Exploring processing and reflection methods and how they can be utilized in music therapy sessions at an adolescent acute psychiatric ward

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Abstract

This study explores how other music therapists and mental health professionals process [1]and reflect[2] on their sessions and what issues are relevant and instrumental in achieving this. The primary focus is on an acute psychiatric ward for adolescents. The intent is to improve my ability to process and reflect on my clients' responses and actions during and after future Music Therapy sessions. Research began by exploring the various ways of processing content that emerge during sessions by exploring the literature, interviewing an Occupational Therapist and a Clinical Psychiatrist from the unit and by analysing my reflective journal. Using multiple sources of information, methods, techniques and theories I will endeavour to uncover meaning, improve my understanding and thus improve my future practice. The initial perspective was endeavouring to discover how a therapist can better reflect on or process their sessions. Findings showed that the therapist processing with intent to "fix" or "cure" a client is misdirected. Through self-reflection, observation, 'mindfulness'[3], empathy, awareness of countertransference and several other tools, a therapist is able to become client-centred and potentially assist the client to self-reflect and develop mindfulness. The way in which a therapist processes and reflects is often influenced by an underlying psychodynamic theory that they adhere to.

[1] For the sake of this paper, "Emotional processing...involves the meaningful integration of emotion and cognition, resulting in emotional insight and a reorganization of the patient's sense of self and/or others and improved ability to resolve problems and respond adaptively" (Bridges,2006, p552).

[2] The use of the term 'reflection' in this paper is understood to mean: to look back at an activity, comment, action or composition that has occurred during a session and thinking about its' meaning and/or significance.

[3] Mindfulness is an awareness of one's thoughts, actions or motivations. (Wikipedia, 2008).

Experience and training can also influence this processing. With this client group, it is difficult to fully comprehend what a client is feeling or thinking. A therapist best serves the client by initially focusing on the client-therapist relationship. By building a trusting, safe environment, meeting the clients where they are emotionally or physically and by making exercises meaningful, clients needs can begin to be met. This all contributes to the ultimate goal of the therapy at this unit - to help clients “gain skills, gain independence and gain wellness” (Appendix 1, lines 514-515).

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The history of psychotherapy abounds with healers who were effective, but not for the reasons they supposed. At other times we therapists throw up our hands in bewilderment. Who has not had a patient who made vast improvement for reasons entirely obscure to us?

(Yalom, 1975, p5)

Background:

I did my second year Masters in Music Therapy practical placement at an acute psychiatric unit for adolescents. Clients had a variety of diagnoses such as schizophrenia, depression, eating disorders, bipolar disorders and borderline personality disorders. When I began this placement on the unit, I found one question was constantly surfacing for me. How do I know what is the underlying reason for what my clients are expressing during the sessions? How do I accurately process and reflect on what they have offered (or not). When they react, speak or play in a certain fashion, how do I, as their therapist, act in their best interest? This is a client group that often does not identify how they are feeling today or how an experience was for them. Music making, in my experience at the unit, has become an outlet for many of the clients to express themselves in ways that they previously did not.

> Music is often considered a symbolic language allowing the therapist to explore its meaning for the client in improvisations followed by verbal therapeutic dialogue and/or hermeneutic ('morphological') interpretation.
> (Wigram,Pedersen, Ole Bonde, 2001, p37)

The following is an excerpt from my reflective journal. It illustrates my struggle to understand how to process for myself and for the client, what occurred in a song writing session that we had together. This is when I decided on this research question to discover some answers:

10-05-07 A message for …

I tried to listen
I tried to help
Were you asking for me to stop you?
Did I let you down?
You spoke of a journey

I had a feeling
I knew
But the question for me was
What do I do?
I told other people
I gave them your song
I said I was worried
Everything felt wrong
Should I have kept you there?
Was the music session not long enough?
Should I have given you all my time?
What did I do wrong?
What didn't I do? To help you….

My question strives to answer how we, as therapists, uncover this meaning? How do we process what is presented in order to be more effective practitioners?

Qualitative research:

> A process wherein one human being genuinely attempts to understand something about another human being or about the conditions of being human by using approaches which take full advantage of being human. (Wheeler, 1995, p426).

Methodology:

This study is qualitative due to the nature of the material being studied. There are elements of action research although the cycles that are typical of this are not clearly defined. This research is exploratory and endeavours to make use of "layering" of data. This is the "blending of different voices, stances…and sources of information to create a more complete portrait" (Wheeler, 2005, p219). I have taken a holistic or hermeneutic approach in that I gathered information, made observations of individuals, myself and the client group in general, implemented them, observed my experiences, and began the cycle again.

> The basic method of hermeneutic researchers is the hermeneutic circle, a formal expression of circular thinking. The elements of the hermeneutic circle are experiences, wholes, contextualizations, parts, integrations, and back to experiences…hermeneutic inquiry is holistic in nature and is an unending circle of knowledge creation. (Wheeler, 2005, p66).

Methods:

I began my research by searching and analysing the literature to discover what other professionals were experiencing in this area. Information that was gathered during the literature review and the interviews I found to be extremely relevant to my practice and I endeavoured to use it when possible. I kept a reflective journal during my placement at the unit that was used as data as well. Though it was ethically necessary not to discuss directly my observation of clients and different techniques that were implemented with them, my reflective journal provides evidence that my confidence and skills as a therapist were evolving. My experiences and impressions were a vital part of this research.

> One of the ways that qualitative researchers own their research is by …the stance of the researcher or a self-hermeneutic, in which the researcher shares who he or she is in relation to the research, including the motivation for the research, prior ideas about probable results, and other things that might affect his or her perspective on the research. (Wheeler, 2005, p67).

I undertook two semi-structured interviews to uncover issues, techniques and elements of sessions that other professionals working in acute adolescent mental health consider to be important. I chose to use an interview as opposed to a questionnaire because it allowed me to elaborate with further questioning based on the responses. I used interview guidelines in order to provide a framework for the interviews and to keep myself focused on the topic. Several weeks before I needed to begin interviews, letters were placed in all eligible candidates mailboxes inviting them to partake in the interviews. They were given an information sheet on the research project and were given a deadline of 3 weeks in order to respond. One occupational therapist and one clinical psychologist answered my invitation and agreed to be interviewed. Times were arranged that suited each of them and interviews took place in a private office on the unit. At their request, I supplied them with some interview guidelines prior to our interview.

The interview guidelines were as follows:

1. Are there any specific techniques that you use during your sessions with clients here at the unit which you feel help you process and reflect what is occurring during the sessions? If so, what are they?
2. What media have you used during your sessions? Does this assist in your understanding of the clients?
3. Do your sessions all have a similar structure or does this change depending on what is occurring in the session?
4. Do you consult other professionals to help you process on the sessions? If so, how does this help?
5. How does supervision (if at all) help you reflect and process on your sessions? (This question may be used if Supervision was not mentioned in previous responses)
6. Do cultural aspects of the clients affect your reflection process?

Data Analysis:

A thorough analysis of literature was undertaken to discover themes and patterns in the data. Interviews were audio taped and then transcribed verbatim. Copies were returned to each interviewee for examination and editing. All data was first read or listened to in order to establish an overview of the material.

> Whatever the data and format, the main idea is to get an overall picture of what gives each particular set of data set its coherence, meaning , character or distinctiveness. At the same time, the researcher will be beginning to identify the unique properties of each type of data comprising the case" (Bruscia in Wheeler, 2005, p182).

The literature was first analysed, then the interviews, and then finally the reflective journal. The data gathered in the literature review, interview transcriptions and the reflective journal transcription were all rigorously analysed after the first reading. On the second reading, I made margin notes relating to possible categories. Categories were grouped and themes were developed from the categories. Descriptions of these categories were made. Bruscia states that "descriptive codes … are created inductively, that is, they emanate directly from the data" (in Wheeler, 2005, p183). Themes were then generated from within these categories. After this was done for all data, comparisons were made, convergent and divergent categories and themes were noted. Original graphs were then constructed based on the findings, which compared the reflective processes of new therapist and more experienced therapists.

> Deciphering the meaning of behaviour is a bit like putting together the pieces of a puzzle. (Delaney, 2006, p171)

Literature review:

This literature review forms a significant part of this research paper because it is also used as a data source for this study. I have included more direct quotes than might usually be expected, to demonstrate how the categories and themes were generated. The subheadings for each section relate to categories uncovered in the data, and the themes are articulated at the end of the literature review.

This literature review begins with an examination of the Music Therapy literature, and also includes relevant information from psychology literature, experience based learning, and interactive drawing therapy literature that specifically related to processing and reflection. Streeter (1999,p18) stated, "defining music therapy in relation to other closely associated disciplines, as opposed to exclusive of them, is a way of acknowledging the intrinsic nature of music." This paper by Streeter(1999), "Finding a Balance between psychological thinking and musical awareness in music therapy theory – a psychoanalytic perspective", gave rise to a debate and several articles published which study in-depth how music therapists understand and process what they do. Brown (1999,p70) comments

> Sometimes the musical interaction is enough, sometimes it is not. But surely if we have chosen to work as music therapists, we need to give true consideration to what music has to offer that is unique – otherwise, why not only use words?

