louie smiled and the group returned to a more organized dynamic. This first clinical theme was not only a result of therapeutic intervention directed to meet the clients' needs but, interestingly, appeared to be more in response to the therapists' needs of establishing leadership and norms in order to minimize chaos in the group.

Session 2: Therapeutic Rigidity versus Flexibility

Before the second session started, Carly and Chad planned how to initiate it. They had watched the video from the first session and agreed that the music that had a positive impact on the group was "Tem que se sentar" (You have to sit down). Thus, they decided to play the song right in the beginning of the session. The therapists did not remember the exact melody they sang, but remembered instead it as shown in Figure 6.

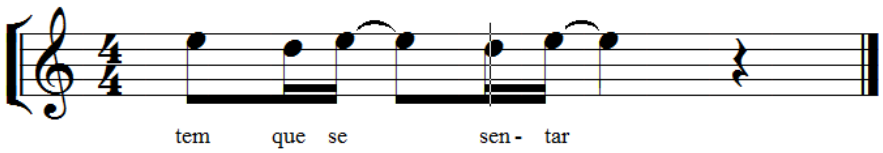

Figure 6. Song 1 as Remembered in Session 2

According to Carly's memory, this remembered clinical theme had more flexibility than the original. It contained more swing rhythms, presenting two syncopations in the main phrase. The first tone had a longer duration and the two following semiquavers offered more of a dance mood to the music. Carly started bringing the possibility of greater flexibility to the co-leadership dynamic.

This first important song was created in Session 1 and was planned to be used again in Session 2 as a representation of establishing group norms and leadership. It was strongly played to reinforce the *tempi forte*, the semiquavers did not offer any pause/space, and the lyrics stated what the therapists were imposing, which was that clients "tem que se sentar" (have to sit down).

Within the first few minutes of the session, before the music started, Louie was running in the group and exhibiting aggressive behaviors towards other group members.

He tried to hit Gustavo in a more violent way. Carly intervened saying that that behavior was not accepted in the group. She offered Louie the tambourine, proposing a different focus for his energetic need. He played it with a closed hand punching the instrument strongly.

Music was slowly reintroduced in the session. Chad played the bongo and, with Carly, he started singing the song "Tem que se sentar" (You have to sit down) as they remembered and planned. Louie continued to demonstrate aggression, trying to hit Chad. In response, Chad grabbed the guitar and started improvising a rock'n roll song in the key of G. Carly improvised, singing the name of the clients and describing their clothes (i.e., their socks, shoes, shirts, hats, etc.). Louie, Gustavo, and Sonia demonstrated interest in the improvisation. They looked at Chad with the guitar and smiled. Carly was vocally improvising and the group was calm and responsive. When the harmonic progression reached the tonic, Chad initiated the vocal improvisation and Carly stopped singing.

When Chad finished the rock-n-roll song, he said "aeee" (indicating closing). Gustavo, from the other side of the semi circle, clapped his hands and vocalized a similar sound. Louie and Gustavo then touched hands. That was an indication of potential for communication, already visible in Session 2. The therapists told the clients that they had to sit down. The group demonstrated calm and organization. Chad responded, "muito bom, pessoal. Muito bom" (very good, folks. Very good).

The therapists were working to establish trust, confidence, norms, and leadership. At this point the group was enormously unpredictable. The responses were characterized by moments of balance and moments of disorganization, consequently making the therapists intervene at times with more rigidity and at other times with more flexibility.

About 20 minutes into the session, Chad started a new improvisation with the guitar. The music Chad improvised had a consistent pulse, with a firm *tempo* in 4/4 meter. Carly joined Chad's improvisation with a shaker and voice. Chad raised the guitar volume and both therapists sang "Eu tô aqui com o Joshua bem sentado aqui na música" (I'm here with Joshua who is seated in the music). The second clinical theme was created: Eu tô aqui (I am here; see Figure 7).

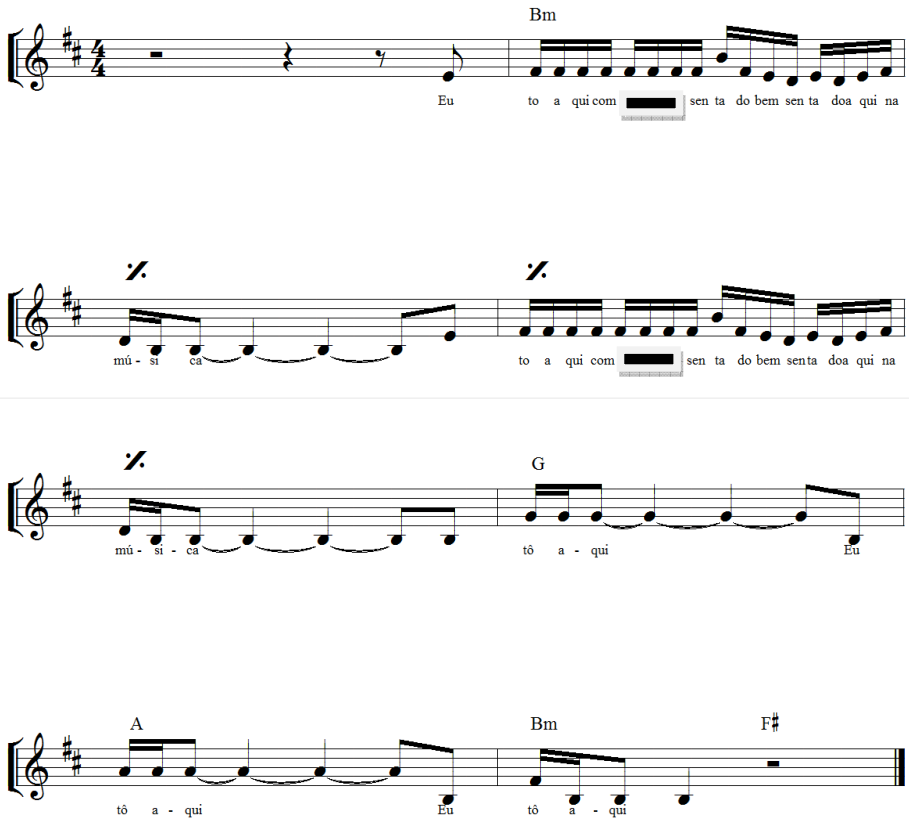

Figure 7. Song 2: Eu Tô Aqui (I am here)**.** The black tag on the score covers where the name of the client was sung.

One of the most important characteristics of this composition was the fact that it was composed in a reggae style. Musically, the second song contrasted to the first one and the musicing translates what participants (therapists and clients) were experiencing: moments of rigid structure and moments of flexible structure. In other words, 'You have

to sit down' and 'I am here' translated the dilemma of rigidness versus freedom that therapists and clients were facing. In addition, the main content of each song, created by the therapists, is meaningful. Song 1 verbally expresses an order which comes from the therapists to the clients (You have to sit down). Song 2, on the other hand, expresses availability (I am here).

The natural accompaniment for this reggae song had a semi quaver pause proposed by Chad. The two first measures of the song are in Figure 8.

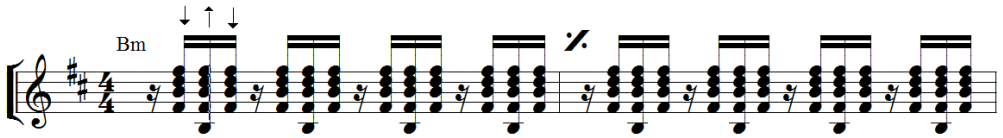

Figure 8. First Two Measures of Song 2

The pause proposed a relief in the *tempo* of each measure, offering more lightness to the composition. This relief proposed an accompaniment with more swing than the creative atmosphere that had been offered through the use of the previous theme "Tem que se sentar" (You have to sit down).

Approximately half an hour into the session the group was experiencing a more flexible atmosphere, which led Chad to dance for the first time while playing the guitar with the clients. The session was more joyful. For the first time, Joshua was motivated to go to the instrument basket, grab a tambourine and come back to his seat to play. Clear norms were now providing guidance to the clients, facilitating meaning for their actions. It appeared as though the therapists and the clients were having fun together. The group was more organized and became more responsive while interacting with the new composition. The group seemed to be more relaxed and consequently more spontaneous. Everybody was enjoying the music. Chad said to Carly: "vai no swing" (Swing it), which led to music that was more flexible and joyful.

As the music continued, Gustavo looked at Chad and sang a melodic interval three times. Chad imitated it, while Carly went to the keyboard, listened to what they were singing and offered harmonic support to it. The therapists were still facing the challenge of an inconsistent group dynamic, but their roles seemed to be clear and they were listening to each other in a connected way.

A bit of disorganization occurred when Valeria took one of her shoes off and tried to take her socks off, as well. Chad did not allow it and had trouble trying to put her sneakers back on, having to ask Carly to stop the music saying "Carly, wait a second. I have to put the sneakers back." In doing that, he reinforced a norm to the group: "quando colocarmos o tênis a música volta. Estão entendendo? (when we put back the sneakers, music returns. Are you understanding?). While Chad was dealing with Valeria's sneakers, Carly asked anyone who stood up to return to his/her place.

When the music resumed, it continued to have characteristics of joy and swing. Chad danced and invited people to play the tambourine. Valeria played the tambourine, as well. There was energy invested in the instruments and in the group. The group started to demonstrate some elements of cohesion. Before the session ended, the group moved back to a more chaotic atmosphere, which demonstrated that cohesion was still very fragile.

Session 3: Trying to Find Balance Between Rigidity and Flexibility

After watching the video of Session 2, Carly and Chad decided that the reggae song "Eu tô aqui" (I am here) was the strongest song created thus far. They planned to utilize it in the third session. The session started off chaotically, as only Sonia and Joshua were seated at its start. Donald, Valeria, Louie and Gustavo were agitated and walking around the room. While physically managing the clients, Chad and Carly whistled the theme of "Eu tô aqui" (I am here) to the group. Gustavo started singing the

interval E-D-E-D-E-D. Carly called Chad's attention to it, but he kept playing the first theme in Bm, demonstrating a lack of therapeutic listening in that moment.

Carly was experiencing a hard time trying to physically manage Donald. She asked Chad for help and expressed frustration. Chad, then, was firm to Donald saying: "vamos sentar!" (we gotta sit down). Carly appeared stressed and frustrated. She then proposed the first song, "Tem que se sentar," making the group re-experience the norm of remaining seated. Louie and Donald still resisted but the group seemed calmer and more organized.

The group members exhibited aggressive behavior in this session. Donald was frustrated and tried to hit Sonia, and Louie tried to hit Carly. Chad and Carly were physically and verbally firm with them and managed the situation. A chaotic dynamic emerged when Louie lay on the floor and Valeria stood in the middle of the room. Finally, Chad invited Donald to use his hands in a meaningful way by playing guitar. Chad was offering context and meaning for the musical experience with Donald.

The therapists were experiencing frustration by having to alternately deal with moments of chaos and balance in the group. Approximately 15 minutes into the session, Carly forcefully interrupted the music and said "Meu Deus!" (Oh, my God). The therapists then re-created the first song, "Tem que se sentar" (you have to sit down), trying to reestablish organization. Carly tried to interact with Valeria but she refused contact. After the song, in a moment of silence, Valeria, produced a vocal sound that was like a controlled scream. Carly proposed to build a theme based on this scream, which was produced in the key of D (see Figure 9). The therapists initiated an improvisation, and the group was seated and attentive.

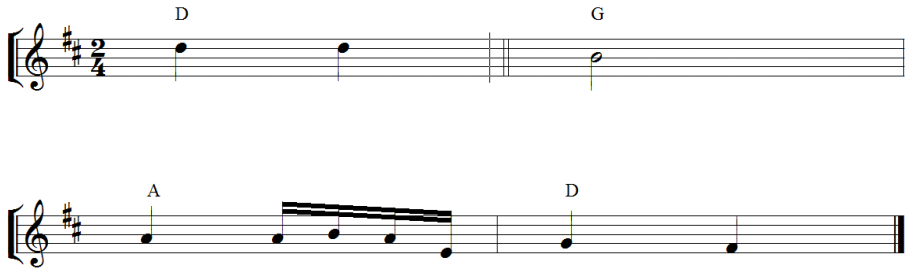

Figure 9. Song 3: Valeria's Scream in D

Chad asked Carly to finish the melody in Bm instead of D. This demonstrated that the music and music therapists were working together. Chad decided to finish the song using the minor relative chord instead of the root chord of the original key. In doing this intervention, he tried to stimulate a continuation of the song instead of offering a closing theme. The new song, based on Valeria's scream in D, started taking form. The song was smooth and rhythmically predictable, providing grounding and safety to the dynamic. The group was calm, attentive, and organized.

The group had an important moment of cohesion. Valeria seemed to be singing and vocally playing with Chad and Carly. Chad suggested that Carly vocally interact with Valeria. He stopped the song and gave them space to play together, facilitating their contact. Then, Chad proposed the end of the song using "agora gurizada, vamos se sentar" (now folks, let's sit down), once again reestablishing the norm.

At the end of the session, Valeria's body expression reverted back to chaos. She demonstrated aggressive behavior by trying to kick Sonia. Chad intervened by asking her to stop and decided to sit in between them. Valeria finally calmed down by stretching.

First Team Meeting

After Session 3 the research team had its first meeting. In these meetings, as mentioned in the method section, the role of the researcher was to be a consultant,

which meant not directing therapists' opinions but influencing them and being influenced by them, as well. According to the proposed method, the therapists started each meeting.

In the first of these meetings, the main theme seemed to be the therapists dealing with initial dynamic of chaos and balance. Chad said:

> This research group reminded me of the first groups I used to run in the beginning of my career. I felt like a soccer player who is now used to playing in great conditions and is no longer used to playing in adverse environments. I was a little bit tense seeing myself back in this hostile environment.

Carly had a similar feeling. She said:

> My first feeling in the beginning was wow, how disorganized this group is. What chaos! This chaos made me anxious. I agree with Chad that until halfway through the sessions, everything we had created did not cause any significant impact, and we focused much more on issues related to behavior management.

This is a meaningful quote because it expresses the therapists' internal conflict of wanting to be as available as possible to each of the clients and having to face what Chad called "hostile environment," full of disorganization and chaos. At this point, reflections on the importance and support of the musicing and music production started.

Chad talked about CT 2 and the addition of more flexibility in the dynamic.

> I noticed that our partnership got more integrated after 20 minutes of session time…At a certain point I started dancing. When I noticed myself dancing I realized that I was less nervous and more comfortable in the group. At that point, melodies with personalities started to be created.

> Then, the group started to establish contact with us, and it felt more organized.

Carly said:

> The second session…much better. Much better. We are more organized. I think the organization of the second session started earlier because we thought about the music which caused a more significant impact. So, it gave a good support to the group. Then, the song "EU TÔ AQUI (I am here) has emerged. This was the moment where everybody was OK.

Chad described music as a partner, however, brought up the fact that some of the musicing did not help what he called "melody with personality" to emerge, such as a meaningful clinical theme. Chad attributed this fact to what he metaphorically described as the therapeutic pair acting as "scary soccer players," who were facing adversities. The conflict was apparent.

The researcher-consultant offered the following reflections in the team meeting: 1) the therapists were too rigid in how they established norms at times; and, 2) the therapists appeared frustrated when interventions constantly failed. When they experienced rigidity and frustration, two behaviors seemed to occur: 1) they could not perceive/think about other therapeutic options; and, 2) they could have experienced a feeling of wanting to give up and unknowingly excluded group members. When a person with ASD experiences exclusion, he/she can have his/her symptoms reinforced, creating a vicious autistic cycle. This may mirror their home experiences, as the clients in the study may have experienced exclusion within their families due to not being able to satisfy their parents' expectations.

Therefore, some questions were raised in the meeting by the researcher to the clinical team: (1) do they experience the dynamics mentioned above? (2) Could norms

and leadership be possible with less rigidity? (3) Would the therapists have other options in terms of organizing the music therapy room? (4) Would they have other ways to physically position themselves in order to facilitate the establishment of norms and leadership? Chad and Carly agreed that they were experiencing rigidness and started reflecting on other possibilities of intervention which could allow structure for the group and creative freedom.

Session 4: The Room is Transformed and there is a Call for Spontaneity

Carly reorganized the music therapy room according to what was discussed in the team meeting (Picture 1, Appendix F). The benches were organized close to the wall. The therapists were seated to physically block the rest of the room to help minimize the potential for distractions.

Before the session started, Carly said to Chad, "espontaneidade" (spontaneity). This quality seemed to be what clinicians started looking for in order to respond to Chad's aim of decreasing his rigidity. The session started by playing the second song "Eu tô aqui" (I am here), Valeria started dancing in front of the keyboard. Louie played the tambourine with Carly, producing a rhythmic cell that was strong and constant. Chad responded to it through the use of the guitar. There was more flexibility in the group dynamic.

Then, Louie and Valeria started demonstrating aggressive behaviors. Louie punched Carly, and Valeria tried to hit Sonia. Chad decided to recreate the song "Tem que se sentar" (You have to sit down), using the guitar and establishing a more firm rhythmic pattern for the new improvisation. Carly went to the keyboard and offered support for the recreation. In recreating the song, Chad started to rap the clients' names. Carly supported it rhythmically through the keyboard. They improvised lyrics, "se sentar aqui no banco, se sentar" (sitting on the bench, sitting here). The therapists were

now using a song that served as a representation of the initial rigidity, however they were verbally improvising in a fluent and free way that was in accordance with the rap style. There was rigidity and freedom side by side in this intervention. The musical intervention diffused the aggression. Chad, Carly and Valeria interacted musically and physically. The rap was intense and Louie played the guitar with Chad. The recreated song demonstrated the possibilities for both: freedom and structure. The therapists were achieving more openness and creative spontaneity.

Entering Group Stage Two: Experimental Engagement

Session 5. Cohesion is the Turning Point

The therapists discussed how to initiate Session 5 before inviting the clients into the room. Chad proposed starting with the lyrics and harmony, extracted from the reggae song "Eu tô aqui" (I am here), but offering grounding without using the semi quaver pause in the beginning of the measure. Although the group started off in a disorganized fashion, the group became more organized after about 10 minutes. The clients were seated, except for Louie who was playing the guitar with Chad. The clients were also able to sit in silence after the music ended.

For the next musical intervention, Chad proposed a rap song. The clients appeared engaged and more interpersonally connected. Sonia looked at Carly and smiled during the improvisation. Louie stood up and interacted with Carly by clapping his hands and smiling. Gustavo, Donald, and Valeria played the tambourine with Carly and looked at her. Louie stood up and stopped in front of Chad and the guitar and excitedly looked at him. Again, once the music ended, the group was able to sit calmly in silence.

The next song emerged from Donald singing the tone of G. Carly responded by harmonizing his tone. He stood up, looked at Chad, and danced as if he was running.

Chad imitated him and they danced together. The therapists started improvising and a new significant song emerged (see Figure 10).

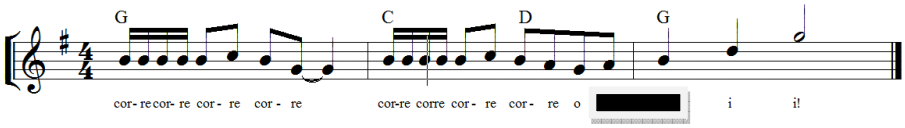

Figure 10. Song 4: Corre, Corre, Corre (Run, Run, Run)**.** The black tag on the score covers where the name of the client was sung.

The therapists alternated the names of the clients in the song. They also alternated the word "run" for "dance," pointing out that Donald was dancing. Chad danced in front of each client singing the song while Carly was supporting him on the keyboard. The clients interacted with the therapists, and exhibited behaviors like touching them and smiling. To end the song, Chad changed the lyrics to "já correu, já dançou e agora senta aqui" (you've ran, you've danced. Then, it was time to sit back), re-establishing the organization and instruction for clients to be seated on the benches.

When Chad asked Valeria, "que tu qué?" (what do you want?), Carly went to the keyboard and started a rhythmical improvisation with the words "que tu qué" (what do you want?). A new important clinical theme was created (see Figure 11).

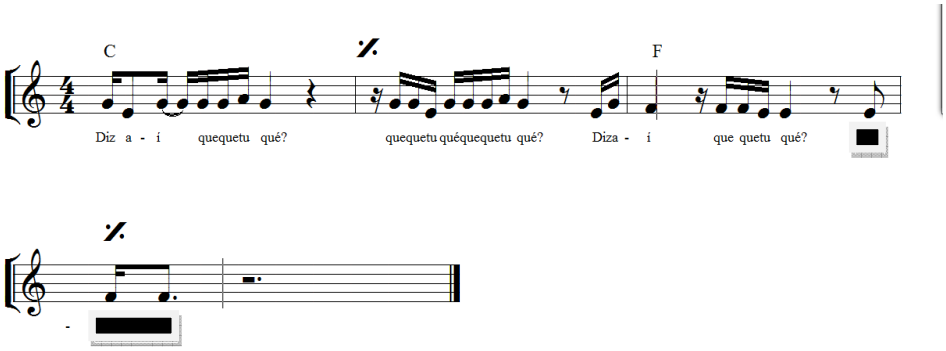

Figure 11. Song 5: Que que tu qué? (What do you want?)**.** The black tag on the score covers where the name of the client was sung.

Chad remarked that Session 5 was start of cohesion, ending the "bad introductory phase" of the group that took place. Musically speaking, until Session 3, therapists and group members were experiencing the dilemma of rigidity versus flexibility through the use of 'Tem que se sentar' and 'I am here.' Then, 'Tem que se sentar' started being modified, through the recreation of it in the form of reggae and then in the form of rap, becoming a more flexible song and becoming what Chad called 'the bridge' pointing to more flexible possibilities for which the group was ready.

Session 6. The Room was Rearranged and the Song "Que que tu qué" (What do you want?) is Re-created

Carly thought that the room could start offering more possibilities of space for clients to explore, so she rearranged the room once again. Through these actions, Carly was establishing her role as a leader who observes not only individual and group aspects but also takes care of material and room organization.

At the start of the group, everybody was seated and physically attentive to the music. There was significant participation in music, and clients looked at the therapists and smiled. Carly started playing the Brazilian tambourine, Sonia joined her, Valeria

danced, and Donald played the tambourine. Everybody seemed calm, seated and attentive. There was clearly more cohesiveness in the group.

Chad proposed the recreation of "Que que tu qué?" (What do you want?; see Figure 12). During the recreation, Chad proposed a bass line with the guitar while Carly was offering support through the use of the keyboard. The clients and therapists danced together in response to the song. Sonia sang, looked at Chad, and smiled. Chad proposed an interaction with the guitar and she accepted it, putting her hand on the instrument.