Andsel(1999,p74) notes an opposing view presented to Streeter's "preference for verbal 'processing' being essential to music therapy" and comments that

> It is interesting to note how many experienced music therapy practitioners (across any current theoretical divide) admit to a spiritual dimension to their experience of music and in their music therapy (as witnessed by those talking in Mercedes Pavlicevis's book *Music Therapy- Intimate Notes*(1999))

A final point, Aigen(1999,p79) notes

> Every area of human inquiry begins by adopting explanatory models and theories from other disciplines

Since my starting point for this research is from the music therapy perspective, I think it is important to first look at music therapy and music. The World Federation of Music Therapy produced the following definition of music therapy in 1996:

> Music therapy is the use of music and/or musical elements (sound, rhythm, melody and harmony) by a qualified music therapist with a client or group, in a process designed to facilitate and promote communication, relationships, learning, mobilisation, expression, organization and other relevant therapeutic objectives, in order to meet physical, emotional, mental, social and cognitive needs. Music therapy aims to develop potentials and/or restore functions of the individual so that he or she can achieve better intra- and inter-personal integration and consequently, a better quality life through prevention, rehabilitation or treatment. (Wigram, Pedersen, Ole Bonde, 2001, p30)

This research is concerned with the "how to" facilitate, the "how to" understand what is being expressed, the "how to" meet the needs of this client group, the "how to" understand what these needs are.

The Language of Music

Other disciplines "speak" in the language of words, body movement, drawings and other expressive arts. In music therapy, the language that we speak, is that of the music, the body language and verbal expression to name a few. We can look to other professions for help in interpreting, processing and reflecting on other forms of expression – but what about music? How do we as music therapists, know what music is expressing for our clients – the meaning?

Wigram, Pedersen & Ole Bonde(2001) stated that music can be considered a language and that music can express and contain meaning that is beyond the laws of musical composition and in addition, that in the absence of words, music can still have meaning. For the sake of this paper, I will include lyric writing under the umbrella of music and nonverbal expression

because I feel that lyric writing is different to verbal conversation. It is in the context of the music that the lyrics often are created and they are often more metaphoric in nature than words in a conversation.

Music is acknowledged as a kind of expressive language that a Music Therapist might need to be able to interpret. Therapists using reflection and processing models can try to understand the meaning. Merlin Donald defines a concept called mimesis:

> The ability to act, dance and sing out a narrative of experiences and feelings by moving the body, any part of it, with expressive rhythm, depicting absent events and imaginary transformations. With mimesis came the ability of humans to understand each other's acting as a dramatic, or melodramatic, message. This must be why, for modern humans, music always carries meaning beneath and beyond language. (in Pavlicevic,1997,p xii).

Thereby creating another language to be interpreted.

<u>There's more than just music to process:</u>

Music is a kind of language with meaning. Many people would agree that this meaning surpasses the spoken word. This meaning is presented in a variety of ways but is not always obvious to the therapist and often the presentation creates more questions than answers.

> Flowing in this steady stream [of encounters] are messages and cues from the client for the therapist to process, multiple physical and emotional reactions that the therapist has, and a unending current of thoughts and questions to ponder, relevant and irrelevant, lucid and fragmented. (Bruscia,1998, pp93-94)

Exploring what issues are relevant and important to the processing and reflection of sessions starts by looking at the language that is being interpreted. It seems to be more than just the language of music that music therapists are faced with when working with this client group in this environment. They appear to be looking at clients' body language their spoken word, their actions/or lack of actions, their drawings(which are done in response to music), or more than likely, a combination of all.

Looking outside the music therapy profession for information appears to be accepted practice in order to understand WHATEVER is seen or heard and to know how to best serve the clients. Therefore, talking to and reading about what other professionals working in allied professions are doing can be helpful to individuals in their practice. Other professionals have ways of processing and reflecting what happened in their sessions. These general techniques can be used across the board – to help understand no matter what the "expressive language" is.

Underlying Theories/approaches used for reflection and processing

A lot of the therapist's perception of what direction the session should proceed in and what is best for the client reflects a personal theory – whether or not the therapist is aware of this theory.

> Acceptance of a psychotherapeutic theory…indicates that [the therapist] has integrated the assumptions and procedures of the theory and looks to them for answers as to why certain processes occur in therapy and how to manage them. (Wheeler, 1981, p10)

The way in which the therapist chooses to respond, the way they interpret what a client means, what this meaning represents in the client's life, what the goals of therapy are, what the therapist's role is and how to achieve these goals reflects a theory that is being put into practice (Wheeler, 1981). Music therapists use a variety of theories and techniques to understand their clients and to provide what they believe the client needs.

> Integration of a psychotherapeutic theory…helps to explain what happens in therapy, to make predictions, and to evaluate and improve results…like a good map it tells us what to look for, what to expect, and where to go. (Wheeler,1981, p10)

Music therapists draw from a variety of theories. Odell Miller (1999) used a group model that was influenced by several different theoretical frameworks. The focus of the music making was on improvisation. This improvisation, she believed, could reflect the client's current state which may then lead "to an understanding of internal and external, interpersonal and intrapersonal changes (p120).

> Although music therapists from diverse theoretical and practical backgrounds define distinctive therapeutic priorities, music is at the heart of all music therapy. It is the basis on which therapeutic relationships are created. It is also the basis on which, after the session, therapists (and clients) reflect not only about 'what happened' during the session, but 'what it means'. (Pavlicevic,1997, p1)

This brings the topic back full circle to the original point about reflection and processing. Using particular theories, the therapist is able to not only self reflect but assist the client to self-reflect.

There are many different therapies, approaches and theories that guide processing styles. Some were more dominant in the literature than others. Several have been briefly outlined in order to provide the reader with examples of differing processing techniques that might be employed.

Cognitive Therapy: The aim of this therapy is to correct unhelpful or inaccurate ways of thinking in order to improve the client's mental state/mood or to reduce anxiety. The basic premise is that behavioural and emotional disorders stem from clients' dysfunctional thoughts about themselves and the world. (Davis, Gfeller, Thaut, 1999; Harrison, Geddes, Sharpe, 2005). In music therapy, the music therapist may use lyrics or look at the musical content of songs to explore individual beliefs and to help identify emotions that are a result of these beliefs. The goal of this processing is likely to be to have "increased self-awareness and insights into irrational thoughts and how they result in unhealthy behaviours" (Davis, Gfeller, Thaut, 1999, p104).

Behavioural Therapy: This intervention is based on the notion that a lot of our actions can be explained by learned behaviours or conditioning. By changing this behaviour, a client's mental well-being can be helped (Davis, Gfeller, Thaut, 1999; Harrison, Geddes, Sharpe, 2005). This therapy often involves graded exposure to the source of anxiety, rewards for positive behaviour and reduction of negative behaviour by eliminating any reinforcement for them. Davis, Gfeller & Thaut (1999) comment that "one key is finding a reinforcement that is truly meaningful to the particular client" (p102). Part of the therapist and client reflection process may be the discussion regarding whether certain interventions were meaningful and

whether this has a positive (or negative) effect on the behaviour. Corey (in Davis Gfeller, &Thaut, 1999) notes that many therapists believe that behaviour therapy only deals with the external behaviour and though this may be changed, the processing of internal beliefs that created the problem still exist.

Cognitive behaviour therapy (CBT): This involves both behaviour and thought modification. In this approach, both the behaviour and the self reflection and awareness of internal issues are dealt with.

Personal construct theory: George Kelly developed this theory and it is based on each individual's unique perception of an event. "He identifies the need for [therapists] to be aware that what is in their heads is not necessarily translated to the heads of their [clients] " (Boud, Keogh, Walker,1985, p23). Kelly believes that the meaningfulness of particular events, concepts and objects is based on the perspective of the person viewing or experiencing it. Therefore, when reflecting on a situation (or a session), both the client and the therapist's perspective could affect the outcome of the processing that occurs(or does not occur).

Integrated approach: see eclectic approach

Eclectic approach: This approach uses a variety of techniques, models and approaches which the therapist feels will best suit the client - using the premise "if it works, use it" (Standley, 1991, p2; Davis, Gfeller, Thaut, 1999). This approach would allow the therapist the flexibility to process and reflect on sessions in a variety of ways based on each particular situation and client.

Attachment Theory: A theory developed by John Bowlby which emphasizes the mother-child connection and relationship. He believes that infant attachment to the mother is instinctual and that behaviours are developed in order to maintain this contact to ensure "survival and protection from predators" (Hadley, 2003, p9). This theory holds that we are attracted to the familiar and try to avoid the unknown or strange – how we respond to the unknown or different, "reveals the degree and qualities of the primary attachment that have been internalised" (Hadley, 2003, p9). This could be illustrated in the client's ability or willingness to self reflect, to work on

processing their emotions/behaviour with the therapist, or a client's ability to build a trusting relationship with their therapist. If unable/unwilling to face the unknown issues, uncomfortable group therapy sessions or the unknown/new situation with a therapist, this could reflect problems with attachment as an infant.