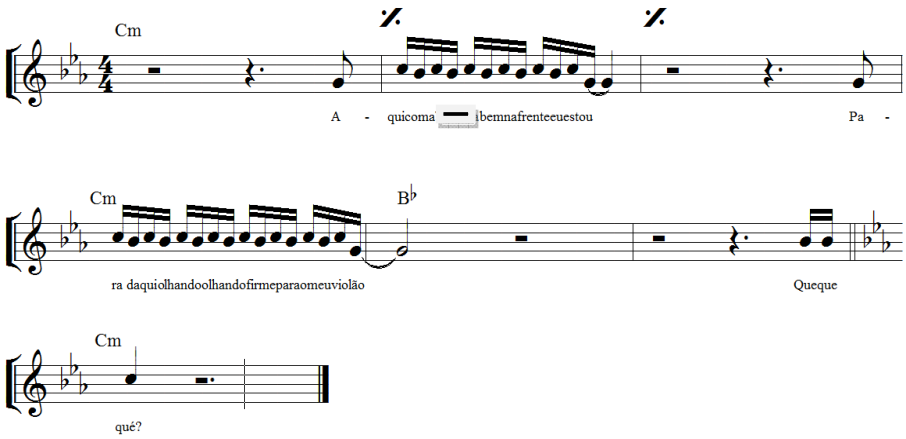

Figure 12. Song 6: recreation of Que que tu qué? (What do you want?)**.** The black tag on the score covers where the name of the client was sung.

When Valeria became aggressive towards herself and peers, Chad intervened by proposing the recreation of 'Tem que se sentar' (you have to sit down). He recreated the song in a more flexible way, though, with more swing and rapped the song. The group was again organized and attentive, until Valeria hit another client, again. Valeria's behaviors were requiring more attention from the therapists and the researcher, and this became one of the main topics of the second team meeting.

Team Meeting 2: Cohesiveness, Integration and Joy

In the second team meeting, after Session 6, one of the topics brought up by the researcher-consultant was aggressive behavior. It was observed that the main clinical themes had been created after 20 minutes into the sessions (see Appendix C), yielding the hypothesis that although improvisation was present in the group, the clients could be experiencing the music in a more receptive way instead of stimulating the therapists for mutual production. The consultant raised the possibility that the aggressive outbursts were being caused by this dynamic, and proposed that the clients take on a more active role in the music making. The therapists agreed that interventions proposing a more physical activity could help decrease aggressiveness.

In the meeting Carly and Chad brought up feelings of being more comfortable and more creatively spontaneous in the process. They used terms such as fluency, spontaneity, freedom, and patience.

Carly expressed:

> In Session 4, I felt our co-leadership to be less rigid. We could be more free. The session flow became better. More spontaneous… I felt the group much more organized and I felt myself less tired.

Chad said:

> In Session 4, my first comments were "lightness" and "dance," and "patience." There was a division…I was rapping and you [Carly] started singing back-up vocals based on what Valeria and Sonia were doing…and we were in the same music. Beautiful to see it. We were together physically and musically.

Both therapists were feeling safer in relation to each other, to the group and to the process itself. As a result of the therapists feeling more confident, comfortable, and cohesive in the group, joy became more present.

Session 7: The Group Became More Active

Before Session 7, the room was reorganized once again. Instead of benches, chairs were used in order to make individual places for people to chose and sit in the room (see Figure 2 in Appendix F). There were two situations that were presented to the group that could have generated stress and disorganization at the start of Session 7: there was loud construction noise from a neighboring building, and a client who was not a member of the group heard the music and ran into the room. However, the group was not disturbed by those events. This was meaningful information about the group because these intrusions could have made the group feel unsafe and unprotected. Cohesion could have been affected. Instead, the group remained calm in both situations, demonstrating safety and control.

Chad started the session by playing 'Eu tô aqui' (I am here). The clients had a positive response to the song. Louie and Valeria interacted with Chad by playing instruments, dancing, and establishing meaningful eye contact. The group was more spread out in the room, which allowed the clients to have freedom to both have their own space and make contact with others. There was more freedom in the music, as well: Louie played the tambourine with Carly, and Sonia joined them. Joshua took the tambourine from Carly's hands and started playing it. Chad offered the guitar to Donald who started playing it with the stick. Valeria danced, and Donald and Gustavo played the tambourine with Carly. When the song 'Eu tô aqui' (I am here) was played, the group was organized. At the end of the music, the group looked calm and relaxed. Sonia

stretched. There was only one moment following the music when Valeria demonstrated aggressive behavior.

After the song, a new musical theme emerged when Louie sang the interval A#-G#. Carly went to the keyboard and started supporting it. Chad added a beat (see Figure 13). This rhythmic pattern is called a "chamada" (drum call) in Brazil.

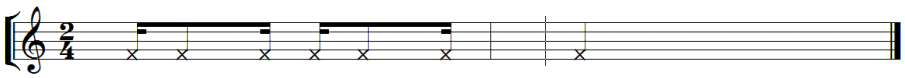

Figure 13. Chad's Beat in Session 7

The clients made a circle in front of the keyboard and Chad. The music was rhythmically and melodically strong. Some clients were seated and some were standing in front of the therapists while singing and playing. For example, Louie played the tambourine with Carly. There was a sense of freedom in the music. When the music ended and therapists started the good- bye song, everybody was close to the keyboard. The session was ending with everybody close to each other, demonstrating greater intimacy in the session.

Notably, Valeria was only aggressive once during the session, and Louie was not aggressive at all. An initial observation was that Louie's and Valeria's aggressive behaviors could have been one of the possible reactions caused by not being active enough in the sessions. In this session, where they were more active, their aggressive behavior decreased.

Session 8: Autonomy Begins to Occur

Session 8 showed the participants demonstrating more autonomy. The song 'Eu tô aqui' (I am here) started the session. The clients played the tambourine, smiled, and danced with the therapists. The group seemed relaxed. After the music ended, the group

was immersed in a long pause. It could have caused tension and disorganization, but the group held the silence nicely.

When Chad started the song 'Tem que se sentar' (you have to sit down) with the guitar, Valeria became physically aggressive. She kicked Carly who responded by asking her, "tu queres atenção, não é?" (you want attention, don't you?). The therapist, then, danced with Valeria. The therapists recreated the lyrics to mirror Valeria's activities: "podemos pular, podemos dançar, podemos tocar, podemos caminhar mas, daí, a gente tem que se sentar" (we can jump, we can dance, we can play, we can walk around but, then, we have to sit down). Carly and Chad were focusing on making the musical experiences more active and meaningful to the clients because that seemed to help them be more interpersonally connected and less aggressive.

During the Good-bye song to end the session, Chad asked participants to sit down and remained between them and the keyboard. He ended the session a few minutes early and without an opportunity for the group to play together the good bye song, later stating it was because he was tired.

Entering Group Stage Three: Cohesive Engagement

Session 9: More Communication and Contact

During the beginning of Session 9, Louie played the tambourine and looked at Chad. There was significant eye contact between Louie and Chad, demonstrating increased communication and contact. When Louie and Donald started running around the room, Carly and Chad started supporting it. Carly ran with the clients, and Chad improvised the song 'Corre, corre, corre, corre' (run, run, run, run). Carly invited other clients to join in, like Gustavo, who walked with her around the room.

The clients were increasingly playing the instruments and interacting with the therapists. Louie played the guitar and the tambourine, and Chad danced with him and

Donald. Sonia played the tambourine with Carly. Then, Chad's melody was sung back by Louie, demonstrating an even greater level of communication. Sonia communicated to Carly through her hands and vocal sounds. Chad then asked Sonia to play the keyboard with him, which she did before the music and session ended.

The working stage had started. Trust and accommodation had been reached and more productive activities had taken place. Besides, more collaboration as described previously, started to happen. The requirements for this stage to initiate had been accomplished: a) time; b) stable setting to help members to feel safe; c) an atmosphere in the group that was conducive to individual self-expression; and, d) a democratic rather than authoritarian leadership to prevent dependency and destructive coalitions.

Session 10: Regression to Isolation and Rigidity

At the start of Session 10, Donald tried to force Carly's arm down. In response, Carly firmly asked him and Louie to sit down. The clients were all seated, but when the music started again, they stood up. Valeria danced and Sonia went to pick up an instrument in the basket. Carly said "no," exhibiting rigidity and asking clients to remain seated without reason. She was clearly frustrated with the clients' behaviors, such as how Donald grabbed her and did not want to sit down. She asked Chad for help, and he kneeled down and asked Donald to remain seated with the group.

Chad then proposed a new style: Reggaeton. Its rhythmical pattern is in Figure 14:

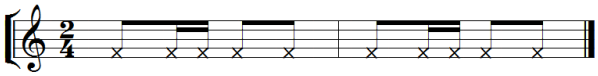

Figure 14. Chad's Reggaeton in Session 10

Carly started creating lyrics and offering the bongo to clients. Sonia, Louie, Donald, Gustavo, and Joshua all played it with her. After the music ended, Chad and Donald had an intimate, quiet moment where they communicated with each other using their hands and fingers.

At the end of the session, Sonia spontaneously hugged Carly's neck and gave her a good-bye kiss. This interpersonal connection with Sonia was more intimate than previous examples.

Later, in the fourth team meeting Chad shared his more negative feelings about Session 10:

> I went to the keyboard and became very self-centered, wanting to invest a lot in the music… I can be too concentrated only on the music that is being produced. I saw you [referring to Carly] running all over the place. I think the group may have felt our, our fragility.

Session 11: A New Clinical Theme and Relational Work Emerge

At the beginning of Session 11, Chad started improvising and created a theme called 'A galera aqui curtindo esta canção' (Everybody is enjoying this song). Carly joined him. They sang *a cappella*. Valeria started shaking her body toward Chad, who went to the keyboard. Carly joined Chad using the guitar. While Chad supported the song and the group with the keyboard, Carly got closer to each client adding their names in the song and inviting them to play the guitar. In response, Donald played the guitar and Valeria danced. Joshua also played the guitar and Chad added his voice to the song. The music became more intense. This song "A galera curtindo uma canção" (Everybody is enjoying this song) was a new clinical theme (see Figure 15).

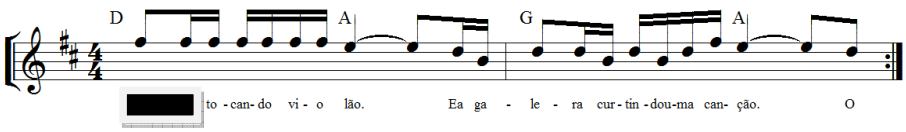

Figure 15. Song 7: A galera curtindo esta canção (Everybody is enjoying this song). The black tag on the score covers where the name of the client was sung.

The group was calm and organized in the music. The therapists were playing and Valeria was dancing. Louie came to Carly and played the guitar with her. Carly invited Sonia to play the guitar and she did, as well. Louie, Valeria, and Gustavo played it with her, too. As the music became louder, Joshua came to Chad's side on the keyboard. During the music, the group members were not seated but were exploring possibilities in an organized way.

When the clients were spread out in the room, there was greater interaction between the clients and therapists, but no interaction among the clients. Session 11 was demonstrating the development of intra-relationships between the clients as they became more active, free, spontaneous, satisfied, and less aggressive. However, this interpersonal connection was limited to clients and therapists.

When Donald ran to Carly and started pulling her smoothly, she started running in the room to a rhythmical pattern. Chad, on the keyboard, recapitulated the music "Corre, corre, corre" (Run, run, run). By doing this, Chad demonstrated a quick ability to listen to the context of the game Donald and Carly had started and helped to contextualize it based on the sounds of Carly's heels on the floor.

Session 12: Parents are Present in Session

Before Session 12 started, Carly and Chad arranged the room in order for the parents to sit near their kids. Chad started the session by singing hello with the song "A galera vai curtindo essa canção" (Everybody is enjoying this song; see Figure 16).

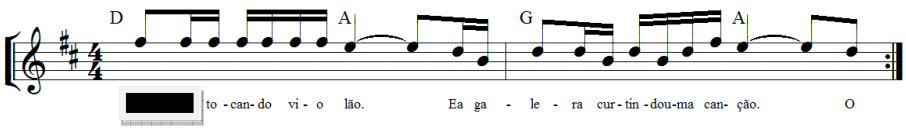

Figure 16. Recapitulation of "A galera vai curtindo esta canção." The black tag on the score covers where the name of the client was sung..

The parents were asked to wait in the waiting room until the session was started. In the beginning of the session, Valeria danced in front of the keyboard. Louie was in front of Chad who was playing the keyboard. Louie and Chad made eye contact at the keyboard. Louie sat down on Chad's side, picked up the tambourine, and brought it to play with Chad in front of the keyboard. These first descriptions about Valeria and Louie are important because both clients started Session 12 demonstrating an interest in interacting with Carly and Chad. In terms of both clients' aggressive behaviors, the turning point occurred in Session 7 when Carly and Chad started intervening, aiming to stimulate all clients to become more active in the musicing. This helped Louie to not behave aggressively and helped Valeria to reduce this behavior to only once in the session, as opposed to Session 6 when she was aggressive seven times. In other words, Valeria and Louie learned that they could play with Carly and Chad as an alternative to interacting aggressively.

While Valeria and Louie were interacting with the music and with the therapists, Carly left the room to call the parents. All the parents were present, but Gustavo's parents were late. Carly told the parents that they were free to participate however they wanted, such as playing instruments or dancing. Interactions between the parents and clients were immediately visible. Joshua was closer to his mom, and, Sonia held her mom's face and gave her a kiss. Gustavo, Joshua, Sonia, and Donald all remained close to their parents throughout the session.

However, Valeria and Louie had difficulty connecting with their parents. When Valeria's mother entered the room she was chewing gum. She got closer to her daughter and kissed her but sat down when Valeria started dancing in front of her. She did not appear to be motivated to sing and did not seem to be connecting with her daughter. She remained physically distant from Valeria for the duration of the session. In addition, Louie's father opened his arms to hug Louie, who did not return the gesture. He walked in front of his father to instead play the tambourine with Carly. Louie held Carly's hand to play the tambourine. Louie's father was playing the bongo while looking at his son, who was instead closer to Chad and Carly. When Louie walked closer to his dad, he invited Louie to join playing the bongo. Louie ignored the invitation. However, once Chad made the song more rhythmical and energetic, Louie played the bongo with his father for a few moments.

When the music ended, everybody applauded. Louie's dad smiled and invited his son to sit by his side, but Louie refused. His father was clearly frustrated. It seemed difficult for Louie and his father to connect. Carly and Chad asked Louie to sit with his father, but Louie rejected it and returned to be closer to Chad on the keyboard. Together with the rejection towards his father, Louie was demonstrating the strong bond he had established with Chad. When the music started again, all the clients were seated next to their parents except for Louie and Valeria. Valeria and her mother continued to be physically distant, and when Carly sang close to them, Valeria's mother continued to chew gum and remain seated. Valeria was dancing but her mother did not seem interested in connecting. When Carly went to sing with Louie and his father, Valeria pushed her, exhibiting an aggressive behavior that is of note. However, although Louie was ignoring his father for the most part, he did briefly play the tambourine that his

father was playing. When his father tried to hold Louie's hand, Louie sharply pulled his arm away.

At the end of the music, Chad instructed the parents to sit with their children. Everybody was seated in silence, until Louie went to the keyboard and started playing. Chad grabbed the guitar and joined him. Carly joined Louie on the keyboard, as well. Then, Louie went closer to his father and put his hand on his father's mouth. The therapists improvised based on Louie's rhythmical pattern, creating a new musical theme. The other clients participated by playing instruments and dancing. Louie continued to mostly ignore his father, but allowed him to help remove his pullover.

Chad danced with Valeria while her mother remained seated. Carly sang that Louie and his father were playing by her side. From this, a strong theme developed, singing "Com o pai e com a mãe" (with dad and with mom) (see Figure 17).

Figure 17. Song 8: Com o pai e com a mãe (with mom and dad)

Carly held the harmony in the keyboard and Chad played percussion using the guitar's wood. Louie sat behind his father. Then, his father turned to Louie and he did not reject him this time. When the music ended, everybody applauded.

Carly invited everybody to get together near the keyboard to finish the session together. There was meaningful eye contact between Louie and his father. Finally, Louie came and played in the tambourine his father was holding. When the session ended, everybody applauded.

Session 13: Therapists' Agreed to the Decisions Made in the Team Meeting

Parents were not invited to attend Session 13. The music began when Carly, while playing the guitar, said to Chad: "let's play a waltz." She started improvising. Chad changed the keyboard's timbre to accordion, which is typical in the arrangement of this "country style" in Southern Brazil. The therapists tried to use a 3/4 meter. This may have been because the researcher-consultant had mentioned during team meeting that seven out of the eight most important improvised songs had been built in a 4/4 meter. That observation may have created some kind of idea that the therapists should try breaking this pattern.

However, it seemed that what the therapists were trying was not connecting with the clients. The therapists later expressed frustration and Chad blamed the researcher by complaining about the session duration.

Session 14: Parents are Present Again

Session 14 was the second session with parents. The team considered Session 12, with parents, to be significant for assessment and intervention. From that session, the team perceived that group music therapy could help Louie's and Valeria's parents in their connection with their respective children.

Chad welcomed the clients by playing the song "Com o pai e com a mãe" (with mom and dad), which had been the clinical theme created in Session 12 (see Figure 17). The therapists prepared the clients by singing the phrase, "daqui a pouco vão chegar o pai e a mãe" (in a bit we'll have mom and dad with us). Louie played on Chad's keyboard and sat on Chad's side. The keyboard area, with Chad, seemed to be the gravitational center of the relationship between Chad and Louie.

When the parents entered, Louie surprisingly allowed his father to kiss him and touched him in return. Louie got closer to his father and played on the instrument that

his father had chosen. In this session, Louie and his father were able to share an instrument and an improvisational music experience. Louie held the tambourine while his father played it. Louie did not run. Throughout the session, Louie was sporadically physically distant from his father, but he was generally more receptive to his father's invitations for interaction by playing instruments together.

Valeria moved her body and smiled towards her mother, who was asked not to chew gum during the session. Later in the session, Valeria's mother kissed her. The therapists allowed the parents to sing to their children, and when the music ended, everybody clapped.

To start the next musical theme, Louie's father spontaneously played a rhythmic call on the Brazilian tambourine, but the therapists did not support this. Instead, Chad asked who wanted to start playing music. Joshua started playing a rhythm with the shaker and Chad supported this rhythm for the group. Everybody joined him. Louie ran to Valeria's mother and kissed her. The group was musically together and the music was rhythmic, loud, and energetic. Louie danced, totally in sync with the improvisation's rhythm, close to the keyboard. He played with his father. Valeria's mother played with her.

When the music ended, Louie ran towards Sonia and her mother. He grabbed a tambourine and, perhaps accidentally, hit Sonia with the instrument. Louie's father called to him. It was unclear whether this was an act of aggressive behavior. However, Louie gradually became increasingly emotionally dysregulated. He started playing the keyboard strongly and out of rhythm, then he made a tambourine spin loudly on the floor. His father intervened by grabbing the instrument. Louie then went to Valeria's mother and hit her strongly. The therapists and Louie's father immediately intervened. Louie then hit himself. His father held him and he started crying, but his father was

frustrated, stating, “Chega” (enough). Louie sat down on the bench between Chad and his father, but continued to cry and then hit the bench.

When Chad started the good-bye song, Valeria’s mother was playing with her daughter, and Louie tearfully received a hug from his father.

Session 15: The Last Session with Parents

Session 15 was the last session where parents were invited. In the beginning of the session, Louie was agitated. He hit the keys of the keyboard and made a vocal sound indicating discomfort. Chad invited him to sit on his side. When the parents entered the room, Louie touched and looked at his father.

The parents were more involved in the session. Joshua’s father came for the first time, and Valeria’s mother interacted with Sonia’s mother. Louie was physically closer to his father, as he was seated between him and Chad. But when Carly invited Valeria to get closer to her mother, Valeria instead moved to the other side of the room. The therapist allowed her to do that, then went closer to her mother and started singing that she was close to her. Valeria started moving her body closer to them and smiled. Carly then sang with Joshua and his father, and invited Louie and his father to play an instrument together.

Joshua’s father, who had previously been resistant to his son’s diagnosis and treatment, picked up the guitar and learned the key of the improvisation. He then played together with the therapists. A previously defensive and resistant father was now integrating himself and his music with his child, his child’s peers, and other parents. Carly invited Joshua’s father to start an improvisation for the group. He started by playing a typical style from Southern Brazil, “rancheira.” Chad started supporting him on the keyboard, and Carly vocally joined them. The other parents smiled and joined in the music with percussive instruments.

Carly went around, adding other member's names in the lyrics of the new song. The clients and their parents were dancing and interacting with each other. Then, Louie became angry and tried to hit his father and Chad. In response, the therapists lowered the volume of the improvisation. When the music ended, the group applauded Joshua's father and thanked him. The group had offered a significant space to this father who could be more open to his son and others.

During the good-bye song, Louie and Valeria both became agitated but responded positively to the holding and containment provided by their respective parents.

Entering Group Stage Four: Disengagement

Session 16. Final Session and New Themes Emerged

At the beginning of Session 16, which was the final session, Louie played the tambourine in a solid tempo. Chad and Carly started supporting it through improvisation, and a new theme emerged (see Figure 18).

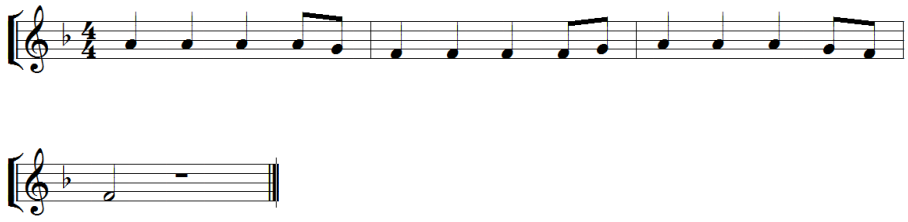

Figure 18. Song 9: Louie veio pra música (Louie came to music).

Louie ran around Carly, and they played and danced together. Louie, then, played the tambourine with Chad. The tempo was in sync. Sonia played the tambourine with Carly, making a significant eye contact, and then played the keyboard with Chad. Donald started running and Carly supported it by doing the same.

The last clinical theme that was developed was “Dança” (Dance) (see Figure 19).

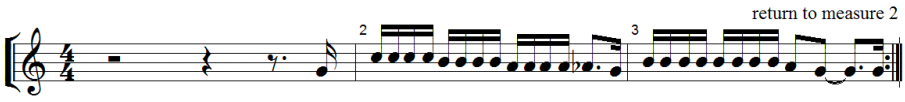

Figure 19. Song 10: Dança (dance)

Carly danced with Valeria and Donald, and invited Joshua to play with her. Chad opened space in the song for dialogue through a call and response. The pauses, in Figure 20, indicated where clients were invited to respond.

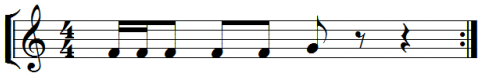

Figure 20. Pauses in the song ‘Dança’

Valeria was in the center of the group, dancing. Donald started doing percussion on the window with a strong and firm beat. Carly and Chad started improvising based on this rhythm. Louie joined them by playing the keyboard and Chad helped him to adjust on Donald’s tempo. Chad also played with Joshua on the keyboard. Everybody was musically playing together, stopping and restarting musical improvisations in a cohesive, interactive manner. At the end of the session, Louie went to the keyboard, where Carly was playing with Joshua, and joined in. Joshua played strong percussion on the keyboard, and was supported by Carly. To end the session, the therapists invited the clients to join them closer to the keyboard, where they terminated the group together.

Last Team Meeting

In the last team meeting Chad reflected about the last session that he knew their clients and was able to balance his levels of expectations. Regarding the last session, he said:

> I would say it was a day of therapeutic maturity. People were not responding a lot…but we were completely available, attentive. I would say that nothing happened without our perception this time. We 'gave voice' to everything that happened in the session.

Chad's expression of "giving voice" to the therapeutic incidents in the last session may be considered a good representation of the therapists' efforts to facilitate clients to achieve meaning through their expressions throughout the process. Through therapeutic interventions, Chad and Carly offered context and possibilities for clients to relate, communicate, and play.

Chapters 5 and 6 will discuss the observed phenomena related to the two research questions regarding intra and inter-relationships, as well as the advantages and challenges of the research design itself.

CHAPTER FIVE

THE INTRA- AND INTER-RELATIONSHIPS

Introduction

The findings related to the research questions of this study will be presented in the following two chapters. Chapter 5 is the start of the analytic section, where the first research question is answered. Chapter 6 presents reflections on the second research question. The two research questions and their sub-questions are presented below:

1) What is the nature of the clinical process of a music psychotherapy group utilizing a music-centered approach with clients with ASD?

Sub-Question 1: What elements characterize the intrapersonal and interpersonal dynamics of the group?

Sub-Question 2: How do the clients engage with and utilize the music in the intrapersonal and interpersonal dimensions?

2) How effective is Smeijsters and Storm's (1996) research design in studying a music psychotherapy group with clients with ASD?

Sub-question 1: How useful is the design in understanding the process of therapy?

Sub-question 2: How useful is the design as a research method? What challenges and advantages emerged?

For the purpose of this study, interpersonal and intrapersonal achievements are defined as follows:

Intrapersonal Achievements

Intrapersonal achievements are defined as relating to group members' personal development and growth through the group process (e.g., interest/curiosity, regulation, initiative, sense of self, ability to operate symbolization).

Interpersonal Achievements

Interpersonal achievements are the abilities that group members can develop in order to interact physically, verbally and/or musically with each other (e.g., relationship, communication, ability to establish two-way communication).

The Nature of the Clinical Process for Client-Participants

Donald and Louie (8 years old), Sonia (9 years old), Joshua (10 years old), Valeria (12 years old), and Gustavo (14 years old) were the client-participants of the study. They engaged in three different types of diverse inter-personal relationships throughout the study: (a) Clients in relation to therapists; (b) Clients in relation to clients; and, (c) Clients in relation to parents. These dynamics are related to the five insights that will be discussed in Chapter 7 in more details: (1) the music therapy room has therapeutic plasticity; (2) Therapists have expectations, they experience frustration and they frustrate: They can promote isolating autistic cycles; (3) Everybody can include and everybody can exclude; (4) The dilemma of rigidness versus flexibility; and, (5) The importance of integrating parents into clients' developmental processes and a reflection about symptoms.

The participants have engaged in intra- and inter-relationships along the research process. The observed relational phenomena of each group member were discussed based on the nine developmental stages proposed by Greenspan and Wieder (2006).

Developmental Stages of Healthy Children

The three main areas of deficit in a person with ASD are related to relationship, communication, and thinking (Greenspan & Wieder, 2006). According to the authors, there are nine developmental stages that healthy children must achieve that can also be applied to the understanding of a child with ASD. They are: (1) Regulation and interests

in the world; (2) Engaging and relating; (3) Intentionality and two-way communication; (4) Social problem-solving, mood regulation, and formation of a sense of self; (5) Creating symbols and using words and ideas; (6) Emotional Thinking, Logic, and a sense of reality; (7) Multicausal and triangular thinking; (8) Gray-area, emotionally differentiated thinking; and, (9) A growing sense of self and reflection on an internal standard.

Stage 1: Regulation and interests in the world. This developmental level relates to an ability to find interest and initiative in, look, listen, and pay attention to the outside world (Greenspan & Wieder, 2006). Caregivers facilitate this process through touch, a soothing voice, and smiling. The development of intelligence is influenced by the way babies interact with the world, perceive it, and find patterns, such as knowing the difference between a mother's and father's voice. If early sensations are unpleasant, babies tune out the outside world.

Stage 2: Engaging and relating. Through nurturing, babies become more invested and interested in certain people, being able very early to distinguish primary caregivers from others (Greenspan & Wieder, 2006). When the caregiver becomes a special person to the baby, bringing joy, interactions improve and a new level of intelligence is reached. Babies can very early start deciphering patterns in the caregiver's voice and facial expressions that reflect the caregiver's feelings and intentions. Thus begins the development of the capacity to recognize patterns and organize perceptions into meaningful categories. The child needs to develop the desire to be involved in a relationship.

Stage 3: Intentionality and two-way communication. Babies begin transforming emotions into signals for communication (Greenspan & Wieder, 2006).

For this to happen, caregivers need to read and respond to babies' signals and challenge the babies to read and respond to theirs. Through these exchanges, babies begin to engage in back-and-forth emotional signaling, or two-way communication. For example, a baby smiles at his mother; he gets a smile back, so he smiles again. This is called a 'circle of communication.' The baby's smile becomes purposeful.

Stage 4: Social problem-solving, mood regulation, and formation of a sense of self. Babies make momentous strides between nine and eighteen months. In this stage, they use two-way communication to solve problems (Greenspan & Wieder, 2006). They learn to point to the swing to show they want a ride. The mother responds to a baby's gesture, closing the 'circle of communication.' During this stage, social problem solving emerges. Later, this leads to putting words together in a sentence, and to scientific thinking and math.

Stage 5: Creating symbols and using words and ideas To understand and use words and language, children must first be able to engage in complex emotional signaling, which allows them to separate actions from perceptions and hold images in their minds (Greenspan & Wieder, 2006)**.** They must able to connect these images with their emotions to give them meaning, thereby forming symbols and ideas. Thus, language ability arises, because images acquire meaning through emotionally relevant experiences and exchanges.

Stage 6: Emotional thinking, logic, and a sense of reality. At about two and a half years of age, children show an increasing ability to connect symbols together logically, yielding more logical thinking and reflecting (Greenspan & Wieder, 2006). By logically linking ideas together, the child can help explain emotions and organize knowledge of the world.

Stage 7: Multicausal and triangular thinking. From simple casual thinking, children progress to recognizing multiple causes (Greenspan & Wieder, 2006). For example, if a friend does not want to play, the child can think ”maybe he wants to play with someone else today.” Grasping multicausality enables a child to engage in “triangular thinking.” For this to happen, children must invest emotions in more than one possibility.

Stage 8: Gray-area, emotionally differentiated thinking. Multicasual and triangular thinking enable children to understand the varying degrees or relative influence of feelings, events, or phenomena (i.e., “I’m only a little mad;” Greenspan & Wieder, 2006).

Stage 9: A growing sense of self and reflection on an internal standard. By puberty and early adolescence, more complex emotional interactions help children progress to an internal standard and a growing sense of self (Greenspan & Wieder, 2006). Children can now judge experience. For example, children can say for the first time: “ I was angrier than usual.” Children at this age learn how to make inferences and to think in more than one frame at the same time. They create new ideas from the existing ones.

The Intra and Interpersonal Dynamics of the Group Members

Intra-relationship Development

In terms of intra-relationship, data analysis demonstrated that all the client-participants could only operate according to Greenspan and Wieder’s (2006) first developmental stage. They could demonstrate interest and initiative (see Tables 2 to 7). In terms of inter-relationships, they presented characteristics of Greenspan and Wieder’s (2006) second developmental stage, being able to engage and to establish relationships (see Table 2).

Tables 2, 3, 4, 5, 6, and 7 describe examples of the way each client operated in each session in terms of intra and inter-relationships. The tables present each client-participant with clinical examples of how and when they demonstrated interest, initiative, and regulation, which are characteristics of Greenspan and Wieder's (2006) first developmental stage. In addition, the tables demonstrate how and when they showed abilities to engage and to establish relationships, which are characteristics of Greenspan and Wieder's (2006) second developmental stage. The analysis of these clinical data is presented and discussed in detail in this chapter (see Tables 8 to 20).

Sonia

Clinically speaking, Sonia consistently demonstrated the ability to be regulated and open for relationship with the therapists. It was after the group entered its second stage (experimental engagement) that she began to use instruments. In Session 9 she had the initiative to kiss Carly and she did the same with her mom in Session 12 (see Table 2).

Table 2

Sonia's Examples of Intra- and Inter-relationships.

Sessions	Intra-relationships and inter-relationships with parents (interests, regulation, initiative)	Inter-relationships w/ therapists (engagement, relationship)	Inter-relationships w/ peers (engagement, relationship)
Session 1		Happy facial expression with music.	Fear related to Louie.
Session 2		Eye contact with Chad.	

Session 5	Looks calm.	Looks at Carly and smiled.	Enters the room and closes the door, leaving four members outside.
Session 6		Plays the tambourine with Carly; plays the guitar with Chad; sings with Chad and smiles at him.	
Session 7			Joins Carly and Louie playing the tambourine.
Session 8	Initiative to play the tambourine.	Smiles at Chad.	
Session 9	Looks at Chad when he is tensioning music; communicates with Carly through hands and vocal sounds; presses the keyboard's keys, and kisses Carly when the music ends.	Plays the tambourine with Carly.	
Session 10	Goes to the basket and picks up an instrument; plays the instrument.	Dances with Carly; kisses Carly.	
Session 11		Plays the guitar with Carly; interacts with a music game with Chad.	
Session 12	Comes closer to mom, holds her mom's face and kisses her; gets closer to his parents, dances.		

Session 14	Plays the tambourine with her mother.		
Session 15	Plays the tambourine with her mother.		Plays the tambourine that Louie was holding.
Session 16		Plays the tambourine with Carly; plays the keyboard with Chad.	

Donald

Donald initiated his process in an agitated way (e.g., taking his sneakers off, not sitting down). Like Sonia, it was after the group entered its second stage eExperimental engagement) that his involvement with instruments started. In Session 16 he had the initiative to start playing a beat on the window, controlling his strength (see Table 3).

Table 3

Donald's Examples of Intra- and Inter-relationships.

Sessions	Intra-relationships and inter-relationships with parents (interests, regulation, initiative)	Inter-relationships w/ therapists (engagement, relationship)	Inter-relationships w/ peers (engagement, relationship)
Session 1	Takes his sneakers off.		
Session 2	Stereotyped body movement; takes his sneakers off for two times.		Touches hands with Gustavo.

Session 3	Stereotyped walking.	Eye contact with Carly; interacts with Chad with music.	
Session 5	Tries to take his sneakers off for two times; stretches, sings the tone G.	Plays the tambourine with Carly; looks and Chad and dances; smiles at Chad.	
Session 6	Plays the tambourine; dances.	Dances with Chad.	
Session 7		Plays the guitar with Chad.	Plays the tambourine with Gustavo and Carly; pulls Gustavo for interaction.
Session 8		Goes to Chad's side; plays the tambourine with Carly.	
Session 9	Looks at Chad when he was tensioning music.		Dances with Chad and Louie.
Session 10		Physically interacts with Carly; plays with Chad using hands.	
Session 11	Plays the guitar.	Runs toward Carly and pulls her.	
Session 12	Gets closer to his parents.		
Session 16	Has the initiative to start percussion using the window and controlling strength; plays on his chair, pulls the couch to center of the room.		Dances with Carly and Valeria.

Gustavo

It took Gustavo four sessions to make closer contact with Carly (Session 4). Interestingly, in Sessions 1, 2 and 3 he produced various sounds (e.g., rhythmical sounds with his feet, melodic intervals singing). In Sessions 5, 7, 9, and 11 he demonstrated a clear connection with Carly, playing various instruments with her. He was open to interacting with his parents in Sessions 12, 13, and 15. In Session 15 he positioned his body in front of the music therapy room's door, waiting for his parents to enter (see Table 4).

Table 4

Gustavo's Examples of Intra- and Inter-relationships.

Sessions	Intra-relationships and inter-relationships with parents (interests, regulation, initiative)	Inter-relationships w/ therapists (engagement, relationship)	Inter-relationships w/ peers (engagement, relationship)
Session 1	Makes rhythm w/ his feet; sings a descendent major second.		
Session 2	Sings a melodic interval.	Eye contact w/ Chad.	
Session 3	Stereotyped walking; sings a melodic interval.		
Session 5		Plays with Carly and looks at her.	
Session 7		Walks in the room with Carly.	

Session 9		Plays the bongo with Carly.	
Session 10			Plays the tambourine with Donald and Carly.
Session 11		Plays the guitar with Carly.	
Session 12	Gets closer to his parents.		
Session 14	Came with his father to the instrument basket.		
Session 15	Waits for his parents looking at the door.		

Joshua

Joshua was the first group member who had the initiative to go to the instrument basket to pick up an instrument (Session 2). He also used his body, proposing the opening of cycles of communication with Carly (Sessions 5 and 7). In Session 11 he had the initiative to come closer to Chad at the keyboard. This was the exact same gesture he made in his parents' presence in Sessions 12, 13, and 15. In Session 12 he came closer to his parents and initiated a dance and, in Session 15, he waited for his parents to enter at the door of the music therapy room (see Table 5).

Table 5

Joshua's Examples of Intra- and Inter-relationships.

Sessions	Intra-relationships and inter-relationships with parents (interests, regulation, initiative)	Inter-relationships w/ therapists (engagement, relationship)	Inter-relationships w/ peers (engagement, relationship)
Session 2	Initiative to pick up an instrument.		
Session 5		Raises his hand to Chad interacting with the music.	
Session 7		Plays the tambourine with Carly; raises his hand towards Chad.	
Session 10		Plays the bongo with Carly.	
Session 11	Plays the guitar; comes to Chad's side on the keyboard.		
Session 12	Comes closer to mom Sylvia; gets closer to his parents, dances.		
Session 14	Starts a song.		
Session 15	Waits for his parents looking at the door.		
Session 16		Plays the keyboard with Chad.	

Valeria

Valeria started her process by demonstrating a clear conflict between a desire to become closer to the therapists and being resistant to that closeness. In Session 1 there was a significant smile directed to Chad. In Sessions 2 and 3 she acted out with several stereotyped movements such as talking her sneakers off, being aggressive with a peer (Sonia), and refusing contact however, sang with Chad and Carly. From Session 4 until Session 6 there was a significant increase of aggression directed towards herself, peers, and therapists, which led to discussions in team meetings on the best way to intervene. In Session 12, in the presence of her mom, she kept distance during the entire session. However, in Session 14, again in her mom's presence, she allowed her mom to hug and kiss her (see Table 6).

Table 6

Valeria's Examples of Intra- and Inter-relationships.

Sessions	Intra-relationships and inter-relationships with parents (interests, regulation, initiative)	Inter-relationships w/ therapists (engagement, relationship)	Inter-relationships w/ peers (engagement, relationship)
Session 1		Smiles at Chad (w/ music).	
Session 2	Takes her sneakers off.		
Session 3	Stereotyped walking; refuses contact with Carly; sings in D; stretches.	Sings with Chad and Carly.	Tries to kick Sonia.

Session 4		Tries to hit Carly; physically interacted with Carly w/music.	
Session 5		Looks at Chad; screams with control and directs her hand towards Chad's guitar.	Hits Joshua.
Session 6		Dances with Chad.	Aggressive with peers for 7 times.
Session 7	Dances.	Tries to kick Carly.	
Session 8	Dances.	Rejects contact with Carly;	
Session 9	Initiative to make percussion on a wooden decoration element.	Kicks Carly.	
Session 10	Dances.	Dances towards Chad, plays the guitar with Carly.	
Session 11	Sings.		
Session 12	Dance; always distant from her mom.		
Session 14	Smiles at her mom; allowed her mother to kiss her; plays with her mother.		
Session 16			Dances with Carly and Donald.

Louie

Similar to Valeria, Louie alternated between a potential for contact and aggressive behavior directed towards the therapists and peers. In the beginning of his process, he used his body for interactive contact (e.g., getting closer to the instrument a therapist was playing, smiling at a therapist) or for aggression (e.g., tried to hit Sonia and Gustavo and the therapists). He demonstrated ambivalence when his father came to session. In Session 12 he rejected his father's initiative to touch him six different times but gradually accepted his father's touch three times. He could get even closer in Sessions 14 and 15, allowing his father to kiss him, exchanging instruments with his father, and, at certain moment, initiating touch with his father (see Table 7).

Table 7

Louie's Examples of Intra- and Inter-relationships.

Sessions	Intra-relationships and inter-relationships with parents (interests, regulation, initiative)	Inter-relationships w/ therapists (engagement, relationship)	Inter-relationships w/ peers (engagement, relationship)
Session 1	Stereotyped run.	Body interaction (w/ music); smiles at Chad (w/ music).	Tries to hit Sonia.
Session 2	Stereotyped run.	Plays the tambourine with Carly; tries to hit Chad; tries to hit Carly.	Touched hands with Gustavo but tries to hit him as well.
Session 3	Stereotyped walking.		
Session 4		Plays the guitar with Chad.	

Session 5		Plays the guitar with Chad; eye contact with Chad; interacted with Carly; plays the tambourine with Carly.	
Session 7	Initiative to pick up a drum stick and play the tambourine; sings the interval A# - G#.	Plays the tambourine, the guitar, and establishes eye contact with Chad; plays the tambourine with Carly; dances with Chad.	
Session 8		Plays the tambourine with Carly.	
Session 9	Sits near the keyboard; sings back a melody which was sung by Chad; looks at Chad when he was tensioning music.	Plays the tambourine with Chad; plays the guitar with Chad using a drum stick; plays the tambourine with Carly.	Dances with Chad and Donald.
Session 10		Plays the bongo with Carly.	
Session 11	Goes to the instrument basket and picks up a tambourine.	Plays the guitar with Carly.	
Session 12	Picks up a tambourine; rejects the father's contact 6 times; gets closer to him 3 times; gets closer to dad and puts his hand on his mouth; goes to Chad's side; plays the piano.	Sits on Chad's side.	

Session 14	The father could kiss him; Louie touches his father; Louie played the instrument his father had chosen; Louie accepted the shaker his father gave him; dances; cries; father grabs him.	Sits on Chad's side.	Hits Sonia with the tambourine; hits Valeria's mother.
Session 15	Hits the keys of the keyboard strongly; touches his father; plays with his father; complains vocally.	Tries to hit Chad.	
Session 16	Plays the tambourine; goes to the instrument basket.	Runs around Carly; plays and dances with Carly; plays the tambourine with Chad; looked for Carly to play with her.	

Intrapersonal Development

Client-participants demonstrated intra-personal development (see Tables 8 through 13). Each client developed interests, initiative, and regulation, which mirror Greenspan and Wieder's (2006) first developmental level. These developments were analyzed and categorized in terms of stages in the group therapeutic process, as explained in Chapter 2: induction, experimental engagement, cohesive engagement, and disengagement.

Sonia. Sonia demonstrated that she was self-regulated even when the group had no clear guidance in Sessions 1 to 3. She could remain calm, curious and establish eye contact with the therapists. In terms of demonstrating interests, she was the first group

member who started moving from her seat to the instrument basket and, once she got familiar with this dynamic, she started spending more time exploring the instrument basket trying out the instruments before choosing them. She was also the first member who directed a smile to one of the therapists in Session 2 (see Table 8).

Table 8

Sonia's Development in Terms of Interests, Initiative and Regulation

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
Sonia was relaxed and curious, happy facial expressions, and eye contact with the therapists. Demonstrated fear related to Louie. No other contact with peers.	She developed curiosity and interest to action from session 6.	Became more musically active in in session 9. She went towards the therapists' instrument (keyboard) and plays it.	No meaningful actions and/or feelings were identified during the disengagement stage.

Donald. Donald was able to develop from an initial state of confusion and aggression to initiating a solid rhythm in the group dynamic. It was not possible to recognize Donald's ability to establish an intentional two-way communication through his gestures. He made a clear transformation from the lack of mood regulation to a strong musical engagement, starting in Session 6, dancing and playing the tambourine. During the cohesive engagement group stage he was able to look for the therapists and

participated of some mutual music playing. However, he did not establish dialogue. In Session 16 he demonstrated a strong initiative to use his body to play on the window in a controlled manner, opening a significant circle of communication for the group to join and improvise (see Table 9).

Table 9

Donald's Development in Terms of Interests, Initiative and Regulation

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
Confused. No mood regulation, presenting stereotyped and aggressive behaviors.	Confusion and stereotyped gestures started to be transformed in session 6: Donald played the tambourine and danced.	Became more musically active in in session 11. He went towards the therapists' instrument (guitar) and played it.	Presented the initiative to play a solid and firm rhythmic pattern in the room's window which became a significant group improvisation.

Gustavo. Gustavo was very musically active in the first three sessions, which comprised the first group stage of induction where individuals are likely confused and looking for guidance and leadership. Therefore, it was inferred that his musicality was being used as a way for him to feel safer and protected because it is coherent with the way he tended to use his body (i.e., stereotyped walking) until Session 4. It seemed that the vocal sounds he was producing were not being used for contact purposes but as a way to regulate his mood in a stage where chaos was being experienced.

In Session 5, Gustavo started to demonstrate interest in the instruments and began to engage with them. During the stage of coherent engagement (from Session 9 to 15), he then started using the instruments for contact with the therapists (see Table 10).

Table 10

Gustavo's Development in Terms of Interests, Initiative and Regulation

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
He was musically active in this stage producing sounds with his body (i.e., rhythm with his feet, melodic intervals through singing). Presented stereotyped walking.	Started to be more musically active in session 5.	Could use the instruments in a more interactive way with the therapists and parents.	No meaningful actions/and or feelings were identified during the disengagement stage.

Joshua. Joshua was self-regulated and able to remain calm during the Induction group stage. That allowed him to stay focused, express his curiosity, and explore instruments. This initiative and self-regulation also led him to expand his explorations and look for contact with the therapists. He did not have any contact with peers, though. He had established significant trust at the point of group stage of cohesive engagement, being able to initiate a song in Session 14 (see Table 11).

Table 11

Joshua's Development in Terms of Interests, Initiative and Regulation

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
His interest was directed to the instruments but in a non communicative way.	Became more musically active, starting in session 5, and his initiative was directed towards contact with the therapists.	Much more communicative being able to start an improvisation in session 14.	No meaningful actions and/or feelings were identified during the disengagement stage.

Valeria. In the beginning of the process Valeria alternated moments of stereotyped movements and aggression with moments of curiosity and potential for engaging with others. Valeria demonstrated a clear psychodynamic in her process: The more related she became with the therapists (starting in Session 5), the more possibilities there were for being increasingly active in the group. Then, once the therapists were able to engage her in more of active experiences (i.e., playing the tambourine and dancing), her aggressive behavior decreased. In Session 7, it was possible to associate more musical and physical engagement with less aggressive behaviors towards the therapists and peers. In the presence of her mother she alternated moments of being calm and engaged with being distant. However, she did not reject being closer to her mom in several instances (see Table 12).