Interactive Drawing Therapy: This is a client-centred, process-directed therapy that uses the images, words and behaviours of a client to reveal where they are in their therapeutic process, how to best proceed and perhaps the nature of their underlying issues.

> It uses right-brain drawing, writing and experiential techniques to complement and extend the more common left-brain talking and cognitive processes. IDT accesses deeply resourceful and wise parts of the unconscious, and provides us with new tools for understanding and working with the client's natural therapeutic process…it is particularly useful with clients who are not verbally or conceptually fluent, who have depressed affect, or are overwhelmed…the page is used as a therapeutic tool to mediate the interaction between counsellor and client… (Withers, 2001, p4)

Reality Approach: This was developed by William Glasser, and is focused on the present and the future, rather than the past. Involvement in activities is key to this approach in order to build a client's self worth. Therapists also help their clients accept responsibility for their behaviour. (Wheeler, 1981)

Humanistic approach: There are several approaches that can be considered humanistic. Gestalt therapy, person-centred which is associated with Carl Rogers, and existential therapy. In humanistic therapies the basic premise is that when a client is not personally fulfilled and is lacking in his/her life, an emotional disorder can occur. The relationship between the therapist and client is of vital importance in order for the client to feel secure enough to face issues. This approach emphasizes the clients inherent ability to control their own lives and to make positive decisions for themselves (Davis, Gfeller, Thaut, 1999). The therapist provides a safe environment that is conducive to client self-reflection and processing.

Gestalt therapy: Gestalt means wholeness. " A goal of Gestalt is to return to wholeness by helping individuals to become aware of, responsible for, reclaim

and integrate their fragmented parts. Integration releases a surge of energy that was used to suppress these emotions…" (Luckner, Nadler, 1992, p132). It is based on belief that humans have an inherent drive towards growth and needs satisfaction. Therapists will emphasize awareness in clients in order for these needs to be recognized and experienced (Wheeler, 1981). "This permits more responsibility for their feelings, thoughts and actions" (Luckner, Nadler, 1992, p132).

Psychodynamic approach: This approach maintains a belief that a person's behaviour is a result of an interaction of various elements of their personality such as ego, id and superego and interaction of past and present events. Therapy is generally focused on bringing the unconscious into the conscious mind and the process includes learning to recognize and understand projected feelings (transference and countertransference).

> The psychodynamic framework [in music therapy] appears to be based on the ability of music to bypass conscious verbal censorship and reach deeper parts of a person's psyche, to facilitate nonverbal expression and communication and to build ego. (Wheeler, 1981, p14)

There are several different approaches and theorists associated within this umbrella: Freud (Drive psychology), Erikson (Ego psychology), Winnicott (Object Relations theory), Kohut (Self Psychology), Jungian Theory influenced Priestley (analytical music therapy) (Hadley,2003).

Solution oriented/solution focused processing: The emphasis in this approach is that the client is looking for what they want, not what they do not want. The key is to emphasize client strengths instead of focusing on weakness (Gass, 2003). The client and therapist can reflect on the positive direction that therapy can move and process how a situation can be seen from a positive perspective.

Framing: Framing sets the stage for what is about to take place. It provides individuals with time before an activity to reflect upon the upcoming activity and how they are feeling about it (Luckner, Nadler, 1992). It gives clients a chance to prepare themselves for the event. The therapist, by framing, can introduce the activity, have the client aware of what is forthcoming, and also to

assist the client to process how they are feeling and what may be appropriate steps to take to deal with this.

Half-way interpretation: "The capacity of music to reflect and suggest without interpreting has a parallel with this psycho-dynamic approach. It leaves the patient to take the defining steps of attributing meaning"(Wetherick, 2004, p93). The therapist is not interpreting or reflecting what is occurring for the client. The music does this and the client may decide what the music means for him/herself.

Experience based learning: This approach is learning through participation. Clients are asked to take responsibility for their own behaviour and learning. It is based on the concept that, "one's own reactions to, observations about, and understanding of something are more important than someone else's opinion about it" (Luckner, Nadler, 1992, p3).

> It is only when we bring our ideas to our consciousness that we can evaluate them and begin to make choices about what we will and will not do. (Boud, Keogh, Walker, 1985, p19)

Therapists assist clients to self reflect on their behaviours and to process their experiences. Knowing that this is crucial, Boud, Keogh and Walker (1985), observed that, "the skill of experiential learning in which people tend to be most deficient is reflection"(p8).

The client/therapist relationship

To understand what is happening during a session and how to process and reflect on the sessions, a therapist must initially focus on establishing a relationship with the client. First and foremost in therapy is the client-therapist relationship. "In building up the first stage of working, the therapeutic relationship is considered to be a main instrument of change" (Sabbatella, 2002, p1497).

> The way the therapist interacts with the client…may determine the approach being used, and in fact, may very well be the most important factor in therapy. (Wheeler, 1987, p15).

Others consider music, as a tool to establish the relationship, to be just as important as the relationship itself.

> The relationship with the therapist is of equal value to that of the art form-music. The music therapist will focus on the person as a whole, primarily through the music, but also paying attention to aspects of the person shown not just through the music – for example, talking and thinking. (Odell-Miller, 1999, pp119-120).

Empathy is an important element of this relationship that the therapist needs in order to gain insight, process and reflect and assess the needs of his/her client. To understand this inner state the therapist has, on his side, the instrument of empathy that Kohut defines as "vicarious introspection"(Katz, 2002, p937). Katz continues by discussing Kohut's concept of a client having a self object and the importance of the therapist understanding this relationship. The self object for a child could be, for example, the mother. When she is in the room, the child is calm, secure – his/her needs are being met. When the mother leaves, the child then becomes distressed and anxious. "Awareness of this self object relationship gives the therapist insight" (Wolf, 1980, p44). Taken a step further the client/patient relationship can be a metaphor for that of the mother/child relationship (Wigram,Pedersen and Ole Bonde, 2001)

The mother/child relationship can be considered alongside the concepts of affect attunement and non-verbal communication. Affect attunement is the act in which a mother, out of awareness, matches the affect that lies behind the actions of the newborn. This non-imitative approach can be used with any client (not only infants) who may have been deprived of the adult attunement when he/she was a baby or who perhaps has difficulty attuning to or having relationships with others.

> This process permits the sharing of the [client's] affective state and, consequently, the intersubjective exchange, which is indispensable for the construction of the sense of subjective self.(Nirensztein, 2003, p 229)

The music therapist, out of awareness for the state of the client, can provide a response which supports the client's current needs. In order to provide a response that is empathetic, a therapist must enter a state that resonates with the way in which the client is feeling.

> One must therefore create within oneself a state of emptiness, like in the resonance box of a cello, and of utmost concentration, in order to be able to resonate with the inner state of the patient…the second step adds to intuition…the abstraction of empathic knowledge from the experience of emotional resonance. (Katz, 2002, p938)

This knowledge is then integrated into an empathic response. Intuition in conjunction with empathic knowledge assists in formulating a response that is seemingly reflective of the client's feeling state – what the client needs.

> Music allows the therapist to provide a closeness that is suitable for the client at that given moment of his experience, without going through the process of symbolization and, in certain ways, of alienation of the experience… which is intrinsic in verbalization. (Nirensztein, 2003, p228-229)

Rather than a verbal response to the client, which is the therapist's interpretation of the client's feeling state, music is used to respond, support, and build a relationship.

Stern et al (1998) comments that "something more than interpretation is necessary to bring about therapeutic change (p903)." These moments- "now moments" – when there is empathic connection, are capable of modifying the basic structure of the relationship between the client and the therapist. The way in which they relate and know each other can be changed which can then modify the client's understanding of the nature of relationships and his way of being with others (Stern,1998; Nirensztein, 2003).

Therapist perspective - client perspective

When a therapist reflects back to a client a response, be it verbal or nonverbal, musical or non musical, it is important at this point of therapist reflection that the "techniques to assist reflection need to be applied to the constructions of the [client] rather than those of the [therapist]" (Boud, Keogh and Walker , 1985, p23). In contrast, Schonfeld(2003) describes her process "with my ear I tune into my client, becoming aware of his/her vulnerability, his/her idea. Within the scope of music I let myself be guided by the creativity of the client and then my response is guided by my own inspiration"(p208). This variation in the way therapists tailor their responses may reflect an underlying theoretical practice or perspective. Each of us has a unique

perception of the world and experiences. The way one person reacts to a particular situation will often be quite different from someone else. The way that a client responds to new experiences is often significantly influenced by past experiences which have contributed to the client's perception of the world (Boud, Keogh, Walker, 1985). Perspective is important. Interactive Drawing therapy speaks of the drawer's and the therapist's projection on a situation or an object (Withers, 2001). Projection is the filter or lens in which something is viewed. This can be influenced by our religion, ethnicity, age, personality, parents or past experiences to name a few. As a therapist, it is crucial that personal projections do not interfere with a therapeutic interaction.

> Any given experience may be important or helpful to some members and inconsequential or even harmful to others…the further we move from the patient's experience, the more inferential are our conclusions… (Yalum, 1975, p5)

Standley (1991) notes, "persons who counsel or teach act upon their own value systems by making many choices for others…among these choices are determining another's problem, deciding what to teach to promote its resolution and selecting the most appropriate technique to use in this endeavour" (p2). These choices should not be based on personal projections or perspectives of the therapist but rather the client experience and what is inferred and expressed by the client through such processes as observed body language, musical/artistic production and spoken word.

Client self- reflection

It is a therapist's responsibility to assist clients' reflection process which involves self- reflection by both the therapist and the client. There is some evidence in the literature supporting the importance of client self reflection, but it also maintains that as therapists, we still must reflect on what we think is being presented.

> There are complex and multi-layered meaning in music therapy – verbal, musical and neither of these – that we need to unfold without being too conclusive, in order to enrich our insights into the work. The richer and more complex our understandings and insights, the richer the experience we are able to share with our clients. (Pavlicevic,1999, p76-77)

Understanding this can then enable the therapist to assist the client to self-reflect. Many music therapists, Odell-Miller (1999) for example, use the process of improvisation and talking to assist clients to gain insight and understand more about themselves. From a psychodynamic point of view, it is thought that improvisation reflects internal processes and beliefs. Continuing from a slightly more humanistic angle, if the therapist has established an environment of security and empathy, the client's innate ability to want to heal and become whole will be supported. Nirensztein(2003) comments about her "faith in [a] person's intrinsic capacity to develop and cure himself given proper relational conditions" (p238). The client's ability to self-reflect will be not only encouraged but supported.

> Only learners themselves can learn and only they can reflect on their own experiences. Teachers can intervene in various ways to assist, but they only have access to individuals' thoughts and feelings through what individuals choose to reveal about themselves. At this basic level, the learner is in total control. (Boud, Keogh, Walker, 1985, pp10-11)

It is apparent that a key feature of self-reflection is that clients need to have the freedom to make a genuine choice for themselves, rather than having to abide by decisions or be influenced by choices of the therapist. None the less, the therapist's approach will affect the sessions and will on some level influence the process, the direction that it proceeds and the choices the client makes.

Counter-transference[4]

In order to be helpful to clients, some literature suggests that a therapist must process his/her own counter-transference. A Music therapist's skill lies in not becoming overwhelmed by personal feelings in sessions.

[4]**Countertransference:** "The process through which the unconscious conflicts and motives of the therapist are activated by the contact experienced with the client, and are then transferred to the client" (Wigram, Pedersen, Bonde, 2002, p317)…
Transference: When a client brings to therapy expectations and assumptions from past experiences and transfers them to the new encounter. "When a patient comes to therapy there will invariably be a complex range of feelings directed towards the therapist, some positive and some negative. Feelings or attitudes felt towards earlier significant people in the patient's past life…will be transferred in an unconscious way into present relationships and onto the therapist" (Bunt & Hoskyns, 2002, p42).

> It would not help the client to have the therapist dissolve into tears or give vent to frustration. Rather, by feeling those feelings and by being able to contain them, music therapists allow themselves to be open and responsive to the other person. (Pavlicevic, 1999, p142)

When discussing Interactive Drawing therapy and a therapist's role, Russell Withers(2001,p12) comments, "lean back or you'll fall into the content."

> As the therapist, you realise that you are playing in a certain way in response to the patient, which previously you had been unaware(or unconscious) of. You then are able subsequently to make use of this musical experience…by consciously altering your musical style; and/or after the music has finished, making a verbal interpretation during discussion. This interpretation helps the patient understand how they may have influenced your response. (Odell-Miller,1999, p121)

The difficulty for the new music therapist, would be in knowing when a response is as a result of counter-transference.

> The therapist must be in deep contact with his/her own countertransferential reactions, especially those that pass through and express themselves in such a way that they interfere with the client's music. (Bruscia in Nirensztein, 2003, p229)

The therapist must be aware of his/her own feelings, try to understand them and then use this understanding to guide therapy.

Alternative media to assist therapeutic reflection and processing

Although this research is being done by a music therapist, there are tools that can be used other than music, to help reflection and processing for both the therapist and the client.

> For me music and images are very compatible, they both allow us to access different states of consciousness and to experience a transformation of the present moment to see more in the here and now. (Pavlicevic ,1999, p76-77)

In the same way that a music therapist can use his/her skills in observation and empathy to try and understand how to be with a client musically, he/she can also use these skills to understand when music may not be the best intervention.

> We, the therapists, are very lucky when our clients are able to open themselves up and when they manage to look together with us for ways that

> bring them farther…music therapists can-and even must-deviate from our established therapeutic techniques…if it turns out that music is not as beneficial as another therapeutic tool in an individual case. However, if our senses of hearing and of understanding are wide awake and if we can react in a flexible and creative way to what is happening, and what is displayed by the client, then we are of help. (Schonfeld, 2003, p208)

Music therapists must use whatever tool feels "right" and that which they are competent to use to meet the needs of the client at that particular time and place.

Summing up recurring themes in the literature:

1. The client-therapist relationship is a primary focus in therapeutic sessions.
2. Client self-reflection is an important issue in therapy and is a focus and goal for many therapists.
3. The therapists' responsibility is to provide an environment conducive to client reflection and safety.
4. A Therapist's empathetic response and the use of intuition are vitally important in trying to understand what feeling state the client is in.
5. Affect attunement and non verbal communication are tools used in therapy to help clients feel understood and heard by their therapist.
6. Adhering to a Psychotherapeutic theory can be of value to the therapist on various levels.
7. In the psychotherapeutic literature, processing your (the therapist's) counter-transference is necessary in order to be helpful to the clients.
8. Non-musical therapeutic techniques as a means for a music therapist to understand and help a client have been utilized in therapy.

The Interviews:

Two staff from the unit replied to my letter requesting participants for this research project. Letters had been placed in the mailboxes of the 1 occupational therapist, 2 social workers and 2 counsellors who were eligible for this study. I invited staff that have been in professional practice with this client group for at least two years and were not students. . One occupational therapist and the clinical psychologist both agreed to be interviewed at the unit and both met the research criteria. Both participants requested to have a copy of the interview guidelines prior to the interview (see page 5). The fact that the interviewees were aware of the questions prior to the interview may have limited the diversity of the data and the possibility of the interview following an unpredictable direction. Nevertheless, the interviewees both felt that they would rather have a chance to think about the questions before hand so that they could more thoroughly deal with the subject.

Interview Results

Interviews were analysed as per the methods outlined on page 6.

Clinical Psychologist (CP) interview:

This interview was done in two sessions at the request of the interviewee because she felt that there was more information that she would like to discuss.

The Therapeutic relationship:

The CP commented, “with therapy, the most valuable thing is the relationship with the person and not so much the techniques that you are using…” (Appendix 2, lines 304-305). It is the establishing of this relationship that needs to initially be focused on as the primary goal of therapy. As a new therapist, one often wants to immediately have the answers all of the questions, solve all of the problems, know what the client is thinking/feeling and know what techniques to use to process what is happening in a session. This interviewee emphasized the fact that focusing on the client and the relationship that they have with you, is vital in the initial phases of therapy before anything else can occur.

Meet the clients where they are instead of trying to fix them:

When initially establishing a therapeutic relationship, therapists often approach the situation with the thoughts that they can fix the problem – that they need to fix things. For many service providers there is a push to “fix [the patients] and get them out because there’s a long waiting list” (Appendix 2, lines 300-301). This interviewee pointed out that once the therapist “makes peace with [the notion] that you can’t fix anything for anybody” (Appendix 2, line 303) the truly therapeutic relationship may be established.

The Interviewee suggested that a therapist can not force clients to deal with issues before they are ready. Clients can only process and reflect what they are ready and able to deal with.

> It’s like a child learning to walk, if they are not ready, their muscles are not strong, you can lift them up and put them on their little legs all you like, it’s just not going to happen. (Appendix 2, lines 310-312)

She emphasized that it is important to know the client by observing them, listening and being there for them as opposed to trying to fix them.

The CP, from a seemingly Gestalt perspective, views the client first as a person, not a patient, who is presenting symptoms and trying to find balance and potentially a solution to their problems. The therapist should question what function the symptoms serve in this person's life.