Table 12

Valeria's Development in Terms of Interests, Initiative and Regulation

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
Confused. No mood regulation, presenting stereotyped and aggressive behaviors. However, interests towards the therapists.	Mood regulation improved: Became more interactive with the therapists and less aggressive. However, mood regulation was unstable.	She could sing in session 11. Stayed calm and interactive with mom's presence.	Danced in a more interactive way with the therapists and peers.

Louie. Louie, despite his aggressive behavior, immediately demonstrated a potential for exploring contact and music in the group process. He indicated a certain curiosity and openness for relationship with the therapists in the first session. In terms of mood regulation, Louie responded similarly to Valeria. Starting in Session 5 through Session 11, before parents were invited to come to the session, Louie demonstrated that the more he became engaged with the therapists and with the music, the better he could regulate his mood. The presence of his dad, starting in Session 12, was a challenge for him and, as a result, he reverted back to moments of aggression, distance, and rejection.

However, he eventually demonstrated an improvement in mood and was able to connect with his dad (see Table 13).

Table 13

Louie's Development in Terms of Interests, Initiative and Regulation

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
Confused. No mood regulation, presenting stereotyped and aggressive behaviors.	Mood regulation improved: Became more interactive with the therapists and less aggressive.	Very interactive with music (i.e., picking up instruments, playing, getting physically closed to the keyboard).	Played musically and physically in a more interactive way with the therapists.
However, interests towards the therapists.	However, mood regulation was unstable.	His mood regulation became drastically unstable with dad's presence.	

Inter-relationships Among Clients

Inter-relationships were examined among clients and their peers, clients and the therapists, and clients and their parents. Tables 14 through 19 illustrate how clients developed inter-personally, meaning engaging and relating to others according to Greenspan and Wieder's (2006) second developmental stage. As above, the inter-

personal developments were analyzed within each group stage (i.e., induction, experimental engagement, cohesive engagement, and disengagement).

Sonia. Sonia demonstrated an enormous achievement in terms of inter-relationship. She developed great curiosity for music and musical instruments. She showed affection towards the therapist and was able to look for interaction with a peer through the instrument he was holding. It was observed that Sonia was almost ready for the experience of the two-way communication (see Table 14).

Table 14

Sonia's Development in Terms of Engaging and Relating

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
She demonstrated openness for the relationship with the therapists since session 2 through eye contact and smile.	In session 6 she interacted with the therapists through singing and playing.	The musical and physical interaction moved to physical contact. Sonia gave the therapist Carly a kiss.	She played the tambourine Louie was holding.

Donald. Donald moved from stereotyped gestures to exploring musical instruments. Until Session 3, he presented with stereotyped movements that blocked his potential for interaction. However, curiosity was demonstrated through eye contact. During the group stage of experimental engagement, he played instruments and made

body contact with the therapists. In that way, Donald was able to expand his interactional activities, going from musical instruments to physical contact with the therapists. He could also interact with other peers with the facilitation of a therapist (see Table 15).

Table 15

Donald's Development in Terms of Engaging and Relating

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
It was a confused start in terms of interaction. However, there was an eye contact with the therapist in session 3.	In session 5 he started interacting with the therapists through the use of the instruments. However, engagement was unstable and Donald was often moving back to stereotyped movements.	From the instruments, he started using his body for contact and improvisation. In session 10 he played with the therapist Chad using his hands.	Donald was able to dance with the therapist Carly and with a peer (Valeria). He also played with Carly and Gustavo.

Gustavo. During the induction stage, Gustavo could avoid contact with others through the use of singing. It was perceived as a kind of protection because the singing was not related to the group's music, and therefore did not appear to have any intention of connecting with the therapists and peers. Throughout the group process, he improved his interactive ability through the use of instruments (see Table 16).

Table 16

Gustavo's Development in Terms of Engaging and Relating

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
His initial confusion was related to a non communicational singing and stereotyped walking. However, there was an eye contact directed towards the therapist Chad.	He slowly started making more interaction use the therapist Carly through eye contact.	Interaction with the therapists improved through the use of instruments.	He was able to play the tambourine with Carly and Donald.

Joshua. Joshua demonstrated a lack of initiative for connecting inter-personally in the beginning of the process. At the stage of experimental engagement he started intentional physical contact with the therapists. During the cohesive engagement, Joshua continued getting closer to the therapists and to the instruments. However, there was no interaction with peers (see Table 17).

Table 17

Joshua's Development in Terms of Engaging and Relating

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
The first interaction was made with the instruments. No interactions with the therapists nor with peers until session 5.	He raised his hand towards the therapists Chad and Carly, in sessions 5 and 7, respectively. Instruments were used with the therapists.	He moved his body close to the therapist Chad and the keyboard. Waited for his parents looking at the door.	No meaningful actions and/or feelings were identified during the disengagement stage.

Valeria. Valeria always demonstrated initiative and interest for interaction with the therapists through eye contact and body proximity. However, her inability to regulate made her ability to engage and relate unstable. Valeria presented with aggressive behaviors towards the therapists and peers. It was in the stage of cohesive engagement that she became more regulated and stable in her ability to establish relationships with others. Her interest was concentrated in the relationship with the therapists, though. There was interaction with peers only through the help of therapists (see Table 18).

Table 18

Valeria's Development in Terms of Engaging and Relating

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
Valeria alternated in terms of mood regulation: directed smiles and eye contact with the therapists, however, presented various stereotyped body movements.	She screams with control in session 5. However, presented aggressiveness and rejection with everyone in the group.	Became more regulated and more able to engage with the therapists and with her mom from session 10 until the end of the process (session 16).	Valeria was able to dance with the therapist Carly and with a peer (Donald).

Louie. Since the stage of induction (i.e., the first four sessions), Louie alternated between initiative and interest in interacting with the therapists and initiative and interest in interacting with music instruments. He used eye contact and body proximity to communicate his interest for interaction. However, his inability to regulate made him present with aggressive behavior towards therapists and peers. It was in the stage of experimental engagement that he became more interactive with the therapists. In the presence of his father, he regressed back to his inability to regulate and alternated moments of interaction with the therapists and his father with moments when he was aggressive, hitting peers and other parents. Louie did not demonstrate an interest to engage with his peers (see Table 19).

Table 19

Louie's Development in Terms of Engaging and Relating

Group stage 1: Induction	Group stage 2: Experimental engagement	Group stage 3: Cohesive engagement	Group stage 4: Disengagement
(confusion, curiosity, and personal protectiveness)	(the group can be tested, members push the limits)	(trust, accommodation, and productive activities)	(resistance and feelings of missing the group)
Sessions 1 to 4	Sessions 5 to 8	Sessions 9 to 15	Session 16
Louie alternated in terms of regulation. He directed smiles and established eye contact with the therapists. He played instruments since session 2. However, presented various stereotyped body movements (i.e., running and walking in the room).	Significant interaction with the therapists and music since session 5. In session 7, started demonstrating initiative to pick up instruments and play.	Presented the interest to look for the therapists physically.	Played instruments and intentionally looked for the contact with the therapists. Louie did not establish inter-relationship with group peers. No reactions/feelings related to the process termination were noticed.

Discussion of Findings

As discussed in Chapter 4, aggressive behavior was present in both Valeria's and Louie's processes. It was observed that Valeria's mother and Louie's father presented with difficulties in interacting with their respective children. Both parents demonstrated frustration when they were trying to connect with their children and being rejected. Greenspan and Wieder (2006) believe that aggressive symptoms may indicate that parents need help. The authors suggest coaching to teach parents to help the child

express his or her needs, better read the child's signals, and respond consistently and calmly. Coaching may help the child improve his or her self-regulation. The authors also recommend that, from time to time, parents take a break.

The analysis of this study has raised some questions regarding Greenspan and Wieder's (2006) strategies: Are they enough to offer support to the client and his/her home environment? What if the aggression is a problem resulting from communication difficulties between caregiver and child? Could the aggression be a parental 'symptom' that the child is exhibiting? Could the aggression be an indication that one or both of the parents need therapy? In other words, symptoms need to be taken into consideration with attention and care in terms of interpretation. Based on the findings of this study, it is important to add two more strategies for a healthy integration of parents and children: (a) individual music therapy sessions exclusively for the parents, and (b) group music therapy sessions that include parents with their children. Music therapists could offer time for parents to process whatever they need, using music, creative arts, and verbalization. Therapists could also invite parents to participate in sessions with their children and help facilitate interactions. If it is deemed to be a conflict of interest to have parents and children in treatment by the same therapist, parents can be referred to other centers or providers.

Inter-relationships with peers tended to be difficult for the studied group members. Donald and Gustavo were able to play mutually with peers with the help of the therapists. The only member who had the initiative to play with a peer was Sonia, in Session 16, when she tried to play the instrument that Louie was playing. The openness for inter-relationships with therapists, however, had greater potential since the beginning of the process. This potential was important because once a child engages with another person, he/she receives a sense of direction, is helped in terms of

regulation, and experiences the joy of relationship (Greenspan & Wieder, 2006). Data demonstrated that all of the clients followed sequential steps related to developing an inter-relationship with the therapists. They all could develop the ability to start opening and closing cycles of communication with the therapists through the use of their bodies (i.e., eye contact, intentional runs, gestures towards the therapists) and instruments (i.e., mutual playing). In terms of group dynamic, this awareness has to do with the development of socializing techniques: social learning and development of basic skills (Yalom & Leszcz, 2005).

As demonstrated in the presented tables, group members were able to mutually play with the therapists and peers. However, the ability to establish intentional two-way communication in any of the participants was not observed. All observed actions seemed to indicate that the group members were trying to satisfy their own needs in an egocentric way, without being able to think about others' (i.e., therapists and peers) needs. The potential for interest was communicated through eye contact, body language, instrument exploration, and musicality. All members showed interest in opening circles of communication. Based on Greenspan and Wieder's (2006) developmental stages, the group members had the indication to keep working in order to move on to a next individual stage related to the formation of a sense of self.

The Use of Music

Music is a fundamental component of music-centered music therapy approach, which was applied in this study and had multiple roles. The music provided: (a) constant assessment; (b) treatment; and (c) evaluation.

Music Provided Constant Assessment

In the applied music-centered approach, assessment does not only occur in the first sessions, but is considered an ongoing task where therapists listen and perceive

clients' needs, abilities, difficulties in the different stages of therapy. Music helped to translate different dynamics (i.e., difficulties with engagement, basic skills, motor development, and aggression) and dilemmas (i.e., rigidness and flexibility).

Music Provided Treatment

Music provided treatment in the way that it offered emotional support, empowered the therapists and clients, offered a variety of creative tonal environments, and stimulated and grounded collective music making. Music provided opportunities for interpersonal learning by organization, ways of communicating, ways of playing, and mutuality. Clinical themes, or songs, emerged when group members started developing a sense of cohesion, which creates a community where people can experience sense of belonging.

Music Provided Evaluation

Clinical evaluation was constantly being done in musical interaction. Clinicians could assess if there was progress in terms of creative activity, individual skills in music, and mutuality and communication. It was previously discussed that the more flexible the therapists became the more creative spontaneity emerged in the dynamic. Through the musical experiences, it was evaluated that none of the group members were able to engage in two-way communication experiences. It was considered that this ability is emerging for all the members. Musical skills did not appear to improve for the clients, but when they developed their potential for mood regulation in the process (in Session 5), the use of their musicality and body rhythm gained more focus and intention. This led them to establish cycles of communication with the therapists.

Clinical Themes

In the first team meeting, as mentioned in Chapter 4, Chad called the most important music themes "melodies with personality," which are considered clinical

themes by the researcher. The songs, which were observed to have an impact on the clients in this study, were built based on different styles, harmonies, melodic patterns. Clinical themes did not emerge based on music theory but on relationships built in music therapy. This study demonstrated the potential for music to be utilized in a capacity that elicits impact, engagement, and client response.

The clinical themes were created using different tonalities and styles. After eleven sessions, the group had experienced songs in Em, G, Bm, D, C, and Cm. However, because Em is the relative of G, and Bm is the relative of D, it is possible to consider that the group had experienced 5 different tonal environments at that point. In terms of meter, there were six songs in 4/4 and one song in 2/4. Therefore, musically, the group had experienced: (a) seven meaningful clinical themes; (b) five different tonal keys; (c) songs in 4/4 and 2/4 meter; and, (d) styles such as samba, rock, reggae, and rap.

Based on this data, it was initially thought that, despite the amount of created clinical themes, the music and creative experience could be broader through the use of more styles (i.e., samba, jazz, baião, funk, arrocha etc) and keys. This suggestion was brought up by the researcher-consultant in the third team meeting. In response to this suggestion, Chad and Carly started proposing a waltz (in a ¾ meter) in Session 13. However, the song was unable to meet the needs of the clients and connection was not elicited. In the next team meeting it was verified that the suggestion of offering more musical variety to the clients might not have necessarily reflected the real needs of the clients. Indeed, the created repertoire had those specific musical characteristics because it was informing the portrait of the musicality of the group in that specific moment in their process.

The Integration of Music-Centered and Music Psychotherapy Concepts

Aigen (2005) believes that to be a music-centered music therapist means to place ideas about music at the core of music therapy theory. Music-centered music therapists understand that musical goals are clinical goals. Agreeing with this concept, Lee (1996) says

> my experiences confirm that verbal explorations in music therapy are secondary to musical explorations. In my work, improvisation is not considered as a channel towards words, but as the source of its own unique experiences and processes. (p. 24)

This study's data and analysis goes in accordance with both aforementioned music therapists by maintaining the philosophy that words are not fundamental for transformation and music can have three main roles in the therapeutic dynamic: assessment, treatment, and evaluation. For example, the reggae song (second clinical theme) was created when the therapists pursued flexibility. However, because they were facing the challenges of unpredictability and potential chaos, the more rigid structure of the first song had to be used at certain times. In recreating the rigid song, music could naturally inform the therapists that more flexible options could help the group to achieve cohesion. In other words, music worked side by side with the therapists and with the clients.

On the other hand, this study raised another question: Is the use of words, in a music-centered music therapy process, always secondary? Does the creative experience through music, in music therapy, facilitate treatment related to all clinical demands? Based on this study's findings, it was thought that verbalization, in some cases, may be what some people need in therapy in order to facilitate their understanding of what is being experienced in the therapeutic process. Some clinical goals are indeed musical

goals. The study also demonstrated the need that some people involved in the research had to talk. For example, the meetings with the therapists became an important element in the methodology because they could verbalize and listen to some issues that were blocking them to be more spontaneous and creative. It was also perceived that parents may experience frustrations in terms of their relationship with their kids. It was discussed that some of the symptoms presented by the children may be related to their parents and their experiences of childhood. It was proposed in the discussion of this study that a space for parents to talk about their own history, expectations, frustrations, sadness, beliefs, and other issues may offer a great support for a music-centered music therapy approach.

All studied individuals improved their intra- and inter-relational abilities. Even when the dynamic in the group was chaotic, communicational elements were expressed: through music by Gustavo, Joshua, and Valeria; through somatic expression by Louie, Donald, and Valeria; and through eye contact by Sonia. These behaviors were all indications that there was potential and desire for interaction with the therapists.

After 16 sessions, the group entered the termination stage. It was observed that the clients continued to have intra- and interpersonal needs. Each individual demonstrated the necessity to keep working in a relational dynamic. It is recommended that participants continue to be stimulated in more profound levels of inter-relationship that will hopefully lead them to more advanced levels of interaction. Through continued work on communication skills, the clients' language and singing may also. It was recommended to the director of the research site that the music therapy group continue in a non-research capacity, and that parents be involved in the group.

CHAPTER SIX

THE RESEARCH DESIGN

Rationale

Autism imposes barriers for people and limits creative potentials, expressions, and emotions. People with ASD are not only a diagnosis but rather whole people with unique characteristics and potential. Therapy for individuals with ASD offers opportunities for the creation of meaning, communication with others, and symbolic interactive play.

The utilized research design was selected in order to best target these aforementioned goals. At the start of this research process, there were several possibilities of how to approach the proposed questions. It was necessary to select a research design that allowed for (a) a clinical practice based on the philosophy that reality has several dimensions; and (b) a natural setting to allow for unfolding of the content. To meet these goals, naturalistic inquiry was the primary research design chosen. This was combined with Smeijsters and Storm's (1996) action research model. The intention of the research process was to be as natural as possible, and as similar as possible to the clinical dynamics that had been practiced by the researcher and by the clinical team.

Advantages of the Research Design

Flexibility

Qualitative research is based on the philosophy that meaning can be found through the interpretation of patterns and trends that emerge in a natural clinical process where variables are not controlled but are instead a part of the phenomena and therefore acknowledged (Wheeler & Kenny, 2005). The researcher aimed to find meaning in the group music therapy experience by establishing a clinical dynamic that was in a natural

setting but ensured trustworthiness of the data collection. Allowing the therapeutic process to unfold naturally was a fundamental criterion for the choice of research design. The therapeutic atmosphere and conditions were needed to represent those that are naturally experienced as opposed to an artificial setting such as a laboratory.

Smeijsters and Storm's (1996) model was found to be useful and appropriate, as it contained two main characteristics: (a) it was sensitive to examinations of a clinical experience where the process itself is relevant; and (b) it allowed for flexibility so that new questions and situations could emerge. For example, the research design was expanded to include a focus on the therapists' intra- and inter-relationships as well as parental inclusion in the process. The design was sensitive to the philosophy that realities are multiple and that generalizations cannot be made outside of time and context.

The Various Roles of the Researcher

In Smeijsters and Storm's (1996) model, the researcher assumed various different roles such as the camera operator, the one who wrote the descriptive log and analytic memo, and the consultant.

As the creator of the video recording, the researcher was able to be closely engaged and present in the sessions, where dynamic phenomena were happening. Based on the recording analysis, the researcher wrote the descriptive logs and analytic memo. These dynamics made the researcher more integrated with the data, its patterns and tendencies that were helpful in the role of consultant where perceptions and interventions were discussed with the therapists during the team meetings.

As the consultant, the researcher facilitated the team meetings proposed after three sessions to discuss the most important observations, thoughts, and feelings, as well as possible connections of the session content with the entire process. It became

fundamental that the researcher spoke last because the intention was for the researcher to listen to everyone else first. Important data came from the clinicians' spontaneous, initial reflections without the researcher's interference. The researcher concluded the meetings with reflections on the dynamics, understandings, and insights for future work in the process.

The action research model allowed the researcher to be involved in the research process in a naturalistic way (Smeijsters & Storm, 1996). In action research, the research process enhances the treatment by means of the researcher's analysis and team discussions. Moreover, the design allowed for distance from the data, because the researcher-consultant would not be in the dual role of therapist and researcher, which was in the interest of client welfare. Distance from the data in this way also helped prevent bias in the data collection and analysis. As the third team member, the researcher, along with the two therapists, added perspectives, analysis, and ideas for the therapy.

Multiple Data Sources

The four sources of data worked together in a way that helped create a fluency in the understanding of the process from week to week. The researcher and the therapists watched the session videos every week, and Chad and Carly would then discuss their reflections from the prior week before starting a new session. It created a fruitful cycle in the team, allowing for constant reflection of the process. The team then had the opportunity to discuss what did and did not work during the team meetings after every three sessions.

According to Aigen (1996), this is a fundamental task to help prevent the projection of feelings onto clients. Finally, the meetings helped improve the study's trustworthiness because they helped the researcher-consultant review observations,

perceptions, and interventions. It resonated with Lincoln and Guba (1985), who maintained that intra-team communication is important to keep all members moving together in a research project.

Trustworthiness

Several steps based on Lincoln and Guba's (1985) suggestions were taken to establish trustworthiness and credibility: prolonged engagement, persistent observation, triangulation, and member checking.

Prolonged engagement. The study duration of 16 sessions provided enough time for the researcher to know the "culture" of the participants, learn the context, and detect possible distortions, therefore long enough to reveal group process and dynamics.

Persistent observation. According to Greenspan and Wieder (2006), every child operates within a wide range of abilities. Therefore, it is understood that the observation of a person with ASD is fundamental in the constant therapeutic assessment. The observation in this study was conducted across different levels: the researcher observed and filmed the sessions. Then, in order to analyze the sessions and extract the moments whose characteristics and elements in the situation are most relevant to the problem or issue being pursued, the researcher observed the video repeatedly and described every single incident utilizing a line numbered word file. This technique allowed the researcher to cite, in the raw data, important contents in the analytic memo. Finally, after every three sessions, the researcher conducted a team meeting where the clinicians shared their opinions about the process with the researcher and vice versa.

Triangulation. According to Lincoln and Guba (1985), triangulation is important in naturalistic studies as it increases the credibility of the findings and interpretations. For this research, different data collection modes were used such as

filming, analytic memo, observation, clinical reports (researcher's and therapists' reports), and musical scores. Triangulation of sources was applied in the analysis: logs, video recording, analytical memos, and interview with the therapists.

Member checking. The member checking occurred on May 29th, 2015 with the therapist-participants. The researcher was aware that the therapists might have only agreed with or given positive comments in response to the presentation of findings. All the efforts were made by the researcher, through the meeting orientation where it was stated that all of the therapists' thoughts and feelings were important to guarantee credibility of the findings. The intention was to achieve safety and honesty in through feedback.

The meeting followed this structure: (a) the structure of the analysis was presented; (b) the five insights and reflections about the two research questions were presented and interpretations were described; (c) the therapists received the time line of the most important research events (see Appendix B) and the list of all the music scores (see Appendix C) as a way for them to remember some details of the process and be able to follow the construction of the findings; (d) the therapists were invited to interrupt the researcher-consultant at any time to bring any content they wanted; and, (e) after each explanation the researcher asked open questions such as: "does that make sense to you?," would you like to add anything else?," "is something missing according to you?"

Member checking resulted with all the findings and analysis being confirmed by Chad and Carly. The researcher left time for them to reflect about possible differences, and they concluded that there were no additional findings to be added or removed from the results. However, some dynamics arose involving their feelings after listening to the analysis related to the therapist's behaviors of inclusion and exclusion. Carly said: "I

admit to all those moments of failure." It opened a debate about those behaviors being a failure or, as the research had interpreted, a human action that may be perceived and managed? Carly said that:

> the thing about exclusion was really strong. I did not admit that I was also responsible for exclusion. Look at all the effort in this work and I notice that I'm excluding...I thought at that moment, I'm not excluding these human beings. And I was.

Carly became emotional upon this realization. Chad and the researcher offered support to her. Chad added: "I have to admit that first I had to get annoyed of Donald's spitting in order to promote redemption." Redemption, in this case, refers to being able to get over the feeling of being annoyed and support the client the way he/she is. Carly agreed with him.

Challenges of the Research Design

Most of the research process was supported by the proposed design. All aspects involving the natural setting, researcher's participation, data collection and analysis offered fluency in terms of allowing reflections and understanding of the process. It was helpful that reflections occurred in the here-and-now of each session since all data from the last session were fresh in the researcher's and therapists' minds.

However, there were challenges that were experienced in the process. They were: (a) the close relationship between the researcher and the therapist-participants; (b) the researcher's silence; (c) dealing with parental anxiety; (d) being mindful of withholding judgment; and, (e) creating respect between therapists.

The Close Relationship between the Researcher and the Therapist-participants

The researcher and the therapist-participants, as mentioned earlier, had a previous and close relationship. On one side it was positive because intimacy allowed the reflections about the process to be spontaneous and free. It was not difficult, for example, for Carly to express feelings through crying and have her expression supported by the researcher and by her peer therapist-participant. Intimacy could provide more openness and spontaneity for feedback to occur.

On the other hand, the meetings with the therapists and the process of member checking could have suffered because the therapists may not have felt comfortable or adequately knowledgeable to question the researcher's perspective. One of the cautions adopted by the researcher in the team's meetings was to let the therapists start the conversation so as not to influence their thoughts and/or feelings.

The Researcher's Silence

One challenge of the research design was that assuming all of the proposed researcher roles was a delicate and difficult task. As previously mentioned, the design offered the possibility for the researcher to be close and, consequently, intimate with the involved participants. However, according to the proposed design, the researcher did not talk about the process except during the team meetings. That was uncomfortable for the researcher and therapists, because the therapists have a history of working professionally and discussing cases with the researcher. Mainly, right after each session, when the entire team (i.e., clinicians and researcher-consultant) had immediate thoughts and feelings, it was difficult not to share and discuss these with the clinicians. Chad and Carly are clinicians who work side by side with the researcher on a daily basis. Therefore, sometimes the researcher's silence evoked some discomfort.

The discomfort was translated by Chad in a form of a metaphor. Chad gave to the researcher the nickname of "Mummy." Mummy represented the researchers' silence. The clinicians had to wait for the team meetings to process their thoughts and feelings according to the methodology of the study. Therefore, Chad's nickname could serve as a metaphor for the silence he also had to handle, having to process the research content by himself and with Carly.

Dealing with Parental Anxiety

The research process began by interviewing parents, explaining the research proposal, and obtaining informed consent. All six recruited families were interested and motivated to participate in the study. The research site is not a big institution, which allowed the researcher and therapists to occasionally meet parents. Often they raised questions such as about their children's progress throughout the study. Therefore, it was important that the researcher demonstrated empathy and was communicative, but was also careful in terms of giving feedback. It was agreed that parents would receive more formal feedback regarding the findings of the research after the analysis was completed.

Being Mindful of Withholding Judgment

The researcher had multiple data sources, which allowed him to interpret and make inferences about the therapists. It was important for disclosure to be constructive and for the researcher to remain mindful of withholding judgment. It reinforced to the team that instead of a "right and wrong" in the process, the researcher was aiming to reflect on the interventions.

The researcher offered different types of feedback in the team meetings: (a) challenging; (b) supportive; (c) emotional management; (d) recapitulative; (e) interpretative; and, (f) other (see Table 20):

Table 20

Types of Feedback Provided by the Researcher During the Team Meetings

Categories of feedback	Examples of feedback
Challenging	Could norms and leadership be possible with less rigidity?
Supportive	Verbal support was offered when the therapists externalized their challenges (e.g., increase of aggressiveness, difficulties dealing with chaotic situations).
Emotional Management	Observation and perception about the way therapists criticize each other (e.g., during team meeting two, Chad criticized the way Carly played the piano). Observation and perception about therapists' feelings (e.g., Chad complained about spitting, Carly complained because the room was not clean enough, Chad complained about session duration).
Recapitulative	During team meeting two, the therapist asked if the clinical team remembered the origin of an Em song they had improvised.
Interpretative	During the second team meeting the reseacher interpreted possibilities for the increase of Valeria's aggressiveness: being more receptive in session and symptom related to parental relationship pattern.
Other (e.g., specific on the room)	During the first team meeting the researcher asked: Would the therapists have other options in terms of organizing the music therapy room?

Creating Respect Between Therapists

In team meetings, the therapists criticized each other due to a plethora of reasons. Common complaints were about the way the other utilized instruments, interventions, and partnership. In a healthy dynamic, criticism must be allowed but in a respectful manner. In this study, the team meetings norms were established so that the therapists were the ones who initiated the talking. Criticism was allowed but with respect, and support for feelings and reactions was offered.

Despite these challenges, the selected research design demonstrated several advantages in allowing the researcher to share the unique story of six children with ASD in a music therapy group. This work will contribute to the literature by being the first one that used principles rooted in both music-centered music therapy and music psychotherapy in a group of people with ASD who operate on a pre-verbal level. Hopefully, this study will help future reflections to unfold and will be another piece of the complex puzzle of understanding and treatment of people with ASD.

In the next chapter there will be a presentation and discussion about the five insights that occurred along the analysis of the data: (1) the music therapy room has therapeutic plasticity; (2) Therapists have expectations, they experience frustration and they frustrate: They can promote isolating autistic cycles; (3) Everybody can include and everybody can exclude; (4) The dilemma of rigidness versus flexibility; and (5) The importance of integrating parents into clients' developmental processes and a reflection about symptoms.

These insights formed a sequence from a more concrete gesture of moving elements in the room to a more abstract one that proposes possible reasons for a symptom to be operating in the dynamic, as well as strategies to facilitate its treatment. The therapists had many years of clinical experience in working with people with ASD.

Despite this, it was noticed that they had to grapple with their own expectations and frustrations in the attempt to minimize their exclusionary forces that operated along the process: their intra-relationships. Without this inner work it was possible that a chaotic group dynamic would continue to exclude and frustrate group members.

The therapists' initial rigidness, when proposing the establishment of leadership and norms, was replaced with flexibility and more accurate perceptions about ways to engage the clients, establish leadership and norms, and create a cohesive group. The organization of the group was built through the use of structure with creative freedom and the therapists could, more freely, follow the children's leads. As the therapists became more creatively free and flexible, the clients became more responsive. More cycles of communication were opened between the therapists and clients and vice versa. Being more open to the group was fundamental for the therapists in order to better listen to the psychodynamics, including the symptoms, of the group members. Symptoms were not perceived in a superficial way but more profoundly, which was related to the quality of bonds and relationships. In this dynamic, music was fundamental, having multiple functions that will be presented and exemplified in this chapter.

CHAPTER SEVEN

INSIGHTS AND RECOMMENDATIONS FOR FUTURE WORK

This chapter will discuss the insights gained from analyzing the research data. The following are the five insights that summarize the group process of music-centered music psychotherapy with children with ASD: (1) the music therapy room has therapeutic plasticity; (2) therapists have expectations, experience frustration, and can frustrate clients, which can promote isolating autistic cycles; (3) everybody can include and everybody can exclude; (4) the dilemma of rigidness versus flexibility; and (5) the importance of integrating parents into clients' developmental processes.

Although this study focused on the two previously presented research questions and sub-questions, the flexibility of the design allowed for new questions to emerge. Consequently, new reflections unfolded. Two new topics became relevant during the process: the intra- and inter-personal relationships that also occurred with the therapists, and the integration of parents in the clients' process associated with the perception of their symptoms. In a study like this, where relationships were a significant component for the efficacy of the process, it was perceived that therapists' intra- and inter-relationships had to be taken into consideration, as well as the connections between the children's behaviors and symptoms, and how they interacted with their parents. However, these phenomena were not expected to be as important as the intra and inter-relationships among the studied clients. Although the focus was on the clients' development, the dynamic between the therapists and the reflection on parental connection became equally important.

The Process of Developing the Insights

As discussed above, the five insights as a result of analyzing the data are: (1) the music therapy room has therapeutic plasticity; (2) therapists have expectations,

experience frustration, and can frustrate clients, which can promote isolating autistic cycles; (3) everybody can include and everybody can exclude; (4) the dilemma of rigidness versus flexibility; and (5) the importance of integrating parents into clients' developmental processes.

The sequence of these insights allowed the researcher to perceive the general qualitative analytic process, and the step-by-step stage of the findings related to the research questions, which were presented in the previous chapters. The organization of the insights' sequence illustrates the way the process organically unfolded, starting with the therapists having to manage with more concrete and basic aspects for the establishment of rapport, which was reorganizing the music therapy room in order to maximize the efficacy of the interventions. During this practical intervention, dealing with benches, chairs, and equipment, the therapists started noticing aspects of the group dynamic that were frustrating them. Following this perception, they started noticing that although their main therapeutic goal was to facilitate the inclusion of each member, they were instead occasionally exhibiting 'exclusionary forces.' Through this experience, the dilemma of rigidness versus flexibility emerged. The research process allowed them to work on these issues and become more flexible and open, in order to provide greater listening to the clients' needs and to creativity itself. The process allowed their listening skills to better perceive the therapeutic content that was being presented by the clients, including their symptoms. Finally, by being more conscious about their feelings and expectations, the therapists noticed the importance of integrating participants' parents and home environments in the process, allowing the creative and the therapeutic experience to expand outside the therapy room.

Insight 1: The Music Therapy Room has Therapeutic Plasticity

According to the *Oxford Advanced Learner's Dictionary* (1989), plasticity is a noun and refers to the state or quality of being able to be shaped. Transferring this definition to the music therapy room, plasticity was defined as the potential the therapeutic room had to become something else, to be musically and/or physically transformed physically (e.g., different position of benches, chairs, instruments, therapists' positions) and subjectively (e.g., into a train station, circus, aquarium, beach), according to the clients' needs. The flexible quality and potential of the music room in the research study turned out to be one of the major therapeutic essences that was used by the therapists not only to better facilitate an organizational environment for the clients but to also manage their feelings when facing a chaotic group dynamic.

The clients are individuals who participate in the therapeutic process, and the group itself can be also understood as a client with unique properties. Therefore, a therapeutic factor of a group is not only individual members but also the connection among them. According to Yalom and Leszcz (2005), group cohesiveness is one of the most important factors in group therapy. The authors consider cohesiveness as the group therapy analogous to the relationship in individual therapy. In all individual psychotherapy, a good therapist-client relationship, involving trust, warmth, empathy, understanding, and acceptance, is essential for a positive outcome. The degree of cohesiveness fluctuates during the course of the therapeutic process. Group cohesiveness operates as a therapeutic factor at first by means of group support and acceptance and later by means of inter-relation of group esteem and self-esteem and through its role in interpersonal learning.

Chad and Carly initiated the group process by offering acceptance and support to individuals who were not integrated in the room. These individuals were not interpersonally relating with others in the room and were moving around the room without purpose or meaning, in a perceived state of confusion and chaos. These were expected behaviors in the first stage of the group process, known as induction. Kottler and Englar-Carlson (2010) consider induction to be the first phase of a group dynamic where members can experience confusion due to facing the unknown. Leadership must be established for the group members, who must identify from whom to receive guidance.

In order to build relationship, group norms, and leadership, the therapists operated from different physical locations and proposed different organization of the room, as described in the previous chapter. Their position in the room and the organization of the room occurred according to the way they were perceiving group movements and dynamics. Sometimes they alternated positions. For example, Chad would come to the left side of the semi-circle and Carly to the right side, and vice versa. Sometimes Chad would go to the back of the room and Carly would stay in front of the semi circle. By moving around the room, the therapists allowed the group members to experience music and their presence in different ways. Depending on their placement, the clients would experience more or less volume, more or less proximity to the instrument, and more or less contact with the therapists. The room was significantly modified three times: before Session 1, before Session 4, and before Session 6. The initial set-up was motivated by the necessity therapists perceived to limit the space so that the clients would not be distracted by a big room. The second set-up occurred after a turning point in the process, when therapists perceived that individuals could better explore the room without being agitated or distracted. The last alteration happened

when the therapists decided to replace the benches with individual chairs. It was a result of academic orientation (researcher advisor's orientation) and a team meeting decision. It was hypothesized that individual chairs would help individuals feel safer and grounded in their own space instead of being uncertain about their space on a bench.

The therapists utilized the different possibilities of the music therapy room in order to better accomplish the needs of group members and of the group as a whole. In other words, the therapists, who aimed to facilitate context, organization, and meaning for the group experience, were not only concerned about musical, verbal and physical interventions, but were also concerned about the physical aspects of the music therapy room. They transformed it, according to their clinical perceptions, to be a place that would be more able to serve as the appropriate therapeutic space for this specific group to express content, achieve meaning, and develop. In addition, they intended to diminish distractions and chaos.

Insight 2: Therapists have Expectations, Experience Frustration, and can Frustrate Clients

Greenspan and Wieder (2006) advise that when a caregiver finds himself/herself annoyed that a child with ASD is rejecting him/her, it is important to take a break for a few minutes to regroup. Although this idea sounds reasonable, this study raises the discussion that constant rejection in therapy may cause difficulties, even for trained therapists, and may not be solved by a simple break. Internal reflection and personal work may be necessary for therapists to fulfill their professional responsibilities. Trained therapists theoretically accept people the way they are. Acceptance is a fundamental quality in therapy. As mentioned above, this study raised questions and reflections about Carly and Chad's acceptance of the research client-participants.

As an initial reflection, the study demonstrated that the therapist-participants did have expectations of the way clients would verbally, musically, and physically act. These expectations were based on the experiences the therapists had in their lives and careers. The first example of an expectation can be seen in the way the therapists organized the music therapy room before the first session. Chad and Carly, before getting to know the participants, thought about possibilities for the music therapy room organization. Chairs and/or benches were set-up in the room according to their previous experiences of having conducted music therapy sessions with groups and according to their expectations regarding the way clients are expected to behave in the room. In other words, the therapists demonstrated expectations about the people they were about to know as their clients.

Before Session 1 started, Chad and Carly decided to position benches in a way that formed a semi-circle (see Figure 2). Once the music therapy room was organized in a certain way, the expectation they had of clients behaving in a certain way was implicit. The room, with its potential for interactions, became a social system, a representation of what was experienced outside the room and the therapeutic process. The expectation of a group to become a healthy one where cohesiveness is achieved and where members experience well-being and possibilities for growth.

Theoretically, therapists are prepared to help each of the individuals to be included in the social environment of the group. However, inclusion and exclusion have to do with internal and external conditions, which have to do with the potential each individual has, including the therapists, for the establishment of relationship and being part of a social system such as a music therapy group. Based on inclusion and exclusion criteria the therapists had previously experienced with other groups, the initial room set-up for this group did not successfully accomplish the task.

Trying to engage a child who does not pay attention can be very frustrating (Grenspan & Wieder, 2006). In this study, therapeutic frustration was demonstrated in several moments, for several reasons. For example, in Session 2 Carly was frustrated, when Donald took his shoes off, as heard when Carly said "pô, Donald" (come on, Donald!). In session 3, Carly was having a difficult time trying to physically manage Donald and she asked Chad for help, expressing frustration by not being able to manage the situation the way she was expecting. In the first team meeting, after Session 3, Chad used the expression "hostile environment" to refer to moments of chaos that were experienced in the first three sessions. The frustration continued throughout the process, as in Session 10, Carly was clearly frustrated with Donald's behavior of not wanting to sit down and grabbing her. In Session 13, Chad expressed frustration regarding the duration of the sessions.

Chad mentioned a difficult moment in the process that he called a "moment of redemption," where he then achieved greater acceptance of the clients' behaviors.

> I had a moment of redemption today in Session 3. I have a hard time dealing with spit. There was a moment today that I felt necessity to scream very loud…with all my strength. I was experiencing anger but it was funny…It was not a coincidence that the music title is "Eu tô aqui" (I am here)… I could free myself today in one moment. It was nice…. From the necessity to scream to…you know what? Yes, come to me with your spit…From that point, to me, everything became more joyful.

Carly also expressed her thoughts and feelings about not being able to manage some clinical situations until Session 3. She said: "My first feeling at the beginning was 'wow, this group is so disorganized. What chaos! The chaos made me anxious." When therapists have expectations of clients, the lack of fulfilling these expectations can be

frustrating, and then therapists may respond to their frustrations by using unproductive interventions or reactions to clients that frustrate the clients. The therapists' frustrations, in this study, had different effects on the therapists themselves, on the individual participants, and on the group as a whole. Under stress, it became more difficult for them to perceive and think about therapeutic options when facing challenges. Their perception became foggy by not being able to clearly identify therapeutic options, and at times, clients were excluded. Unfortunately, when an individual with ASD experiences exclusion he/she can have his/her autism reinforced through a vicious-autistic cycle.

It is recommended that continuous engagement in supervision is important for the maintenance of necessary personal distance from clients' content and a healthy ability to be available for the variety of therapeutic demands that emerge in the music therapy processes. This study demonstrated that personal work is an ongoing necessity for therapists. Although competent music therapy trainings can provide clinical skills, therapists have to deal with different human experiences and are constantly faced with their potentials and weaknesses.

Insight 3: Everybody Can Include and Everybody Can Exclude

Hypothetically speaking, all therapists want to engage and include clients in the therapeutic process. However, this study demonstrated that trained and experienced therapists with the goal to include people also inadvertently excluded them, at times. In a more profound analysis of the data, it was possible to verify a total of six categories of observed relationships: (a) Therapists in relation to clients, (b) Clients in relation to therapists, (c) Parents in relation to clients, (d) Clients in relation to parents, (e) Therapists in relation to parents, and (f) Parents in relation to therapists.

Based on the observations of this study, the client and therapist participants had the potential to periodically include and exclude each other. Forces of exclusion and

inclusion happened in this study, providing four different categories of this phenomenon. These categories are described below:

Internal Inclusion

This is defined as the inclusion experienced by the natural and inner potentials of a person demonstrating the drive to engage in an interaction. As an example of this category, in Session 12, Louie ran towards several parents who were playing with their kids (i.e., Donald's and Gustavo's parents), and looked at them, indicating a desire for contact. In the beginning of Session 14, Louie wanted to play on Chad's keyboard and sat on Chad's side. In that same session, Louie allowed his father to kiss him, not running away from him this time. At the same time, Valeria moved her body and smiled towards her mother, even hugging her.

External Inclusion

This is defined as the inclusion that is facilitated by an external elements such as a therapeutic intervention, music, or a parents' move for contact. As an example of this phenomenon, in Session 12, Louie walked in front of his father, who pulled him and hugged him as if he was tired of being rejected. Other examples of this inclusion between Louie and his father include when his father helped him take off his pullover, and when they played an instrument together. In terms of therapists-parents relationship, when Carly invited Joshua's father to start an improvisation for the group using the guitar, this demonstrated external inclusion in Session 15.

Internal Exclusion

This is demonstrated when the exclusion is caused by an internal factor such as the barriers of the pathology itself. Examples of internal exclusion were illustrated from clients to parents when Louie and Valeria refused to play with their parents. They

exhibited their exclusion through distance and body language. In Session 12, Chad finished the song with Louie on his side, because Louie refused to sit next to his father.

External Exclusion

This is demonstrated when the exclusion is caused by external elements that block a person from being included in any system, such as when content produced by the client is ignored or not perceived by the therapists. For example, at the start of Session 1, Chad closed the door and inadvertently left two of the clients outside the room. In terms of relationships between parents and children, in Session 12, Valeria's mother entered the music therapy room chewing gum. She was not available to interact. In relation to the relationship between therapists and parents, when Louie's father played a rhythmic call on the Brazilian tambourine in Session 14, this was ignored by the therapists and he was excluded.

During member checking, Chad confirmed the interpretations of exclusionary forces operating in the therapists and said: "I have to confess to you – I heard Louie's father at that time and don't…[silence]. Now I'm admitting an almost conscious exclusion. It caught my attention when he did the rhythmic call. And I missed the availability to conduct something with it. I'm being as honest as possible." Carly replied saying that she remembered that therapeutic moment but mentioned that it had not caught her attention.

The initial insights of the study data showed that inclusion and exclusion were present in the research process. Inclusion and exclusion can be thought of not as outside forces which belong to an outside world to where therapists and educators help people with limited conditions to engage. Potential to include and exclude may be present in any social environment. The 'insights' reinforced the importance of constant therapeutic supervision, understanding that these forces may not be completely avoided by

therapists but can be managed. They need to be perceived, understood, and controlled because forces of exclusion, coming from the therapists, can be problematic.

According to Yalom and Leszcz (2005):

> although core negative beliefs about oneself do not disappear totally with treatment, effective treatment generates a capacity for interpersonal mastery, such that the client can respond with a broadened, flexible, empathetic, and more adaptive repertoire of behaviors, replacing vicious cycles with constructive ones. (p. 23)

Yalom and Leszcz (2005) believe that "nothing seems to be of greater importance for the self-esteem and well-being of the adolescent, for example, than to be included and accepted in some social group, and nothing is more devastating than exclusion" (p. 57). Ruud (2004) states that music therapists use music as a way to bridge connection between individuals and communities, to create a space for common *musicking* and sharing of artistic and human values. According to this author, music creates community.

Insight 4: The Challenge of Rigidity versus Freedom

The balance between rigidity and freedom may be considered one of the most important challenges faced by the therapists. This challenge was mainly apparent in the beginning of the process when therapists were dealing with a chaotic group and trying to lead it to a cohesive stage. Sessions 1 through 3 especially reflected it, although it was experienced during the entire 16-session research process.

Initially, due to chaos and the clients' stereotyped actions, the therapists were strongly focused on establishing the norm of asking everyone to remain seated. Through the establishment of this norm, Chad started working on leadership. Focusing on this need, he created the first clinical theme (see Figure 5), which turned out to be the

representation of the therapists' rigidness in their attempt to establish norms. The challenge of rigidness versus flexibility quickly emerged in the following music examples that were created in Sessions 1 and 2.

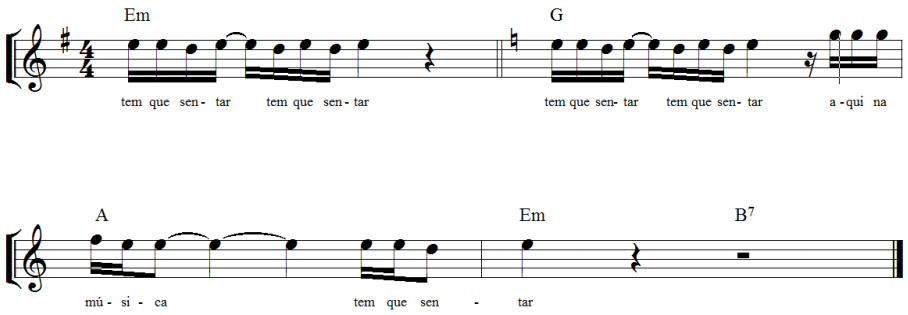

Figure 5. Song 1: Tem Que se Sentar (You have to sit down)

However, before the following Session 1 started, the therapists spent some time trying to remember this theme, which they agreed was the most powerful of Session 1. Carly sang it to Chad (see Figure 6).

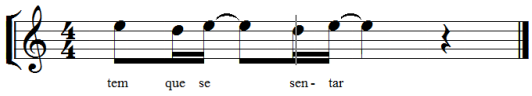

Figure 6. Song 1 as Remembered in Session 2

The difficult balance of rigidity versus freedom was presented in the music. The original theme had been structured as a march reinforcing all the words that intended to ask clients to sit down versus the theme Carly's memory had evoked, which still asked clients to sit down, but with the inclusion of syncopations and swing. The march style was more rigid than Carly's syncopated style.