> Is it a way of asking for help? Is it a way of getting away from a dysfunctional family? Is it a way of getting nurturing?...if people's defences are up or they don't want to talk about stuff or are trying to argue things away or are becoming very intellectual – whatever defence mechanisms they use, I try and not to break that down too quickly because if people are trying to protect themselves there's often a good reason. (Appendix 3, lines 11-16)

Findings suggest that it is important to meet the client where they are, and do not force them to be where you (the therapist or the service provider) wants them to be. The therapist should try to understand the feeling state of the client and should help them to be where they are ready to be by observing, processing and assessing what the client is doing. The therapist should "nurture and step over to [the client's] side of the fence…fight a good fight on their side before introducing different ways of seeing things"(Appendix 3, lines 28-29). Create a context where healing can occur, and then what is ready to immerge and ready to heal, will come to the surface. Through patience and waiting a therapist can begin to process and reflect upon what a client's needs are.

Therapist Mindfulness and Observation:

The CP began the interview by pointing out that therapist mindfulness is key to understanding a client and is where the client/therapist relationship should begin.

> That you are in a situation that is correct for them, that they feel listened to and validated before you do anything…that is almost the most valuable gift that you can give anybody…(Appendix 2, lines 305-308)

There is more to doing therapy than using techniques and having approaches. A therapist needs to have an intuitive feel and sometimes what he/she needs to do is practice his/her own mindfulness with the clients "You

need to… stop the conversation in your own head…I just stop everything in my head and I tune in very closely." (Appendix 2, lines 205- 214)). What often occurs in a session is that a therapist, while the client is talking, tends to be formulating a response. The words are heard, but the undertone can be missed because of being too cognitive. It is vital for the therapist to be totally there for the client, to listen and to be open to what the client is saying. The client needs to feel that…

> "[the therapist] is really there with me, she's listening, she's watching me, she doesn't push her ideas of whatever onto me…she's really there just with me and is quite aware of what's going on with me." (Appendix 2, lines 335-337)

Countertransference and Therapist self reflection:

In order to be mindful and present for the client, it is important to know yourself through continuous self-reflection. Not only are therapists trying to process and reflect on the client's present feeling state, but they also need to be aware of their own responses during a session. The CP noted that a lot of processing is done in her head during a session – "you get to know yourself" (Appendix 2, line 482). Subtle things can be observed and/or felt and countertransference may be the driving force that could effect the way in which a therapist is able to accurately reflect or process during the session. Therapists who have been doing work for a long time may be more experienced in recognizing when countertransference is occurring and with supervisory support and experience, can process how this should be handled. A countertransferential response can exhibit itself in different ways. The CP noted, "Personally, I react physically… you get a feeling this is not your physiological response but you pick up on their anxiety…it's not on a cognitive level…It's intuitive…(Appendix 2, lines 217-222).

The information that can be gained through being aware of this counter transference can be used to better understand the client. The therapist must be quite present and able/willing to open up to the client to reveal these feelings or responses.

> It's a risk that you are taking, it's much easier to be very cognitive and very intellectual and 'this is what I want to do' and 'this is what I am seeing' and 'that's what we are going to do', but it sets you apart – it's that art of moving in and experiencing all the darkness and the stuff that's going around but not to get so deeply into the clients' stuff that you can't disengage. (Appendix 2, lines 235-239)

This is referred to as "therapeutic manoeuvrability" (Appendix 2, line 247).

Therapist Experience

Knowing when you have allowed yourself to be affected by a situation/client too much and awareness of countertransference comes down to experience and supervisory support. The CP noted that over time, the therapist learns to process and reflect on three sets of information about the session. There is "the client stuff, me and the supervisor sitting behind me checking me being with a client (all occurring in your head)" (Appendix 2, lines 262-263). It takes time to develop the observer observing someone else because early on in a therapist's training he/she often does not notice what he/she is doing or saying in the session.

Client mindfulness/awareness:

Enabling clients to become mindful and self-reflective is a challenging goal with this client group. Many are not interested or able to speak about what they are feeling.

> With adolescents…the brain is not fully developed so for them, especially if they are emotionally distressed, to take the turmoil [that is occurring] inside and translate that into words and full sentences to explain it [is challenging]…how do you explain to someone when you feel yuck? (Appendix 2, lines 396-399)

A mood continuum can give clients skills in differentiation and the insight into their emotions. This can be a visual representation with, for example, 'terrible' at one end and 'ok' in the middle and 'better than it's ever been' at the other end. The client can then mark where he/she is that day. If this is done every morning, for example and the client notices that he/she feels 'down' initially, but getting out of bed improves the mood. It is possible that they may eventually become aware of this and be able to reflect that getting up out of bed in the morning could improve their mood. "It teaches them the

differentiation and the insight…It's creating a bit more mindfulness and it's better that they find that out for themselves than [therapists] saying it to them" (Appendix 3, lines 79-84).

Mindfulness and self-reflection of the client becomes very valuable when processing some of the extreme emotions displayed and understanding how the seemingly negative response could be turned into a positive. The CP referred to the 'transmutation of energy' in the continues interview(Appendix 3, line 31). Emotions are forms of energy that can be redirected. For example, someone with an eating disorder who exhibits great determination to achieve perfection may be able to shift this energy to drive getting well. Awareness of this and the ability to reflect on this possibility could give the client a positive and constructive way to view him/herself.

Other media used:

"With adolescents you have to use a whole number of things…anything to stimulate the senses…"(Appendix 3, lines 48-49). Alternative methods such as drawing therapy or drama therapy may be used to assist client and therapist processing and reflection. It is important to keep in mind that whatever media is chosen, it is in a form that is not too challenging for the client(s). "Some of the adolescents find it quite challenging, almost invasive...they don't always understand the real reason for talking therapies…"(Appendix 2, lines 374-376).

Finding a more indirect way for them to express themselves is often desired. There are some clients who are more intellectually inclined and don't mind having a discussion and are able and willing to express themselves verbally. Other clients are more inclined to express themselves if you run around and play ball with them. "In general, they respond well to non-verbal techniques and there's a richness of information that comes through with that"(Appendix 3, lines 87-88). Once they are able to express themselves, the opportunity for self-reflection and processing with or without the assistance of the therapist becomes more viable.

Flexibility and working in the “now” is the nature of the therapy that occurs at this unit. “The core of the structure is to have a plan, know what sort of priorities you have and what you would like to address, but also to grab the opportunity” (Appendix 3, lines 136-137) and use whatever media seems appropriate and needed at the time.

Working with co-workers to reflect and process:

Reflection and processing by the therapist after a session is often assisted by discussions with co-workers. This can occur in multi-disciplinary meetings (MDTs) or informally during breaks or while in the unit in passing. Self-reflection, personal processing and assistance in planning future sessions can be aided by professional supervision session. Conversations with the client’s key worker can also be beneficial with the processing of a session.

Cultural issues when processing:

The unit is bicultural and there is cultural diversity amongst the clients. “It is important to know how this culture and the cultural beliefs fit into their own belief system and lifestyle” (Appendix 3, lines 164-165). A therapist cannot make assumptions about a cultural belief system, but it is something that should be considered. Knowing what cultural influences are involved may help a therapist to begin to understand the perspective that the client and his/her family are coming from and how this manifests itself in the client’s presentation. Clients and therapists could both be considered learners in this context. Both are learning about themselves and others and encountering each other from their own particular cultural perspective.

Occupational therapist (OT) interview:

This interview occurred in one, 45 minute session at the unit.

Observation & Assessment:

Findings show that some therapists process and reflect on sessions "with the intent to set new treatment goals and interventions " (Appendix 1, line 606). Sessions with this client group might require the therapist to constantly be assessing the situation/clients to insure that selected tasks or activities are appropriate for the particular presentation of the client(s). The OT commented that,

> all the time I am assessing [during group sessions]…assessing where they are at with many different things - to give an indication of how well they are, what are the skills they need, what are the therapeutic techniques and strategies they need…all the time I am processing. (Appendix 1, lines 32-37)

Throughout the session she is processing how they are doing. It is challenging to reflect on what the client is presenting when trying to decipher from this what their emotional or mental state may be. The interviewee pointed out that,

> clearly observed task behaviours and social behaviours are much clearer to reflect upon than trying to reflect upon what the therapist believes the client is thinking. That's different because then that does become an assumption unless they tell you what they are thinking…just because they are smiling you think they must be thinking happy thoughts, that is an assumption. (Appendix 1, lines 260-278)

When the client gives very limited verbal feedback, the non-verbal cues and the context can be pieced together to assist the reflection process. With clients whose safety is at risk (suicidal clients for example) the interviewee stressed that it is important to "make sure you get other peoples assessments and process that as well…"(Appendix 1, lines 689-690).

Meeting the client 'where they are': The OT uses an "adventure based" approach for a majority of her client interactions and sessions which utilizes the "just right challenge." Findings showed that,

> [A therapist should not] completely overwhelm [clients] with activities being set too difficult [where they] feel incompetent and incapable and overwhelmed

> and distressed, but also wanting to provide enough of a challenge for them to feel a sense of mastery and to build on capabilities. (Appendix 1, lines 87-93)

After observing the clients, she reflects on what is presented, and then decides what is the appropriate next step in the session. The interviewee commented, "while I'm interacting with them, I'm also grading my interactions…" (Appendix 1, lines 64-65). Challenges are made a little more complex than in previous sessions and then the OT observes and processes how the client deals with that. Then, based on how they react to the challenge she "can make an assumption about their functioning"(Appendix 1, line 72). Based on what is observed, the next intervention is either slightly more challenging or better suited depending on the response. The cycle will then be repeated each session because this client group's emotional and physical state is variable from session to session.

Know the client/provide meaningful activity: When reflecting on an activity, and how the client responded, it is important that the therapist is aware of how meaningful this activity is for the client. This involves knowing the client and what his/her preferences may be.

> As an OT, my aim would be to get [the clients] involved in the activity in a meaningful way as much as possible, but also you do need to know about that person…is this something they absolutely hate doing…and [they] haven't chosen to be there…(Appendix 1, lines 186-194)

The therapist is always observing and processing what is occurring during the session and ultimately, strives to have client involvement in the activities. If a client is not participating, it is possible that the activity has no meaning for them at all as opposed to them not being able to participate. The therapist tries to reflect on what the underlying reason for the client's particular response/lack of response.

> [The OT tries to process] what is going on for that person…do they react this way to all interventions?...ultimately, [the] aim would be to know a bit more about the reasons to what was underlying…but also then to know enough to then get them involved in some way…(Appendix 1, lines 196-203)

This involvement could include getting the clients opinion on the activity or asking them to choose an activity that is more meaningful to them. The OT

comments, "getting them involved in stuff enough [for them] to just be observing and getting secondary consequence from the experience…by listening [or just being there]" (Appendix 1,lines 206-208).

The OT noted that, "[we] especially do that in music" (Appendix 1, line 208). Music can provide the opportunity for secondary consequences because clients are able passively to be involved in a music therapy session and still benefit from attending. The therapist can choose music or a musical activity that he/she believes is meaningful to a client. Observing the client response and through therapist and client reflection the meaningfulness of the activity may be ascertained. In turn, the therapist may then have more information to assist processing the client's state of being that day.

Intuition:

Intuition **based** on experience and theoretical practice is also utilized when reflecting and processing what is observed during session. The OT commented that,

> I wouldn't like to say it's strictly intuition. I think it's something we've done a lot of in our training about assessing functioning and task behaviour…it's a real basis of my training …grading activities, task analysis and observing skill behaviour. (Appendix 1, lines 115-125)

The OT observes what the clients are doing, what they are doing is then giving the therapist information about what the therapist should then do - "Ultimately with the goal of helping them to gain skills, gain independence, gain wellness" (Appendix 1, lines 514-515).

Client Self-reflection: Self-reflection for the clients is a goal during sessions "to the degree of which it is going to be useful…(Appendix 1, line 440). Self-reflection can be difficult at times for this client group. The interviewee observed,

> Self reflection] can seem painful to [the kids] and I know they find it painful at times…so I try to make it as pain free as possible…and also explaining to them why it's good to do it as well…to explain it's good to notice good stuff or notice difficult stuff and not just let it pass on by so we know for the next time…I think it's really useful…a lot of them do just go through the motions [of an activity]…but to actually give them the opportunity to notice for themselves

[that they've done something] is much more effective"(Appendix 1 , lines 441-461)

For the client to self reflect that they have made a beautiful (or nice) drawing, cool music or good tasting food is much more beneficial than only having feedback from the therapist.

The OT runs an Interactive Drawing Therapy (IDT) group at the unit. The therapist assists the client to observe, reflect and process what is drawn on the page. She pointed out that with IDT "[the therapist] gains some insights, but the idea of [IDT] is that they are gaining their own insights"(Appendix 1, lines 235-236). The therapist does not want to make assumptions about what the client is feeling or expressing therefore client self reflection is the ideal path for the therapist to have insight into what is happening for a client.

Processing and reflection techniques: As stated previously, self-reflection is difficult for many in this client group. A variety of techniques and methods can be used to assist. Again, it is important that the activity is suited to the client's presentation. Sentence completion can give clients an opportunity to reflect on various levels depending on how the therapist phrases the sentence. Depending on client wellness, a suitable sentence may be, 'Something I was really proud of today was _____.' The OT commented that "asking the clients, 'tell me how it was for you today?' is too big, it's too broad" (Appendix 1 lines, 425). Many clients may be unable to answer such a question but if phrased suitably, it may give the clients the opportunity to gain some insight about themselves and the activity.

The therapist may be required to only use a closed question such as, 'are you really proud of what you made today?' because the client may only be able to answer 'yes' or 'no' . The interviewee also noted that, "you don't want to make [these reflection sessions] long and drawn out…it needs to be quick and not an hour long therapy session everyone else has to listen to" (Appendix 1, lines 466-470).

Clients can be asked to choose face cards/emotion cards to express how they feel at the moment or to reflect on an activity. Standing on a scale

is another simple activity because clients don't have to speak. It is a way for the client to think about 'how was this for me?' without necessarily having to put it in words. Clients are asked to stand along a continuum that has been illustrated in the room – for example, one end represents 'a positive experience' and the other end is 'an un-positive experience' and along this line is 'feeling somewhere in between'.

Another processing technique that was discussed, is to have the clients think about each other – how did they think some else did in the group? The therapist can ask a client to place someone else on the continuum where they think that client's experience of the activity was. This give clients a chance to see what other people are thinking about them – to see things from other clients perspectives and for others to see how is was for you (the client). That particular activity can be very difficult with this client group. The OT noted that, "it can be quite difficult to do here – it depends on the wellness of the group" (Appendix 1, lines 753-756).

Process/reflect in the NOW: The OT will often use the frontloading technique by ask the clients to think about an upcoming challenge. The interviewee asks the clients to, "start thinking about the process for them, what's the challenge, what can I [the client] do, what do I need help with… " (Appendix 1, lines 346-348). While the activity is occurring, the OT will ask the clients to reflect on the 'now'. How are they feeling during the activity, she may ask the clients to pause to notice what is happening for them and how they are feeling at that moment –

> How is your body feeling? Name it…give it a number…notice and be aware...it is giving them an opportunity [to reflect]…because afterwards they are more than likely to say 'I don't know, I can't remember' (Appendix 1, 392-396)

Therapist Experience and training when processing a session:

Therapist experience and training can be an underlying influence on the way in which he/she processes what occurs in a session. The interviewee commented,

> I guess in my own head I have a vague structure around [processing the behaviours and verbal responses of the clients] but a lot of that is based on

> formalized observation and assessment techniques that I have used in the past. (Appendix 1, lines 39-41)

She mentioned an assessment form that she sometimes utilizes following a session called an OTTOS (Occupational Therapy Task Observation Scale) where she records **her** "observations of what [the client's] experience of the activity or their group is"(Appendix 1, lines 50-51). It was noted that the assessment forms are not always utilized, but the concepts and categories are kept in mind when thinking about the session, when observing a client and when processing what is observed. It is the therapist drawing conclusions and processing what is observed based on previous training and experience.

Difficulties with this client group: Findings suggest that this client group has difficulty with self-reflection. The OT commented,

> You're always trying to find something because here we talk about processing we don't get very deep inflective self aware reflection…it may be that we're just looking for facial expression…for some response…(Appendix 1, lines 170-175)

Accessing thoughts, feelings, and self reflection is difficult not only because these clients are acutely unwell, but also because of being adolescents. The interviewee pointed out that,

> There's all sorts of stuff going on that often leads us to be not completely clear about diagnostics and assessment…if someone is prodromal* and in the early stages of psychosis then they present as being kind of withdrawn and depressed…or even kind of odd and socially anxious…then two years later they present as really psychotic…so you can't always say exactly or definitely they are socially anxious or depressed…the brain's still growing, still growing up, still finding who they are and depending on their family background as to whether they have a little bit more of a sense of who they are and where they fit in the world or culturally…(Appendix 1, lines 643-653)

*prodromal: he early symptoms and signs of an illness that precede the characteristic manifestations of the acute, fully developed illness (Yung & McGorry, 1996)

Cultural beliefs and how they influence processing: Knowing the clients and understanding their cultural background and experiences is important when processing what is observed during sessions. The OT noted,

> [Therapists need to have an awareness of] how well integrated into their culture and how much time [the client is immersed] in that culture – this can effect things [like] assessment and then how [the clients] process experiences for themselves. (Appendix 1, lines 656-658)

There could be an event occurring at home that influences the client in ways that could alter a perceived symptom of illness. The interviewee pointed out that "there are assumptions due to psychotic processes [that] may be altered by cultural beliefs and ideas and experiences going on for that person" (Appendix 1, lines 615-616). For example, if someone has died or an area has not been blessed, the family may be aware of ghosts. When the client expresses this, rather than it being a symptom of psychosis, the therapist needs to, "have it in the context of the cultural [beliefs] rather than taking it completely on the face value" (Appendix 1, lines, 621-622).