This song seemed to represent the therapists' anxiety, which may have caused some consequences such as "foggy therapeutic perception." An example of foggy therapeutic perception, involving Chad, occurred in Session 3. When Gustavo started

singing an interval E-D-E-D-E-D, Carly perceived it and called Chad's attention to it, but he kept playing what he was playing. In doing so, Chad demonstrated rigid therapeutic listening. Some stressful group situations may have inhibited the therapists from not being able to identify different strategies and ways to facilitate clients' and therapists' wellbeing. For example, Chad and Carly had difficulties: a) rethinking the clients' seat locations in order to help them focus; b) perceiving if the movement of standing up was always towards isolation or the movement could be sometimes productive (i.e., intention to pick up an instrument, to explore the room, to get closer to a peer); and, c) allowing the "autism" to speak, offering a bit of release for some of them (i.e., allow a brief isolated walk if a client needs it and then invite him/her to get back to the semi circle). Rigidity was causing what the researcher called "foggy perception" in the therapists, not allowing them to clearly perceive other interventions and exclusion factors.

Before Session 3 started, Chad asked Carly for more flexibility. Again, this points to how the therapists were experiencing the dilemma of rigidness versus flexibility. The therapists wanted to provide structure in order to ensure grounding, predictability, and, consequently, safety in order for engagement and development to happen. However, a structured therapeutic environment does not necessarily need to be rigid. The dilemma was clear: how could the therapists provide structure with space for creativity freedom and spontaneity?

A therapeutic dynamic that is too rigid employs the risk of the individuals becoming limited in their abilities to become more autonomous and creative, which are crucial therapeutic goals. The process demonstrated that the more rigid the therapists were, trying to establish structure, the less the dynamic was creative. The therapists and clients, in the beginning of the process, seemed to not be enjoying the creative

experience but were instead exclusively working on behaviors and group norms. Clients were moving around the room, but not in a fun way, and the therapists were demonstrating anxiety and stress.

Then a reggae song emerged in Session 2. The reggae creation showed the therapists and clients that there were possibilities for more flexibility and fun in the process. The musical production was representing the dilemma: song 1 (Figure 5) vs. song 2 (Figure 7) representing rigidness versus flexibility. Kottler and Englar-Carlson (2010) believe that being flexible leads to being a creative problem solver. Chad's leadership moved from presenting a more authoritative characteristic to a more flexible way of managing group situations. The reggae song (song 2) had opened the door for these new possibilities to emerge.

After the reggae song occurred, Session 4 was a bridge in the dilemma. In Session 4 it was possible to perceive that the group was ready for a turning point, which occurred in Session 5. In Session 5, there were six times where togetherness was perceived. The turning point of the group's process, then, occurred in Session 5, when the group became more internally attractive to the clients and cohesion was achieved. From Session 5 to Session 8 the researcher felt that the group could have moved towards a deeper relational experience. However, this did not occur, perhaps because the therapists were dealing with rigidness and stress. Two main situations were repetitively occurring in the process and were discussed in the team meeting: (1) there was a lack of continuity and progress, and (2) there was insufficient engagement.

Lack of Continuity

The therapists were still dealing with their own exclusionary forces, and there were often distractions in the room. Examples of these distractions include the exercise

stair, someone holding a distractive toy, and the room organization itself offering spaces for distraction.

Although the therapists were reviewing videotapes of the sessions, they were missing achievements from previous sessions, which led to a lack of continuity. One example of the lack of continuity is how the group ended Session 7 around the keyboard together. Then in Session 8, Chad blocked the clients' from the keyboard, prohibiting their closeness.

Insufficient Engagement

The sequence of musical and physical statements demonstrated that the group needed to become more active in the musicing. The outline of "Main Musical Events" (see Appendix B) demonstrates that the main clinical themes were created only after 20 minutes of the sessions, an indication that the there was insufficient engagement with a productive clinical-musical intervention early enough in the group. This insufficient engagement was not due to a disinterest but instead due to the rigid availability of the therapists.

As time went by, flexibility was observed. Chad started being more flexible in his interventions and, after introducing the reggae (song 2), he was more spontaneously creative. According to Kottler and Englar-Carlson (2010), adaptability and flexibility may be the most important characteristic of a group leader. More often than not things will not unfold as expected.

However, in Session 10, rigidness was observed again in several of Carly's interventions. The therapeutic pair positioned each therapist in his/her primary instrument: Chad at the keyboard and Carly on the voice. Chad was behind the keyboard and even though his music was stronger, his physical presence to the clients

and to Carly was weaker. This made Carly have too much work dealing with the six clients, which may have made her become more rigid in bringing the dynamic to a pattern similar to the beginning of the process. The therapeutic pair had to reorganize their presence using their primary instruments and physical presence in the room.

Rigidness and flexibility are also related to interpersonal learning. According to Yalom and Leszcz (2005), the group can be seen as social microcosm: the idea that freely interactive groups, with few structural restrictions, can develop into a social microcosm of the participant members. The more there is spontaneous interaction, the more the development of the social microcosm will be rapid and authentic.

Insight 5: The Importance of Integrating Parents into Clients' Developmental Processes and Reflections on Symptoms

-Aunt, say something. I'm afraid, it's very dark in here.

- How does it matter if I speak? You cannot see me, anyway.

- It does not matter. When someone speaks, it's the light.

(Freud as cited by Mannoni, 1990, p. 13).

The construction of this insight was influenced in part by the functioning of two participants in the study: Valeria and Louie. Due to their presentation of aggressive behaviors, the researcher and team gained important insights regarding ASD symptoms and the importance of having parents present and integrated in their kids' therapeutic processes. Valeria and Louie's aggressiveness became one of the main concerns of the research team. They demonstrated physical aggression directed to therapists, group peers and parents until Session 6. The research team perceived their behavior to be symptoms associated to self-regulation, which needed further investigation, understanding, and treatment.

Greenspan and Tippy (2011) state "autism is a disorder of relating and communicating and not a disorder of extinguishable behaviors" (p. 7). Therefore, a symptom cannot be understood as an isolated behavior that needs to be managed but as an expression that needs to be understood. For many years, the treatment of people with ASD focused the goals on the individuals' symptoms rather than on underlying problems. Therefore, therapeutic goals were limited to changes in behaviors. Causes for the symptoms were not treated (Greenspan & Wieder, 2006). However, it is fundamental that a therapist is able to observe and listen to the symptoms by trying to identify possible causes for them and ways to intervene. If therapists only address surface behaviors, the behavior may improve, but the progress will probably not generalize to the deeper levels of relating, communicating, and thinking (Greenspan & Wieder, 2006).

According to Rosenberg (2002), children present symptoms in order to be heard. One of the parents' personal needs, that is communicated through their children's symptoms, is their own necessity for therapy. Symptoms can also manifest in children due to barriers experienced by their parents when they were kids, in their own relationship with their parents. Rosenberg (2002) believes that children can re-actualize their parents' conflicts.

Therefore, when children are referred to therapy some questions always need to be asked: What is implicated in the symptoms? Whose desire is involved? Who needs therapy? Parents need to be taken into account in children's therapy. One way of doing it is to open spaces for parents to be heard.

The necessity of including parents was discussed in one of the team meetings and it was agreed that parents would be invited to join their children in Session 12. This would be a way for them to experience their children's process and also for them to

perceive the openness of the team regarding their needs, as well. However, it became a challenge including parents because their participation was not part of the initial research plan. The analytic focus was not on the parents themselves but the relationship and ways the interaction between parents and children occurred. It turned out to be very relevant for the understanding of some phenomena (i.e, individual behaviors, connections between parents-children, and difficulties some parents have playing with their children).

Every human being needs interpersonal relationships consisting of someone who can offer love, support, and healthy structure for healthy growth and development, (Yalom & Leszcz, 2005). Poor communication of children's and parents' needs, as well as parental frustration generate feelings of personal helplessness and ineffectiveness in both children and parents. According to Greenspan and Wieder (2006), children with ASD demonstrate that they feel a personal sense of love, specifically with their mother, father, or other primary caregiver (p. 13).

Including parents in the therapeutic processes of their sons and daughters in music therapy is not new. Some music therapists have written about their practices with children and parents (Benenzon, 1987; Oldfield, 2006; Oldfield & Flower, 2008). However, it is still not a common practice in the music therapy setting. Some models do integrate parents of people with ASD by inviting them to participate in meetings where they can follow the course of the therapeutic process through video watching and discussions. Others propose parental training and/or education. These actions can be efficient but may not be enough to change the relationship between parents and children. Parents who participate in their children's music therapy processes through video watching may still be unable to engage in playful moments with their children, but will be able to intellectually discuss the present and the future in technical terms.

They will be parents who 'watch' their chidlren but they may not be parents who 'are' with their children. Research supports the idea that children need the latter.

Greenspan and Wieder (2006) believe that the ability to deeply love is present in children with ASD. Parents need to learn how to tune in with their children's worlds. However, as discussed before, in order for parents to be available for love they need to be as healthy as possible. This study recognizes that some parents may need help, may need their own treatment in order to be affectively available to connect with their sons and daughters.

Kottler and Englar-Carlson (2010) believe that groups provide an interpersonal context that is reminiscent of a family, complete with parental figures, sibling rivalries, and struggles of power and control. Group therapy makes it possible for participants to work through family issues. Yalom and Leszcz (2005) agree and believe that the great majority of group clients have a background of an unsatisfactory experience in their families. The authors call this factor the correction recapitulation of the primary family group.

Yalom and Leszcz (2005) also consider that the range and variety of distortions in groups are greater than in individual therapy. For the majority of clients, therapists become the personification of parental images, teachers, authorities, and established tradition and values. Conflicts in other interpersonal domains can occur, such as power, anger, competitiveness with peers, intimacy, greed, and envy. Thus, it is fundamental that therapists acknowledge and work through these elements.

Parents were invited to participate in three sessions: Session 12, Session 14, and Session 15. According to the therapists, parents were receptive to the invitations. In their parents' presence, the clients demonstrated different behaviors. For example, Sonia demonstrated excitement about her mom's presence and Gustavo smiled for the first

time in the process while interacting with his parents. Donald and Joshua gravitated around their parents. They played together.

For Valeria and Louie, the relational dynamic with their parents was different. The inability of Valeria's mother and Louie's father to connect with their respective children was remarkable. The team meeting after Session 12 raised several considerations on the part of the researcher-consultant that were discussed with the therapists. These considerations were (a) the relationship between Louie and his father; and, (b) the relationship between Valeria and her mother.

The Relationship Between Louie and his Father

Louie was always near Chad, the keyboard, the instrument basket, the tambourine, and the guitar. Those proximities demonstrate that Louie has interests and has the ability to show them. However, in Session 12, he rejected the possibility of connecting with his father by remaining physically distant. When his father invited him to interact, he refused. The therapists encouraged Louie's father to become more musically active. In doing so, he could match Louie's playing interests and there was greater potential for connection. One remarkable moment was when Louie's father gave his son a hug, after multiple instances of repeated rejection.

The Relationship Between Valeria and her Mother

As described in chapter 4, Valeria's mother came to Session 12 chewing gum. In the same session, Valeria was dancing and moving her body, which were significant behaviors for her in the music therapy groups. However, her mother did not engage with her daughter's movements, and instead sat while chewing gum. Parents' feelings can be a barrier in the process of engaging children. A child's constant rejection may lead to the parents wanting to give up on trying to engage (Greenspan & Wieder, 2006).

Valeria and Louie stopped behaving aggressively in Session 7 after the therapists had intervened in a more musically active way. However, in Session 12, in their parents' presence, they started demonstrating the behaviors again. Interestingly, Louie and Valeria were the only clients who clearly rejected playing with their parents. However, they played with the therapists and with other families who were in the session. According to R. Solomon (personal communication, May 28, 2014), "sometimes we have to teach parents to become better players with their kids." The space was open for parents in the children's process when they were invited to attend Sessions 12, 14 and 15.

In session 12, the song "Com o pai e com a Mãe" (with mom and dad) was created composed (see Figure 17).

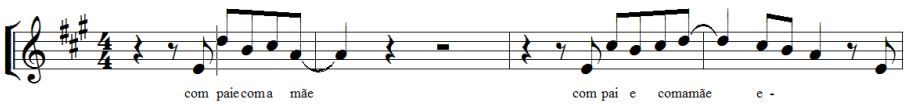

Figure 17. Song 8: Com o pai e com a mãe (with mom and dad)

Since the beginning of Session 14, aspects of the relational dynamics between Valeria, Louie, and their respective parents started to demonstrate that the integration of parents in sessions could be one important clinical intervention related to re-construction of bonds and, consequently, promotion of development and growth. The therapeutic support was being provided in the music, which offered context for the interactions between parents and children. Music was creating a space for the encounter, offering flexibility and openness for relationship to develop.

Louie and Valeria's parents were searching for contact and did not appear to be giving up on building relationships with their children. In Session 14, Louie's father

held his son and gave him a big hug. At the end of Session 15, Valeria became agitated, but when she calmed down, her mother hugged her. Louie and Valeria were observed playing with their respective parents, and receiving hugs from them was a relevant indication of the music therapy interventions.

The music therapy group process had opened a space for parents and their children to experience contact and relationship in a creative and supportive environment. The therapists' acceptance of the clients and creative interventions with music created possibilities for relationship and communication to be re-experienced, and possibilities for parents and children to have fun together. Valeria's and Louie's aggressive behaviors decreased by the end of the research process, which may be related to the stronger relationships their formed with their parents.

In addition to the dynamics involving Valeria and Louie, in Session 15, Joshua's father took on an active role in the sessions and in his son's treatment. The therapists offered him the opportunity to express his voice in the room. This previously resistant father opened cycles of communication with the entire group.

A child with ASD, who faces difficulties in areas related to engagement and/or communication, sometimes may experience issues unrelated to the pathology itself. Children may demonstrate symptoms that do not belong to them but to their parents (Rosenberg, 2002). The need for therapy must be investigated in relation to a child's home environment and family setting. Music therapy with people with ASD may benefit from including parents as a fundamental piece of the treatment, for the benefit of the entire family. As previously discussed, music therapists can facilitate a parent's involvement in their child's treatment and growth.

Final Thoughts

Although all the client-participants in this study worked on a preverbal level, they demonstrated some observed improvement in their relational and communicational skills. Each individual showed efforts in trying to establish relationships with the therapists and developed ways to communicate with them. All of them developed the initiative to open and close cycles of communication through body language and through music. The group members also demonstrated a capacity to solve problems, as they faced confusion and isolation throughout the process. The group as a whole became an inviting space for contact to happen.

Kottler and Englar-Carlson (2010) proposed a group factor called 'magic.' According to the authors, magic has to do with the amazing things that happen in groups, some of which defy description, much less explanation. Why do clients improve? Yalom and Leszcz's (2005) state that there is no consensus about the reasons for client improvement, and yet they sometimes do. This studied group moved from a completely unstable dynamic of chaos and balance (Sessions 1 to 3), to a turning point (Session 5) that led to a period of some stability (i.e., less aggression; Sessions 6 to 8), and a return to instability when parents were involved (Sessions 12, 14 and 15). Although there was an attempt to identify the best treatment model, and understand all the psychodynamics, there certainly are reasons for phenomena to occur that cannot be explained because they belong to the realm of 'magic.'

The findings demonstrated that music-centered music psychotherapy, for the studied individuals, stimulated emotions and connections. The client-participants used their bodies to run, touch, look, smile, and dance. They used their musicality to play and sing. In addition, for two individuals, their bodies were used to hit when they were unable to self-regulate. The aggressive behaviors were understood as an expression that

needed therapeutic response. For these individuals, the findings demonstrated that there are opportunities for treatment that move towards the development of potential and the expansion of interests in the world.

As a qualitative study, process, context, multiple realities, and meaning were important elements to be taken into consideration in the data collection and analysis. Therefore, the aim of this study is not to generalize findings but to offer the reader the opportunity to know about this specific experience and maybe transfer it to other situations. The main purpose of this research was to address the stated research questions. The findings of the study have clinical implications by stimulating a discussion about music therapy with people with ASD. The data pointed to the importance of examining therapeutic availability, inclusive and exclusive behaviors exhibited by the therapists, behaviors exhibited by children and their parents, and creating and analyzing the music that is produced in therapy.

Finally, although the entire team had expectations of having a productive, healthy, engaged last session to terminate the research process, it did not happen this way. Participants lay on the floor inappropriately, the group in general was not as responsive as other sessions, and the clinicians felt that they were not musically responsive. However, in the last team meeting, a metaphor for this session emerged: Session 16 was 'life the way it is.' In therapy, such as in life, although moments of 'magic' can be experienced, a healthy dynamic implies a good amount of work towards a better quality of relational bonds, development, growth, and better integration in the world. Therapy does not follow a "happy ending" script but is a step-by-step process of growth that involves learning to deal with challenges. Session 16 contained some moments of relational connection and communication. In the end, the group was calm and seemed relaxed.

One of the feelings the researcher and the therapists experienced after the last session became one of the clinical implications of this study, and that is the concept that therapy implies work. Although many achievements were made concerning intra and inter-relationships, group cohesion and development of group factors, development of relational music, work remains for these six individuals, their therapists, and their environments.

Perhaps, the most important finding of this research is not that people with ASD, parents, or therapists may need help. The main conclusion may be that all relationships may need help. In music therapy, music has the potential to foster and encourage healthy relationships. Approaching treatment of individuals with ASD from a psychotherapeutic dynamic is also significant in that therapists and researcher were able to work with and see the experiences of the whole person and not the syndrome.

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Appendix A

Publications on Music Therapy and ASD

Music therapy clinicians, researchers, and theorists have been focusing studies and discussions on topics such as the history of music therapy and autism (Reschke-Hernández, 2011), co-therapy (Turry & Marcus, 2005), systematic review of the literature (Gold, Wigram & Elefant, 2010; Gattino, 2012), meta-analysis (Whipple, 2004), survey (Nelson, Anderson & Gonzales, 1984), development of approaches (Brandalise, 1998), development of assessment tools (Walworth, 2007; Carpente, 2009; Lim, 2010b), studies for scale validation (Gattino, 2012), and ways to analyze clinical production (Aigen, 1997, 1998).

Music therapy has been found to promote the improvement of interpersonal relationships (Goldstein, 1964; Stevens & Clark, 1969; Nordoff & Robbins, 1977; Aigen, 1997; Turry & Marcus, 2003; Kern & Aldridge, 2006; Finnigan & Starr, 2010), achievement of expressive freedom (Nordoff & Robbins, 1971), achievement of vocal improvement (Nordoff & Robbins, 1971), improvement in communication (Nordoff & Robbins, 1971; Saperston, 1973; Edgerton, 1994), achievement of vocal and verbal confidence (Nordoff & Robbins, 1977), mutuality (Aigen, 1998, Turry & Marcus, 2003), musical experience (Aigen, 1998; Turry & Marcus, 2003), musical skills (Aigen, 1998; Boso, Minazzi, Abbamonte & Politi, 2007), development of the self (Aigen, 1998; Turry & Marcus, 2003), achievement of higher forms of rhythmic order (Nordoff & Robbins, 1977), improvement in speech production (Hollander & Juhrs, 1974; Lim, 2010), decrease of tantrums (Goldstein, 1964) and promote participation in treatment (Goldstein, 1964).

Among the pioneer music therapists who have worked with people with ASD, improvisation has been the most commonly documented clinical intervention of choice (Saperston, 1973; Nordoff & Robbins, 1971, 1977; Alvin & Warwick, 1978). It remains a common technique in the clinical work with this population. Ten studies were located that discussed the use of improvisation in such treatment (Goldstein, 1964; Nordoff & Robbins, 1971; Saperston, 1973; Nordoff & Robbins, 1977; Edgerton, 1994; Aigen, 1995; Brandalise, 1998; Aigen, 1998; Turry & Marcus, 2003; Kim, Wigram & Gold, 2008).

Another trend is the clinical use of the song in treatment with this population. Nineteen located studies mentioned the therapeutic use of songs (Goldstein, 1964; Steven & Clark, 1969; Nordoff & Robbins, 1971; Mahlberg, 1973; Nordoff & Robbins, 1977; Edgerton, 1994; Aigen, 1995; Buday, 1995; Brandalise, 1998; Aigen, 1998; Boso et al., 2007; Kern et al., 2007, 2007b; Kim et al., 2008; Katagiri, 2009; Finnigan & Starr, 2010; Gattino et al., 2011; Lim, 2010).

In addition, 18 other studies have discussed the use of musical instruments (Goldstein 1964; Steven & Clark, 1969; Nordoff & Robbins, 1971; Mahlberg, 1973; Saperston, 1973; Hollander & Juhrs, 1974; Nordoff & Robbins, 1977; Edgerton, 1994; Aigen, 1995; Buday, 1995; Brandalise, 1998; Aigen, 1998; Brownell, 2002; Turry & Marcus, 2003; Boso et al., 2007; Kim et al., 2008; Finnigan & Starr, 2010; Gattino, Riesgo, Longo, Leite & Faccini, 2011). In addition, one study mentioned the use of clapping (Mahlberg, 1973), one study used message tapes (Benenzon, 1987), one study mentioned the use of dance and body movement (Goldstein, 1964), one study used outdoor music (Kern & Aldridge, 2006), one study used the Tomatis method (Corbett, Schikman & Ferrer, 2008), and one study mentioned the use of music videos (Lim, 2010a).

Appendix B
Time Line of Research[1]

- **EXCLUSION vs. INCLUSION**
- **RIGIDITY vs. FLEXIBILITY**
- **"TEM QUE SE SENTAR" vs. "EU TÔ AQUI (reggae)"**
- **FOGGY PERCEPTION FOR NEW OPTIONS vs. SPONTANEITY**

Session 1
(03/07/14)
Chaos
Norms and leadership being established.

The song "TEM QUE SE SENTAR" is created (representing rigidness)

Session 2
(03/14/14)
The threat of the "vicious cycle"

The reggae song "EU TÔ AQUI" is created (representing flexibility)

Session 3
(03/21/14)
Chad asks the team to be more flexible: Chad's call

Session 4
(03/28/14)
MT room is reorganized. Togetherness for 6 times.

RAP is applied in recriating "TEM QUE SE SENTAR" (structure with falexibility)

first meeting with the therapists (03/21/14)

March

- **A CALL FOR FLEXIBILITY**
- **PHYSICAL STATEMENT "AGGRESSION" (Louie and Valeria)**

vs. PHYSICAL STATEMENT "CONTACT" (aren't the experiences too receptive?)

- **RECRIATING "EU TÔ AQUI (reggae)" THROUGH THE RAP AND MIXING THE REGGAE WITH "TEM QUE SE SENTAR"**
- **WORKING ON MORE SPONTANEITY AND GROUP COHESION**

Session 5
(04/04/14)
Cohesion is happening. Norms are more internalized.