Additional Theories/therapies noted in interviews:

Dialectical behaviour therapy (DBT): This was developed by Marsha Linehan in 1991 to work specifically with borderline personality disorders (Harrison, Geddes, Sharpe, 2005). The therapy usually consists of two main parts. The first part is individual psychotherapy where the therapist and client reflect on the events that have recently occurred, look at the chain of events that led to a particular problem behaviour and reflect on potential adaptive solutions that can be used in the future. The second part is weekly group sessions where mindfulness skills, distress tolerances and reality acceptance skills are the focus (Kiehn & Swales, 1995).

Family Systems theory: This theory views psychiatric disorder as being a reflection of a dysfunction or problem in the family – not just with the member of the family that is presenting the illness (Harrison, Gesses, Sharpe, 2005). Therapists would reflect on the family as a whole and problems facing the youth would be seen in the context of the entire family unit.

It’s to see whatever client you have in context…What’s happening in the family? Is there divorce? Did the grandmother die? Did the pet die? Is there conflict at home? (Appendix 2, lines 16-22)

Reflective Journal Analysis:

Looking back at the journal illustrated the evolution that can occur for a new therapist. The themes that later became apparent were not obvious to me at the time of writing about the earlier sessions. Awareness of what was happening and the ability to accurately process on my reflections was not yet an acquired skill. Over time, my experience and new processing and reflection techniques became evident in the entries.

Returning to the journal now, I am able to recognize various qualities of the sessions that reflect lack of insight and an inability to process what occurred in an experienced manner. There was a noticeable shift in my therapeutic reflection and techniques following the interviews. Using skills and themes that were discussed, I was able to positively influence my sessions. The analysis of this journal is from the present perspective, pointing out themes that are apparent, despite not being apparent at the initial time of writing.

Fixing the client:

The early entries in this journal illustrate how much I assumed it was my responsibility to know the right method, word or song to "fix" clients. This is the issue that began the journey of this research paper. I wanted to know how to reflect and process in order to 'fix' the clients. The poem at the beginning of this paper asks a client who tried to commit suicide, "Did I let you down?...What did I do wrong?...What didn't I do? To help you?" (Appendix 4, lines 40-54). I comment later, on the 25/07/2007, that "I just felt I needed to 'fix' and make them feel better…"(Appendix 4, lines 148-149).

Countertransference:

Throughout the early entries in this journal there is the use of the words, "anxiety/anxious, out of control, frustrated, lost and chaotic." All were self-reflections on the initial stages of clinical placement at the unit. This is interesting because seeing as this was taking place at an acute psychiatric unit for adolescents, these are very likely similar emotions to those the clients

are dealing with. The first journal entry used in this research contains a strong example of how a countertransferential response occurred without therapist awareness of this. The group was behaving in a "chaotic" fashion and the music was loud and disorganized. My response was to initially play calming music, but then to vent my frustration by banging loudly and illustrating what it felt like to listen to that banging. Without knowledge that this was countertransference at work, I was not able to talk to them about my response constructively – only able to musically express my anger. I also had no awareness of what could have been reflected by the clients through their music making.

Experience/Inexperience:

For several months, the entries repeatedly use the words, "inexperienced, inadequate, unprepared and disorganized" during moments of therapist self-reflection. "Trying to emulate [the sessions of the other music therapist] I end up feeling out of control – inexperienced and basically that it's not a good session" (Appendix 4, lines 74-75). Without the confidence or experience to know whether what I was doing during the sessions was the appropriate intervention I was left feeling "so inadequate and out of my depths" (Appendix 4, line 79).

As time progressed, and I had supervision sessions both on the unit and from a visiting music therapist, I began to experience insight and was able to draw on that in my sessions. This experience was reflected not only in my own self-reflection techniques but also in the sessions themselves. My interaction with clients changed. During the group session on 31/10/07 I commented that, "I felt that I had read the situation well and that throughout the session I was more aware and open to what was going on with the clients" (Appendix 4, lines 259 -260).

Assumption vs Observation:

Earlier in the year, the journal reflects a lot of assumptions that were made during sessions rather than observations. I comment that a client "was extremely disturbed" (Appendix 4, line 97) or "I notice…x,y and z don't like my sessions and 'A' gets very low mood" (Appendix 4, line 20) or "I had to fight

with my mind to stop worry that they were not enjoying the activity" (Appendix 4, lines 88-89). Rather than focusing on what was **observed** occurring, much of the reflection was spent on what I **assumed** was occurring.

As the year progressed, the journal started containing a lot more observational language that was then often followed by reflective questions about what could be implied by the observation. Client X "started playing xylophone very fast, with repetitive melody and notes…I mirrored this, then I slowed down as he did. Music became slow and sounded relaxed... X appeared to be caught up with non apparent stimulus (NAS)…was the fast playing the confusion in his head and did it slowly clear when music relaxed and had more gaps and silence?" (Appendix 4, lines 194-199). A lot of this is a result of the interviews that took place. On 29/10/2007 it was noted that I "learned that sometimes it's good to just sit back and observe…feel what's going on" (Appendix 4, line 226). I was learning to become client-centered, to listen and to observe. In the last entry of the journal I comment, "I feel as if I am present and able to be with these kids and really sit back a bit and hear, see, observe [and] feel" (Appendix 4, lines 296-297).

Therapist self-reflection:

Given that this is a personal reflective journal, it is not surprising that a great deal of it was used to process my own therapy practice. The interesting evolution that occurs is that early on, most entries are focused on how **I** perceived the sessions and how the clients effected me. The focus was on what I did incorrectly or inadequately. "I feel as if I let her down" (Appendix 4, line 33). Later in the year, the reflection and processing that took place became more **client-centered.** I began to follow what I observed the clients needed instead of worrying and looking too far ahead for the next activity. On 10/10/2007 I noted, "I felt a bit lost as to what to do to keep [X] interested, so I just followed his lead to play with him…"(Appendix 4, lines 193-194).

Working in the NOW /mindfulness:

Findings from the interviews showed that learning to be focused on the present – the now – is a goal for clients at the unit. I found that this was a difficult lesson for me to learn as a new music therapist at the unit. Again, a

lot of my focus in the journal was on **my** difficulties being with the client(s) without worrying about the next activity. Reacting as a result of countertransference, I was confused and distressed and often changed activities quickly in order to find the "right fit".

A group session that occurred 25/07/2007 had song writing that caused one of the clients to visibly change his presentation from interactive to quiet and withdrawn from the group. I quickly thought of a song that he had liked in past sessions(Bob Marley's 'Three little birds') and was about to begin when the other client suggested 'Stand by me'. Not realizing that she was upset as well, I proceeded with my original selection. She was distressed but I did not observe this until she quickly left the group and was crying to another staff member about how the session made her sad. Hindsight indicates that if I had been more present and in the NOW, I may have noticed that the song I chose needed to suit both clients and that she had suggested 'Stand by me' was significant, would have been appropriate and was perhaps what both needed.

As time progressed, the "mindfulness" focus turned to the clients. During the group session on 31/10/2007, following an activity which required each client to play a different rhythm than the other group members, we "talked about focus and how to help yourself to be mindful or focused while other stuff is going on around you"(Appendix 4, lines 248-249). Kids were willing and able to have this discussion – perhaps because the previous activity was directly related to the discussion and illustrated the point of what we were talking about.

Meaningful sessions:

Making sessions/activities meaningful for the clients is vital. In a session on 04/06/2007 I lamented that "I feel lost, overwhelmed… confused…how do I make these sessions **meaningful???!"**(Appendix 4, lines 85-86). I started to reflect that clients were enjoying particular song writing sessions because they were writing about themselves and making jokes with each other about their diagnosis and the unit. The songs had meaning for them.

Findings:

What is meant by reflection and processing? During the interview with the Occupational therapist my response to this question was,

> I look at it as the ability to think about what's just occurred or what is occurring…as a therapist - how I am feeling in the situation also how I think the client is dealing with the situation. I look at the clients' processing as basically having the ability to look and perhaps discuss what is happening for them during an activity – what's going on for you here? (Appendix 1, lines 671-679)

The intent of this research question was to use the information gathered to potentially influence my future practice by providing effective reflection and processing methods.

> There are three major elements of the reflective process itself: returning to the experience, attending to feelings and re-evaluating the experience…reflection is a process which perceives connections and links between the parts of an experience. (Boud, Keogh and Walker ,1985, p21,25).