The song "TEM QUE SE SENTAR" is used to recreate the reggae "EU TÔ AQUI." "CORRE, CORRE, CORRE" and "QUE QUE TU QUÉ?" emerge.

Session 6
(04/11/14)
Cohesion is established. Valeria's agresiveness (symptom)

Recriating themes.

EASTER

HOLIDAY

Session 7
(04/25/14)
Intimacy: are they ready for a more in depth work? Clients are more active, less aggressive

second meeting with the therapists (04/11/14)

[1] **The rectangles contain the most important topic of each three sessions and it is a result of the researcher's analysis associated with the content of team's meetings.**

April

*** DISTRACTOR ELEMENTS**
*** LACK OF CONTINUITY**
*** MUSIC STRENGTH**
*** GROUP WAS TAKEN CARE IN SECTORS' DIVISION**

Session 8
(05/02/14)
Cohesion - The group is stable. A more in depth work can happen.

Session 9
(05/09/14)
Much more connections

Chad: "WE ARE STUCK RHYTHMICALLY SPEAKING"

Session 10
(05/16/14)
Group is healthy. Therapists' positions changed. They did not connect.

Session 11
(05/23/14)
Therapists very attentive in the new postions. The flow happened.

third meeting with the therapists (05/09/14)

May

*** SOME PARENTS NEED HELP: Suzan, Valeria's mother and Alex, Louie's father don't know how to play with their kids. Few parental care, maybe more aggressiveness**
*** STILL ELEMENTS PROMOTING EXCLUSION**

Session 12
(05/30/14)
Parents' presence. Louie and Valeria were unable to connect with parents

Creation of "COM O PAI E COM A MÃE" (with dad and with mom)

Session 13
(06/06/14)
Different level of inter-relationship (Sonia, Valeria and Louie)

Therapists' intentions vs. clients'needs: Disconnection (Chad complaints about session duration)

Session 14
(06/13/14)
Parents' presence: tension. An impression that relational work is being conducted

Session 15
(06/20/14)
Thinking about the flexibility of the research design

fourth meeting with the therapists (06/06/14)

May/Jun

*** THERAPISTS ACTING WITH "THERAPEUTIC MATURITY"**
*** THERE IS NO "HAPPY END" BUT WORK THAT SHOULD CONTINUE**
*** LIFE THE WAY IT IS**

Session 16
(06/27/14)

The process must continue
A more in depth work can happen.

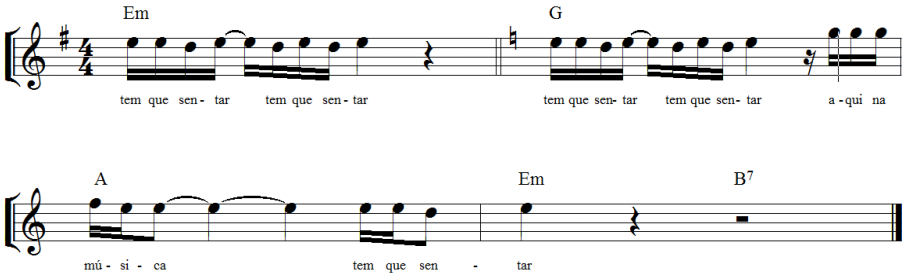
Creation of "O LOUIE VEIO PRA MÚSICA" (Louie came to music) and "DANÇA" (DANCE)

fifth meeting with the therapists (07/01/14)

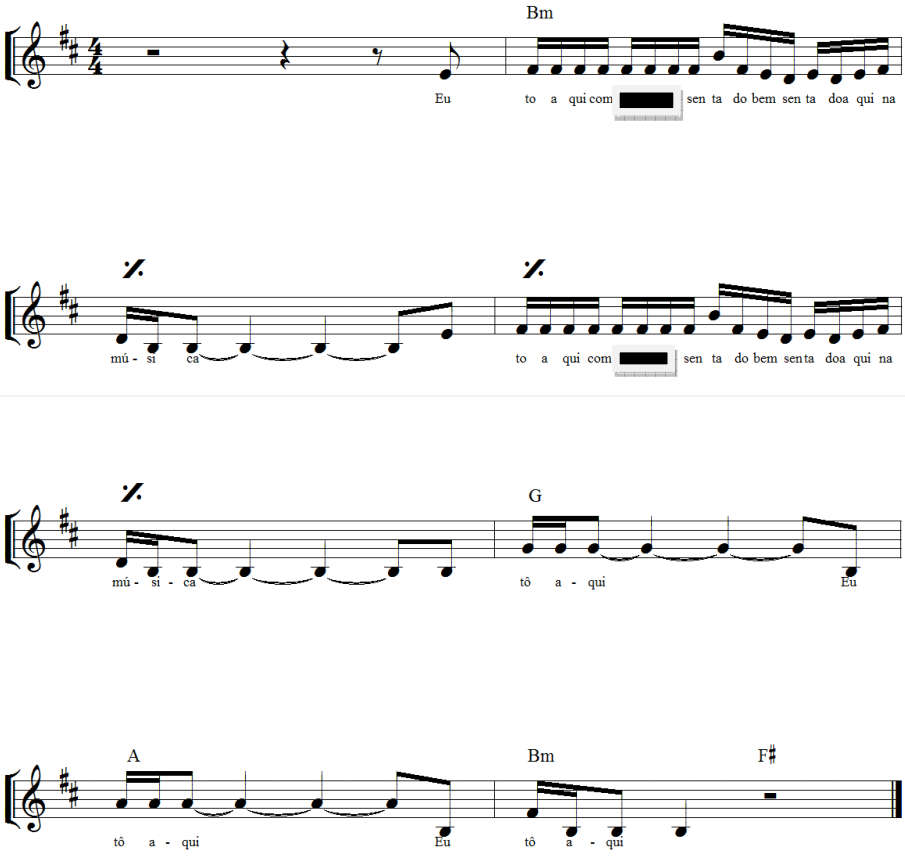
June/JULY

Appendix C
Musical Excerpts

SONG 1: TEM QUE SE SENTAR (YOU HAVE TO SIT DOWN)
28:30 min of session 1

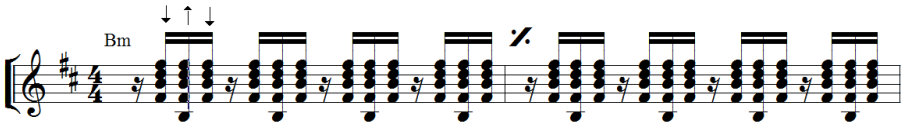


SONG 2: EU TÔ AQUI (I AM HERE) – REGGAE[2]
25:52 min of session 2

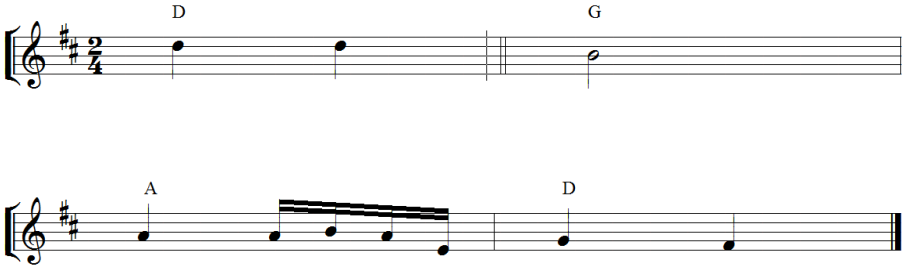


[2] **The black tag on the score is the area where the name of the client is included.**

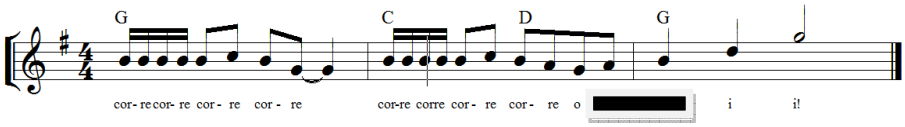
The reggae song accompaniment:



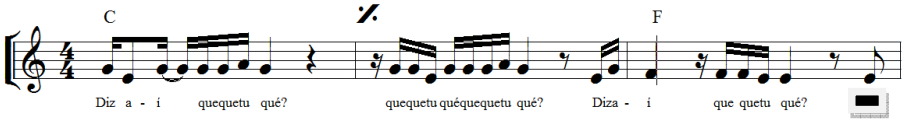
SONG 3: VALERIA'S SCREAM IN D
23:00 min of session 3

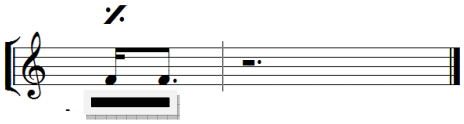


SONG 4: CORRE, CORRE, CORRE! (RUN, RUN, RUN!)[3]
22:26 min of session 5



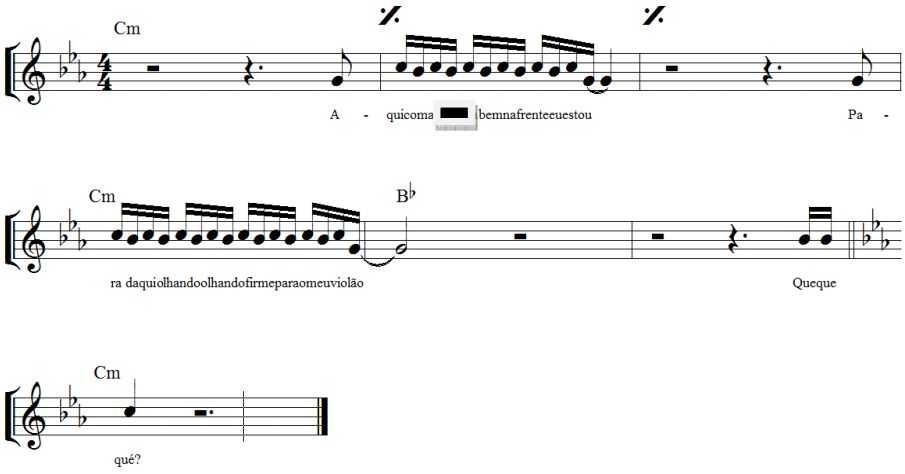
SONG 5: QUE QUE TU QUÉ? (WHAT DO YOU WANT?)
33:40 min of session 5



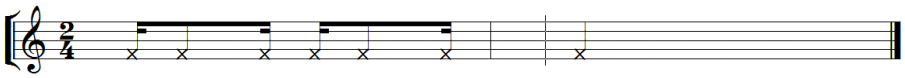


[3] **The black tag on the score is the area where the name of the client is included.**

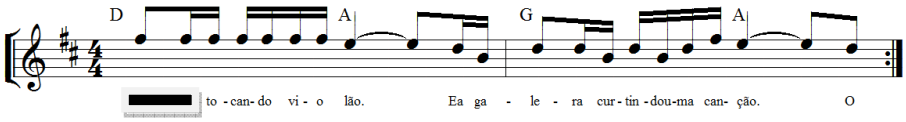
SONG 6: RECREATION OF "QUE QUE TU QUÉ?" (WHAT DO YOU WANT?)[4]
12:22 min of session 6



EXTRACTION 1: THE RHYTHMICAL CALL
25:45 min of session 7

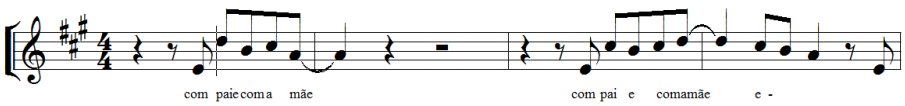


SONG 7: "A GALERA VAI CURTINDO ESSA CANÇÃO" (GUYS ARE HAVING FUN WITH THIS SONG)
3:10 min of session 11

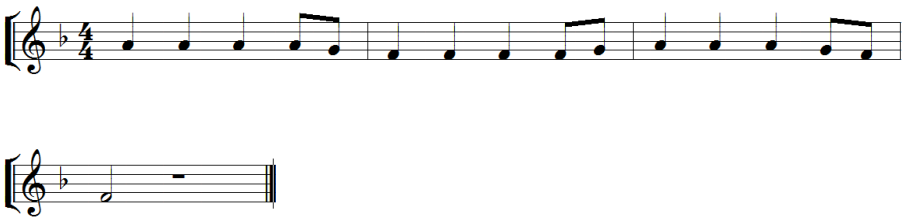


[4] **The black tag on the score is the area where the name of the client is included.**

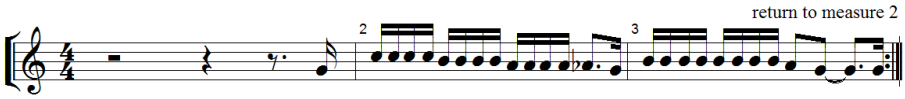
SONG 8: "COM O PAI E COM A MÃE" (WITH MOM AND WITH DAD)
29:20 min of session 12 (with parents)



SONG 9: "O LOUIE VEIO PRA MÚSICA" (LOUIE CAME TO MUSIC)
0:30 min of session 16.



SONG 10: "DANÇA" (DANCE)
15:18 min of session 16.



Appendix D

Institutional Review Board Approval

TEMPLE UNIVERSITY®

Office for Human Subjects Protections
Institutional Review Board
Medical Intervention Committees A1 & A2
Social and Behavioral Committee B
Unanticipated Problems Committee

Student Faculty Conference Center
3340 N Broad Street - Suite 304
Philadelphia, Pennsylvania 19140
Phone: (215) 707-3390
Fax: (215) 707-9100
e-mail: irb@temple.edu

Certification of Approval for a Project Involving Human Subjects

Protocol Number:	21746
PI:	BROOKS, DARLENE
Review Type:	FULL COMMITTEE
Approved On:	28-Jan-2014
Approved From:	28-Jan-2014
Approved To:	16-Jan-2015
Committee:	B BEHAVIORAL AND SOCIAL SCIENCES
School/College:	BOYER COLLEGE OF MUSIC & DANCE (2200)
Department:	MUSIC:THERAPY (22070)
Sponsor:	No External Sponsor
Project Title:	The Psychodynamics of Music-centered Group Music Therapy with People on the Autistic Spectrum (ASD)

The IRB approved the protocol 21746.

Appendix E

Informed Consent Forms

Informed Consent Form for Participants with ASD:

Title of Research Study: The Psychodynamics of Music-centered Group Music Therapy with People in the Autistic Spectrum.

Investigator and Department:
André Brandalise Mattos, MA
PhD Music Therapy Student, Temple University

Advisor: Darlene Brooks, PhD, MT-BC, LPC
Professor of Music Therapy
Esther Boyer College of Music and Dance

Why you are being invited to take part of a research study?
We invite you to give consent for your child to take part in a research study because your child has autism spectrum disorder and may be able to participate in a 40 minute music therapy session once per week for 4 months. In the remainder of this document, "you" or "your" refers to your child.

Who can I talk to?
If you have questions, concerns, or complaints, or think the research has hurt you, contact the research team:

André Brandalise Mattos, MA
PhD Student, Temple University
Porto Alegre, RS BRAZIL
(+55) 51 9251 9016
E-mail: andre.brandalise@temple.edu

Advisor: Darlene Brooks, PhD, MT-BC, LPC
Professor of Music Therapy
Temple University
Esther Boyer College of Music and Dance
Philadelphia, PA
E-mail: dmbrooks@temple.edu

This research has been reviewed and approved by an Institutional Review Board. You may talk to them at (215) 707-3390 or e-mail them at: irb@temple.edu for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

Subject initials:_____
Date:_____

DO NOT SIGN THIS FORM AFTER THIS DATE →

TEMPLE UNIVERSITY
IRB APPROVAL
APPROVED FROM: 1/28/14
APPROVED TO: 1/16/15

Why are we doing this research?
The purpose of this study is to evaluate intra and interpersonal dynamics of people with Autistic Spectrum Disorder (ASD) involved in music therapy group process. Specifically, the study will examine relationships between clients and music, between clients and therapists and between clients among themselves.

Music has been used as a therapeutic tool in music therapy groups in different ways and settings by various professionals and for various purposes. Group dynamics have been associated with music therapy since the 1960s (Boenheim, 1966; Butler, 1966; Liederman, 1967). In 1966, Boenheim wrote about group dynamics and about using music as a new possibility for group psychotherapy. According to him, groups could provide a therapeutic atmosphere for successful learning. He believed that group therapy was an important therapy method.

Within the music therapy literature, a reasonable amount of material has been written concerning music therapy processes with groups. However, only one publication explored group dynamics with people with ASD (Aigen, 1997). Also, individuals with developmental delays are not often treated within psychodynamic or process-oriented forms of therapy. This research has the potential to influence some basic assumptions about work in this area because it will examine and discuss the psychotherapeutic elements not often used with individuals with ASD but that have potential to be of use with them.

How long will the research last?
We expect that you will be in the research study for 4 months (which corresponds to 16 music therapy sessions with one session per week).

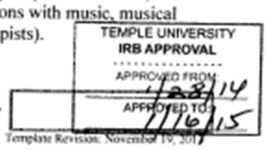
How many people will be studied?
We expect that about 4-6 people will be in this research study.

What happens if I say yes, I want to be in this research?
If you say yes to the research you will be ready to start your music therapy group with 3-5 other peers, on Friday, March 7th, 2014, from 9:30am until 10:10am, at _____(Center's name)_____ which is located at _____(Center's address)_____ in the city of Porto Alegre, Brazil. This group process will last until June 20th when it will be your last session.

All sessions will be based on music therapy interventions and on the use of different types of music according to the needs and interests of the group, as determined by the music therapists who will be working with you. Types of music can vary in terms of styles (i.e., Samba, Bossa Nova, Capoeira, Choro, Reggae, Maracatu, Rock'n roll, R & B, House, Rap, Country, etc.), keys, arrangement (i.e., instrumental music, vocal music, classical music, etc.), and forms (classical music pieces, song, improvised music). Clients will be able to interact in several ways (e.g., interactions with music, musical instruments including the voice, with group peers, with therapists).

Subject initials:_____
Date:_____

DO NOT SIGN THIS FORM AFTER THIS DATE →



What are my responsibilities if I take part in this research?
You have to come to every session.

What happens if I say no, I do not want to be in this research?
You may decide not to take part in the research and it will not be held against you.

What happens if I say yes, but I change my mind later?
You agree to take part in the research now and if you stop at any time, it will not be held against you. Again, it will in no way affect your relationship with the researcher.

If you decide to leave the research, contact the investigator so that the investigator can schedule a meeting to arrange termination.

If you stop being in the research, already collected data may not be removed from the study database.

Is there any way being in this study could be bad for me?
The only discomfort that may be experienced relates to those associated with normal process of psychotherapy where clients may be challenged by the group process as it develops. Learning to manage discomfort caused by social interaction is one of the primary goals of psychotherapy with individuals with ASD.

Also, part of the study focus is to examine the termination process. The intent is for the group to end when the research ends. After all, termination is a vitally essential part of the process and a stage where growth can still occur and gains can be consolidated. If the group needs extra sessions, or if one or more members feel discomfort during the termination dynamics, after the 16 sessions, additional sessions will be scheduled to achieve a satisfactory termination. If after the group has terminated, the researcher believes that continued treatment in music therapy is warranted (group or individual) a recommendation to the referring center and to the parents/guardians of the client-participants will be made.

Will being in this study help me any way?
The music therapy group process can potentially benefit you in terms of inter and intra-personal achievements.

- INTER-PERSONAL ACHIEVEMENTS: abilities that group members can develop in order to interact physically, verbally and/or musically with each other (e.g. ability to wait for others' turn; ability to listen to the other's verbalization; ability to sing together; ability to play together, etc.).

- INTRA-PERSONAL ACHIEVEMENTS: related to group members' personal development and growth through group process (e.g. from rigidness to more flexibility in relation to group norms, to relationships, to contact; development of eye contact; gain of more maturity; personal musical development, etc.).

Subject initials:_____
Date:_____

DO NOT SIGN THIS FORM AFTER THIS DATE →

TEMPLE UNIVERSITY
IRB APPROVAL
APPROVED FROM 1/28/14
APPROVED TO 9/16/15
Template Revision: November 19, 2013

There are no costs to participate in this research. Additionally, there will be no compensation for participating in the study.

What happens to the information we collect?

Efforts will be made to limit your personal information to people who have a need to review this information. We cannot promise complete privacy. For example, though the study team has put in safeguards to protect your information, there is always a potential risk of loss of confidentiality.

Organizations that may inspect and copy your information include the IRB, Temple University, Temple University Health System, Inc. and its affiliates, and other representatives of these organizations, and the Office of Human Research Protections.

We may publish the results of this research. However, we will keep your name and other identifying information confidential.

Can I be removed from the research without my permission?

The person in charge of the research study can remove you from the research study without your approval. Possible reasons for removal include

- *if you become self-aggressive or become aggressive with others.
- *if the researcher notices that the process is causing a significant discomfort for you.
- *if you do not show up for sessions.

What else do I need to know?

If you sustain an injury as a result of your participation in this research study, the physician's fees and medical expenses that result will be billed to your insurance company or you in the usual manner. Other financial compensation (such as lost wages or pain and suffering) for such injuries is not routinely available. By signing this consent form, you are not waiving any of the legal rights that you otherwise would have as a participant in a research study. If you have questions about the study or a research-related injury, please contact

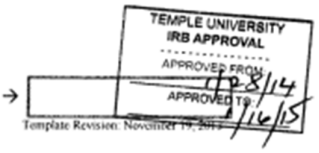
Mr. Chad Pettengill
Temple University Institutional Review Board
1801 North Broad Street
401 Conwell Hall
Philadelphia, PA 19140
(215) 707-8757
chad.pettengill@temple.edu

Your signature below indicates that:

- Someone has explained this research study to you.
- You freely volunteer to be in this research study.

Subject initials:_____
Date:_____

DO NOT SIGN THIS FORM AFTER THIS DATE →



Template Revision: November 19, 2014

- You can choose not to take part in this research study and it will not affect your care.
- You can agree to take part in this study now and later change your mind. Your decision to leave the study will not affect your care.
- You have been offered the opportunity to ask questions and all your questions have been answered.

Your signature documents your permission for the named child to take part in this research.

DO NOT SIGN THIS FORM AFTER THIS DATE → [ ]

_____
Printed name of child

_____ _____
Signature of parent or guardian Date

_____ ❑ Parent
Printed name of parent or guardian ❑ Guardian (See note below)

Note on permission by guardians: An individual may provide permission for a child only if that individual can provide a written document indicating that he or she is legally authorized to consent to the child's general medical care. Attach the documentation to the signed document.

_____
Signature of person obtaining consent and assent

_____
Printed name of person obtaining consent and assent

_____
Signature of the witness

Subject initials:_____
Date:_____

DO NOT SIGN THIS FORM AFTER THIS DATE → [ ]

TEMPLE UNIVERSITY
IRB APPROVAL
APPROVED FROM: 1/28/14
APPROVED TO: 1/16/15
Template Revision: November 6, 2013

Informed Consent Form for the Therapist Participants:

Title of Research Study: The Psychodynamics of Music-centered Group Music Therapy with People in the Autistic Spectrum.

Investigator and Department:
André Brandalise Mattos, MA
PhD Music Therapy Student, Temple University

Advisor: Darlene Brooks, PhD, MT-BC, LPC
Professor of Music Therapy
Esther Boyer College of Music and Dance

Why you are being invited to take part of a research study
We invite you to take part in a research study because you match the criteria of inclusion as one of the therapist participants in this study involving the application of group music therapy with people in the autistic spectrum.

Who can I talk to?
If you have questions, concerns, or complaints, or think the research has hurt you, contact the research team:

André Brandalise Mattos, MA
PhD Student, Temple University
Porto Alegre, RS BRAZIL
(+55) 51 9251 9016
E-mail: andre.brandalise@temple.edu

Advisor: Darlene Brooks, PhD, MT-BC, LPC
Professor of Music Therapy
Temple University
Esther Boyer College of Music and Dance
Philadelphia, PA
E-mail: dmbrooks@temple.edu

This research has been reviewed and approved by an Institutional Review Board. You may talk to them at (215) 707-3390 or e-mail them at: irb@temple.edu for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
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Music has been used as a therapeutic tool in music therapy groups in different ways and settings by various professionals and for various purposes. Group dynamics have been associated with music therapy since the 1960s (Boenheim, 1966; Butler, 1966; Liederman, 1967). In 1966, Boenheim wrote about group dynamics and about using music as a new possibility for group psychotherapy. According to him, groups could provide a therapeutic atmosphere for successful learning. He believed that group therapy was an important therapy method.

Within the music therapy literature, a reasonable amount of material has been written concerning music therapy processes with groups. However, only one publication explored group dynamics with people with ASD (Aigen, 1997). Also, individuals with developmental delays are not often treated within psychodynamic or process-oriented forms of therapy. This research has the potential to influence some basic assumptions about work in this area because it will examine and discuss the psychotherapeutic elements not often used with individuals with ASD but that have potential to be of use with them.

How long will the research last?
We expect that you will be in the research study for 4 months (which corresponds to 16 music therapy sessions with one session per week).

How many people will be studied?
We expect that about 4-6 people will be in this research study.

What happens if I say yes, I want to be in this research?
If you say yes to the research you will be ready to start running a music therapy group with 4-6 participants, on Friday, March 7th, 2014, from 9:30am until 10:10am, at _____(Center's name)_____ which is located at _____(Center's address)_____ in the city of Porto Alegre, Brazil. This group process will last until June 20th when it will be the last session.

All sessions will be based on music therapy interventions and on the use of different types of music according to the needs and interests of the group, as determined by the music therapists. Types of music can vary in terms of styles (i.e., Samba, Bossa Nova, Capoeira, Choro, Reggae, Maracatu, Rock'n roll, R & B, House, Rap, Country, etc.), keys, arrangement (i.e., instrumental music, vocal music, classical music, etc.), and forms (classical music pieces, song, improvised music). Clients will be able to interact in several ways (e.g., interactions with music, musical instruments including the voice, with group peers, with therapists).

What are my responsibilities if I take part in this research?
As the therapist-participant, you are expected to show up on time and run one 40 minute group music therapy session with a colleague each week for 16 sessions.
All sessions will be based on music therapy interventions according to the needs of the group, as determined by both therapists.
You are expected to keep the video recording of each session in your personal HD in order for you to watch each session and take notes that you will share with the researcher. After three sessions you will

participate of a meeting where you be asked to share feelings, thoughts, ideas about the sessions (i.e., perceptions, interventions, feelings, thoughts, etc.) with the researcher-consultant.
At the end of the research process you and your colleague will be interviewed by the researcher-consultant where you will be asked to share feelings, thoughts, concerns, conclusions about the entire process.

What happens if I say no, I do not want to be in this research?
You may decide not to take part in the research and it will not be held against you.

What happens if I say yes, but I change my mind later?
You agree to take part in the research now and if you stop at any time, it will not be held against you. Again, it will in no way affect your relationship with the researcher.

If you decide to leave the research, contact the investigator so that the investigator can schedule a meeting to arrange termination.

If you stop being in the research, already collected data may not be removed from the study database.

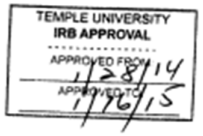
Is there any way being in this study could be bad for me?
There are only minimal risks for the therapist participants primarily related to possible aggressive behaviors from the participants. These minimal risks are no different from any other course of music therapy. You also may experience discomfort since, even though your therapeutic actions will not be the focus of the study, they will influence group dynamics and consequently will be discussed in team meetings.

Will being in this study help me any way?
The research process can help you to gain more skills, abilities and insights. You will experience reflecting in depth on details of group dynamics, in inter and intra-personal levels, such as perceptions of norms, roles, rules, conflicts, leaderships related to musical, verbal and/or body communication with people in the autistic spectrum.
Also, as a participant-therapist you will receive U$ 30 per session.

What happens to the information we collect?
Efforts will be made to limit your personal information to people who have a need to review this information. We cannot promise complete privacy. For example, though the study team has put in safeguards to protect your information, there is always a potential risk of loss of confidentiality.

Organizations that may inspect and copy your information include the IRB, Temple University, Temple University Health System, Inc. and its affiliates, and other representatives of these organizations, and the Office of Human Research Protections.

We may publish the results of this research. However, we will keep your name and other identifying information confidential.



Can I be removed from the research without my permission?

The person in charge of the research study can remove you from the research study without your approval. Possible reasons for removal include

*if you do not show up for sessions.
*if you are constantly late for sessions.
*if the researcher notices that you are not motivated for the work.

What else do I need to know?

If you sustain an injury as a result of your participation in this research study, the physician's fees and medical expenses that result will be billed to your insurance company or you in the usual manner. Other financial compensation (such as lost wages or pain and suffering) for such injuries are not routinely available. By signing this consent form, you are not waiving any of the legal rights that you otherwise would have as a participant in a research study. If you have questions about the study or a research-related injury, please contact

Mr. Chad Pettengill
Temple University Institutional Review Board
1801 North Broad Street
401 Conwell Hall
Philadelphia, PA 19140
(215) 707-8757
chad.pettengill@temple.edu

Your signature below indicates that:

- Someone has explained this research study to you.
- You freely volunteer to be in this research study.
- You can choose not to take part in this research study and it will not affect your care.
- You can agree to take part in this study now and later change your mind. Your decision to leave the study will not affect your care.
- You have been offered the opportunity to ask questions and all your questions have been answered.

Your signature documents your permission for the named child to take part in this research.

DO NOT SIGN THIS FORM AFTER THIS DATE →

Printed name of the therapist

Signature of the therapist

Date

Signature of a witness

Assent for Minors:

ASSENT FOR MINORS

Title of the Research: The Psychodynamics of Music-centered Group Music Therapy with People in the Autistic Spectrum.

Investigator and Department:
André Brandalise Mattos, MA
PhD Student, Temple University
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Advisor: Darlene Brooks, PhD, MT-BC, LPC
Associate Professor of Music Therapy
Temple University
Esther Boyer College of Music and Dance
Philadelphia, PA
E-mail: dmbrooks@temple.edu

Why are we doing this study?
We want to observe you and your peers together in a music group every week. We are interested in seeing you and your peers being together, playing, singing, trying instruments.

What should you know about a research study?
You and your peers will meet with two music therapists, who will listen to you and play with you during the music meetings, for 16 times once a week. So, we will start in March 2014 and will finish the music meetings in June.

Each meeting will last 40 minutes and in all sessions you will be able to be with your peers, try instruments, sing, create whatever you want with your peers and your music therapists. You and your peers will be able to listen, play and sing songs such as children's songs, rock, pop, rap, etc. Whatever you want.

However, in this experience you can also experience discomfort in some situations. I give you examples of when these discomforts may happen:

- You may not become a big friend of some of your peers.
- Someone can ask to sing, listen or play music that you may not like.
- You may want to play an instrument and another peer can be using it and you will have to wait for your turn.
- Each person in the group has the right to choose music, to sing, to play. You may experience discomfort having to wait your turn to choose music of your interest.

Also, at the end of the research you may feel that you do not want to say good bye to your friends and therapists and that you want to keep coming to these music meetings. You will be asked to share your feelings with us. If you need a few more meetings we will provide them. If after the group has ended, we believe that it will be important that you keep coming to music therapy, we will tell the people at your center.

Music meetings can

- help you to play with others, to sing with others, to listen to others' music, to wait for others' turn, etc.

- help you to learn different music with others, to learn how to play in a different way with others, to accept others' music interests, etc.

You will not get paid to participate in the music therapy program.

If you have questions, concerns, or complaints about the music meeting you can call me at (51) 9251 9016 or e-mail me at andre.brandalise@temple.edu.

The university (school) where I study is called Temple University. And there is a place there where you can also ask questions or can complain about your experiences at the music meetings. It is called Institutional Review Board (IRB). If you want, you can contact them at (215) 707-3390 or e-mail them at: irb@temple.edu.

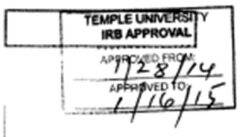
What else do you need to know before you give consent?
I understand that I will participate in the music meetings only if I want to and that I can decide not come whenever I want. I just have to call the researcher telling him about my decision and will schedule a meeting to talk about my decision. Also, I understand that the researcher and the therapists will not tell anyone about things I do and I say during the meetings except with the researcher's professors. They will change my name for nobody to know my real name.

☐ I understand that I will be video recorded by the researcher during each session and that these records will remain with the researcher and with the therapists. Only the researcher's professors will watch the videos.

And if I have questions?
I understand that I am encouraged to ask questions at any time, and that my questions will be given prompt and full answers.
I understand the information that has been given to me. I have been given an opportunity to ask questions and have had all questions answered. I understand that my signature below indicates my free will to participate in this study as described above. I understand that a copy of this assent form will be given to me.

Your signature documents your permission to take part in this study (music meetings).

DO NOT SIGN THIS FORM AFTER THIS DATE →



Printed name of minor

Signature of the minor

Date

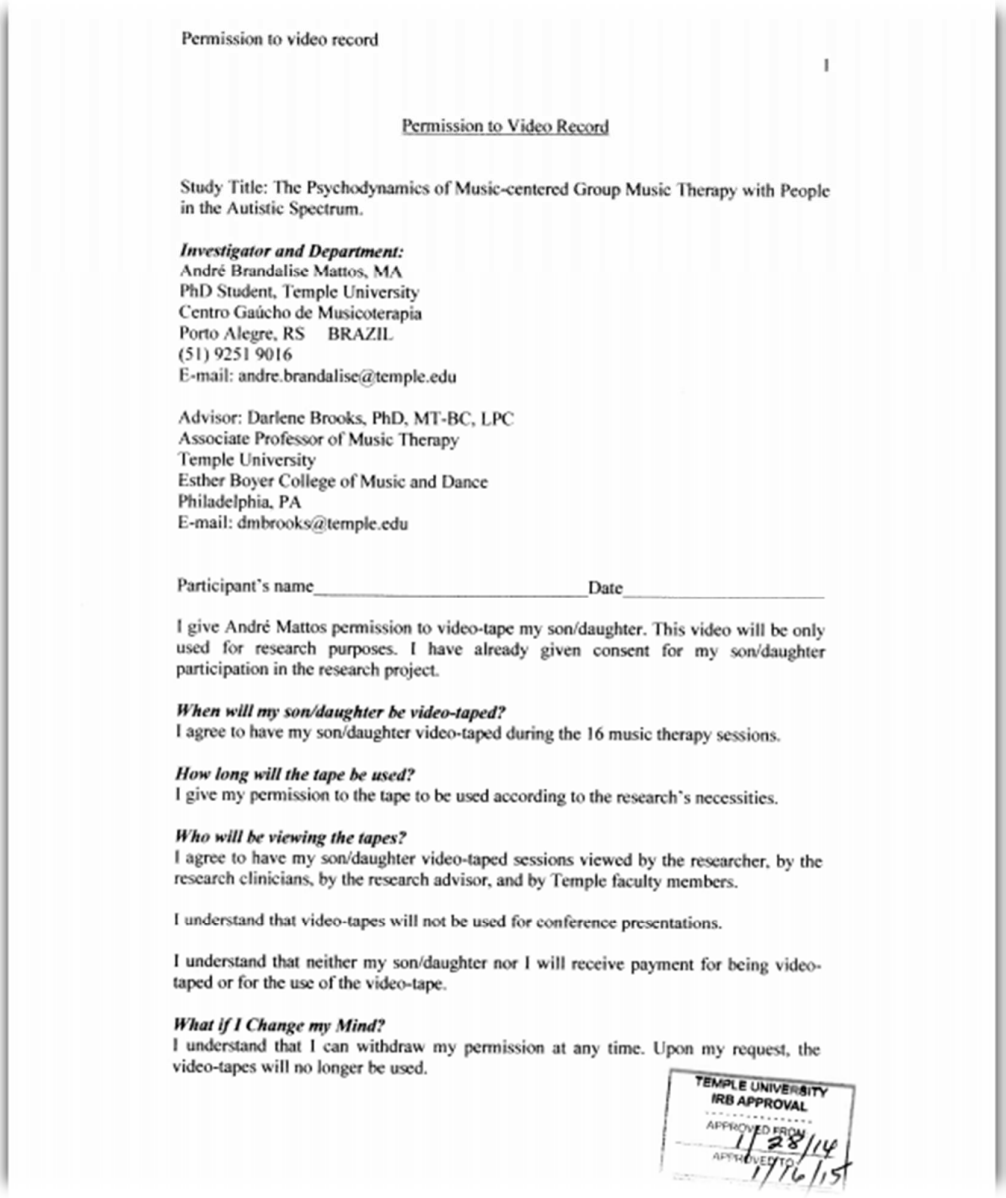
Signature of the witness

Interpreter's Statement

I have interpreted the information presented orally or by sign language to the subject by the investigator or person obtaining this consent, as well as the subject's questions of the investigator or person obtaining this consent in Portuguese (specify the language). To the best of my knowledge and belief, the subject understood this interpretation.

Signature of Interpreter **Date**

Permission to Video Record:



Permission to video record

1

Permission to Video Record

Study Title: The Psychodynamics of Music-centered Group Music Therapy with People in the Autistic Spectrum.

Investigator and Department:
André Brandalise Mattos, MA
PhD Student, Temple University
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Associate Professor of Music Therapy
Temple University
Esther Boyer College of Music and Dance
Philadelphia, PA
E-mail: dmbrooks@temple.edu

Participant's name_____Date_____

I give André Mattos permission to video-tape my son/daughter. This video will be only used for research purposes. I have already given consent for my son/daughter participation in the research project.

When will my son/daughter be video-taped?
I agree to have my son/daughter video-taped during the 16 music therapy sessions.

How long will the tape be used?
I give my permission to the tape to be used according to the research's necessities.

Who will be viewing the tapes?
I agree to have my son/daughter video-taped sessions viewed by the researcher, by the research clinicians, by the research advisor, and by Temple faculty members.

I understand that video-tapes will not be used for conference presentations.

I understand that neither my son/daughter nor I will receive payment for being video-taped or for the use of the video-tape.

What if I Change my Mind?
I understand that I can withdraw my permission at any time. Upon my request, the video-tapes will no longer be used.

TEMPLE UNIVERSITY
IRB APPROVAL
APPROVED FROM 11/28/14
APPROVED TO 11/6/15

For Further Information:
If I want more information about the video-taping, or if I have questions or concerns at any time, I can contact the researcher or his advisor at the numbers at the top of this page.

I understand that my signature below indicates my voluntary consent to have my son/daughter video-taped. I understand that I will be given a copy of this form.

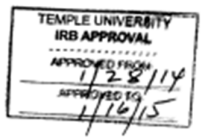
Name_____

Address_____

Telephone numbers_____

Signature_____Date_____

Witness_____Date_____



Appendix F

Photos of Research Environment

Figure 1. The new organization of the music therapy room and research environment after the first team meeting and before session 4.

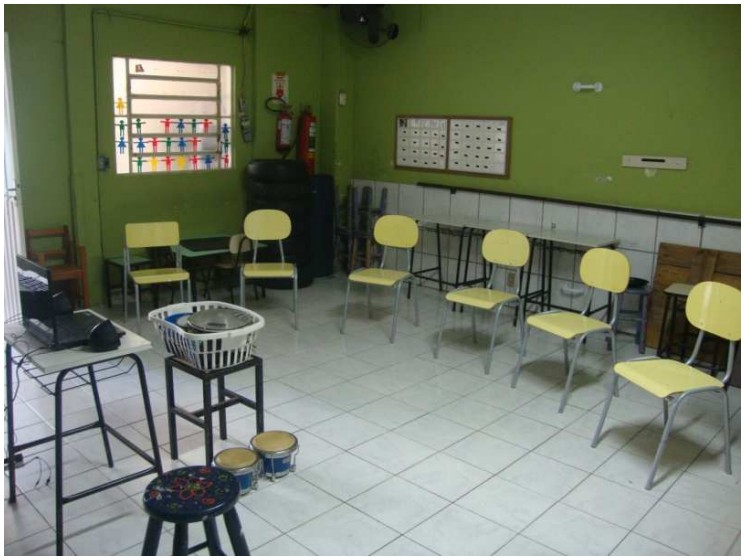


Figure 2. A photo of the research environment demonstrating that benches replaced individual chairs in session 7.

Appendix G
An Example of Session Description and the Generation of Themes and Categories

SESSION DESCRIPTION, CODING AND CATEGORIES
(session 1, March 7th 2014).
ANALYSIS PERFORMED IN: March 7th and 8th , 2014.

The group is comprised by six people with ASD: Donald and Louie (8 years old), Sonia (9 years old), Joshua (10 years old), Valeria (12 years old), and Gustavo (14 years old). Only Joshua and Louie participated in music therapy before, when much younger. None of them have the ability to communicate verbally.

Before session starts, Chad and Carly set the room in a way that the clients are expected to sit in a semi circle in front of both therapists. [THE WAY THERAPISTS ORGANIZE THE MUSIC ROOM POINTS OUT THEIR EXPECTATIONS OF THE WAY THEY WANT GROUP PHYSICAL ORGANIZATION].

[AB1] Comentário: ROOM ORGANIZATION (RO); Possible category: THERAPISTS' EXPECTATIONS.

Joshua and Sonia entered first. Sonia closes the door leaving the other four peers outside the room. The Center's director brings the clients and stays in the beginning in order to introduce all the clients to the team. Carly asks Valeria to sit down in order to start the session and Chad asks Louie to do the same.

Chad closes the door leaving two clients outside the room. In 47 sec they had two clients in the semi circle, two outside the semi circle, and two outside the room. [REPRESENTATION OF INTERNAL AND EXTERNAL EXCLUSION]
Gustavo and Louie enter the room. Carly brings Valeria closer to the semi circle but in a chair.

[AB2] Comentário: It could be a metaphor of a community where some people are included and some are excluded.
Code: INCLUSION AND EXCLUSION (I&E) – two categories emerge here: internal and external exclusions. Internal when it seems to be imposed by the pathology and external when it is caused by an external element (e.g., when Chad closes the door leaving two clients outside the room)

Donald grabs the guitar strongly. Chad asks him to wait and to sit.
1:47 – Louie leaves the semi circle again.
2:26 – Louie raises his hand towards Sonia who demonstrates fear. Louie does not hit her, though.

[AB3] Comentário: Code - SYMPTOM and category - AGGRESSIVENESS.

[THERAPISTS ESTABLISHING NORMS USING SILENCE AND PHYSICAL CONTACT– THE GROUP NEEDS NORM].

[AB4] Comentário: Codes: GROUP DYNAMICS (GD) and THERAPISTS' ROLES (TR). Category: Norms.

3:18 – Sonia looks firmly to Carly and smiles.
Gustavo is on his knees starring at the center's director and giving his back to the therapists and to the center of the group.
3:49 – Gustavo stares at Chad and Donald [HE SEEMS TO DEMONSTRATE INTEREST IN WHAT IS GOING ON].

[AB5] Comentário: Code – INTRA-RELATIONSHIPS (IR); Category – Intra-relationship.

4:48 – the same thing happens with Gustavo and Joshua observing Carly and Donald.
5:01 – Chad and Carly include music in the session. Sonia's facial expression is significantly happy.

[AB6] Comentário: Code – IR; Category – Interest.

Chad decides to improvise a 4/4 song with a strong first beat. Louie responds quickly to it and they start a body interaction. Valeria looks at them. Carly starts offering the tambourine for the group members to play while Chad is playing the guitar. The song lyrics is about their names.

[AB7] Comentário: The beat was strong – Two codes: TR and MUSIC'S ROLE - MR (music is helping in the establishment of norms and leadership).

Appendix H
An Example of Analytic Memo and the Generation of Codes

ANALYTIC MEMO

(after session 3, March 21st, 2014) - after talking with Ken Aigen through skype, I reorganized the format of the descriptive log and, in thinking of codes and categories, I perceived two agents in therapy working side by side in order to achieve some therapeutic goals for the individuals and for the group itself: Therapists and music having similar roles in the first session (working on leadership; facilitating order working on norms). Establishment of leadership and norms seemed to be the two main goals in terms of group dynamics in the first session.

EXCLUSION AND INCLUSION (forces?): I came up with the idea that what the research team is doing is a replication of a community. We are working with people who tend to be excluded from a regular routine of a regular society. As one of the main goal therapists should have is to facilitate their organization and integration in the world through the use of music and creativity – based on the previous coding, I noticed that we may be dealing with different categories of exclusion and inclusion: I think of internal and external "forces." Internal exclusion when the exclusion is caused by an internal factor such as the barriers of the pathology itself (2:5). As an example of external exclusion occurred when, in the beginning of the session, Chad was more worried with the clients that had already entered the room and closed the door leaving two others outside the room (1:19,20). And musically, therapists had a rhythmical pattern (2:22) and an interval (2:28) produced by clients. They seemed not to listen to them (blindness caused by rigidness?).

Comment [AB1]: INSIGHT #1; Theme INCLUSION and EXCLUSION; Categories – INTERNAL and EXTERNAL INCLUSION and EXCLUSION.

Internal inclusion we experienced when we recognized the internal necessity for relationship, for contact, for communication etc (2:32). Therapists and music's roles have the goal to provide external inclusion which means providing external elements such as safety, trust which offer ground for the clients to be included in the group (representation of a community).

Yalom and Leszcz (2005) believe that nothing seems to be of greater importance for the self-esteem and well-being of the adolescent, for example, than to be included and accepted in some social group, and nothing is more devastating than exclusion." (p. 57)

Ruud (2004) has already mentioned that music therapists are using music as a way to bridge connection between individuals and communities. Music used as a personal and social action, as a cultural and political as well as an aesthetic force (Pavlicevic & Ansdell, 2004). According to this authors music creates community.

(after session 2, March 14th) – while participating as the filmer in the sessions and analyzing the videos I feel a weird sensation, never experienced before, of not being able to make any comment to the therapists about their procedures and ways they are perceiving aspects of the group dynamics.

Comment [AB2]: RESEARCH QUESTION #2 – category CHALLENGES.