The data supports the fact that there are **many** factors that influence reflection and processing methods with this client group. Simply discussing the methods would have omitted vital information that is required in order to be effective. It would be like discussing the roof of the building without noticing that it cannot function as intended without the structure underneath. The initial focus of this research was on therapist reflection and processing methods and it became obvious that facilitating **client** reflection and processing is just as important. Most data supports the fact that client self-reflection and processing is an important goal (perhaps long term, but a goal non the less) with this client group. One of the aims of the therapist reflection and processing is to assist the client to arrive at a place of self-reflection and mindfulness. Findings suggest that the goal is not for the therapist to have the answers so much as for the therapist to be aware of what the client needs. Not only is it important for the therapist and client to process and reflect on

their experiences, there are many elements to the therapeutic relationship and session that are required in order for this to occur effectively.

Looking back at the data, there are a number of common themes that immerged:

a. The client-therapist relationship is a primary focus in therapeutic relationship.
b. When reflecting on future/present session plans, meeting the client where **they** are is vital.
c. Empathy and the intuitive response are invaluable tools when processing.
d. Therapist mindfulness and observation are important skills that assist therapist reflection and processing.
e. Processing your (the therapist's) counter-transference is necessary in order to be helpful to the clients.
f. Underlying psychodynamic theories, training and experience influence the way in which a therapist reflects and processes.
g. Client mindfulness, self-reflection and awareness is a primary goal of therapy
h. Knowledge of the client, their perspective and what activities are meaningful helps the therapist to process what is observed.
i. It is often necessary to utilize alternative media in order to encourage reflection and processing with this client group.
j. At this unit, cultural awareness is necessary in order understand the client and his/her presentation within an appropriate context.

With this client group, findings show that reflection is a challenging process for both the therapist and the client(s). The client's ability to self reflect and be mindful can be very daunting and at times emotionally, intellectually or physically not possible. The therapist's job initially, is to focus on establishing a relationship with the client. This relationship allows the client and therapist to potentially form a safe, trusting and nurturing environment that is conducive to expression and perhaps healing.

In order to reflect or process effectively, therapists need to be present, aware and mindful while observing client body language, behaviours, verbal responses, music making, or lack of any of these. Being attuned not only to the client, but to his/her own physical and emotional responses (countertransferential responses) will enable him/her to be a more effective therapist.

The perspective of the client, not the therapist is where the attention should be focused. Kelly suggests that, "techniques to assist reflection need to be applied to the constructions of the learner, rather than those of the teacher" (in Boud, Keogh and Walker, 1985, p23). Therapist projection on an situation should be avoided and awareness that the client's perspective may be a personal projection as well should be noted. In the case of a client where their safety is at risk, the 'whys' are not going to be answered immediately. A therapist is not going to suddenly convince the client that harming him/herself is a poor choice to make.

Having experience in a particular psychodynamic approach such as DBT could help to establish a context where the client feels supported, assist the client to become mindful and present, and by also consulting with other staff members, safety can be ensured. A therapist's job is not to convince clients that their way of interacting/perceiving in the world is dysfunctional. A therapist is not there to 'fix' anybody. Once a therapist comes to this realization, he/she can focus on providing a space that supports the client's needs and the client's journey toward self-reflection.

Despite being provided with this context, without being ready to deal with certain issues, a client may be resistant to reflection and processing on a deeper level. Meet the client where they are.

> There are no resistant clients, just moments of self-protection – therefore, look after the client, don't let your own projections, unfinished business, parallel-process, and counter-transference issues sabotage your ability to work powerfully, easily and effectively. (Russell Withers ,2001 p23)

Through observation, the establishment of the therapeutic relationship and reflection with the client(s), knowledge of what activities and processes are

meaningful to them can be ascertained. For many young people in this client group, activities without meaning, significance or purpose could result in reduced involvement, poor attention, behavioural issues and/or a lack of interest or ability for reflection.

The Unit in which this research took place is bicultural. It is therefore necessary for therapists to be aware of the cultural context and influence that particular cultural beliefs have on the client. Awareness of this can influence reflection or processing of client behaviour.

> Paulo Freire adopted the view that learners have a personal perception of the world which is culturally induced, so that their personal meanings or constructs can only be comprehended in their unique social and political context (in Boud et al,1985,p23)

Knowledge of the client's cultural perspective increases a therapist's understanding and ability to reflect accurately upon the situation.

It was also found that the use of alternative media is often required with this client group. Finding avenues to help clients access the unconscious without using "talking therapies" has been found to be advantageous. There are many different options for this, but some that are utilized at the unit are drawing, pottery and music. The key, while working within the scope of your training and practice, is to use whatever media suits the client, the situation – the moment, best.

> [The element that causes change in the therapeutic process is] the relationship with the therapist, the therapeutic act, even more than the verbal interpretation. Something more than interpretation, in the sense of making the unconscious, conscious, is needed. (Nirensztein, 2003, p229)

> After experience, there occurs a processing phase. This is the area of reflection… recapture [the] experience, think about it, mull it over and evaluate it. (Boud, Keogh, Walker, 1985, p19)

Discussion:

A previously mentioned quote in this paper has been very influential on my developing practice. At an Interactive Drawing workshop I attended the manual had a quote "lean back or you'll fall in [to the content]" (Russell Withers, 2007)… I find this a very useful quote – because I was "falling into the content" when I first worked at this unit. Instead of stepping back and having a look, I became absorbed by what the clients were experiencing and felt a responsibility to fix them and to understand exactly what was going on for them. I felt that I needed to always understand the "why" things were occurring instead of seeing/observing "what" was occurring first. I was not being present, or being 'with' my clients.

As I process and reflect on all of the data gathered in this project, another question comes to mind: Do therapists need to uncover the actual meaning? Following the interview with the OT and the CP, I began to wonder whether the processing in a session is more about helping the client to process and reflect for themselves – not the therapist processing for them.

> "You cannot teach people anything. You can only help them discover it within themselves" (Galileo in ThinkExist.com, 1999-2006)

The therapist is reflecting on what the client MIGHT be thinking or expressing. Therapists can reflect on their own reactions to what the client presented in a session, a therapist can reflect on his/her own actions in the session, a therapist can reflect on any countertransference that may have occurred, and even reflect on what he/she believes the client is trying to express.

I see processing the experience of a session as three fold. The client does/or does not do their own processing, the therapist provides a safe and supportive environment to assist/facilitate the client(s) to process and reflect on their experience and the therapist reflects on his/her own experience and perhaps what they think the client's experience is in the session. "Processing

is a necessary part of instruction…without processing, the activity is simply an experience with limited outcomes and value" (Project Adventure, 2003, p45). With this client group there are times, especially when playing music, where there is an emotional response, and then the processing of this response is difficult if not impossible. Perhaps the client having an emotional response without fully processing it is a starting point - A valuable stepping-stone to client awareness and mindfulness. Helping a client to become aware that a response occurred and identifying what the response was, is a step towards processing why it happened. With adolescent mental health patients, perhaps finding this place to start, an opening, a way to help them view their emotions has great value and the processing starts with the therapist. The client is perhaps too unwell to begin to understand what is to be learned from the session – the therapist's responsibility is then to begin the process of reflection. To try, through observation of client music, words, body language and actions to reflect on what the appropriate therapeutic response should be that would supply the client with what they need at that moment.

An interesting point is that the literature and the interviews support the concept of therapeutic empathy. After observing and being mindful during a session, a therapist should try and establish empathy with a client. Empathy is defined as "the intellectual identification with or vicarious experiencing of the feelings, thoughts, or attitudes of another" ("Random House", 2006). This would indicate that a therapist must process enough about the client in order to provide a reflection of the client's feeling state. Based on experience, training and what is observed, a therapist is intuitive about what empathetic response is appropriate. This is an assumption – or perhaps a more accurate term would be an educated assumption. This seems contrary to most of the data in that therapists are taught to make observations, not assumptions. Deducing what would be an appropriate empathetic response seems to ride on a very fine line between the two.

With this client group, it is very difficult to draw conclusions about what is happening for a client. What I have realized through this journey is that reflection and processing of what occurs in a session is **not** with the intent to

know without a doubt what is being expressed. It is not with the intent to “fix” or “cure” the clients with the perfect intervention. What the processing and reflection **is** for, is to get a sense of what a client’s needs are, it is to attempt to deduce the appropriate empathetic response, it is to provide sessions (present and future) that are relevant, meaningful and supportive. It is not a mystery that is trying to be solved in one session – it is a puzzle that is being put together for the client and the therapist, piece by piece.

Concluding thoughts:

> We don't receive wisdom; we must discover it for ourselves after a journey that no one can take for us or spare us – (Marvel Proust in Luckner, Nadler,1992, p 3)

This began as a search for how do I understand/reflect upon and process what is happening in the session. I developed this research idea when I was working predominantly with girls who were suicidal, self-harming, depressed and had eating disorders. Things that they were expressing were often disturbing and potentially life threatening (to them). I felt an urgency and a need to fix them - to come up with answers. Later, I was working predominantly with boys who were showing psychotic symptoms. The work I was doing with the clients changed and goals of the sessions changed as did the demands on my reflection and processing ability during the sessions. This is the nature of the unit – an ebb and flow of clients with a variety of diagnoses.

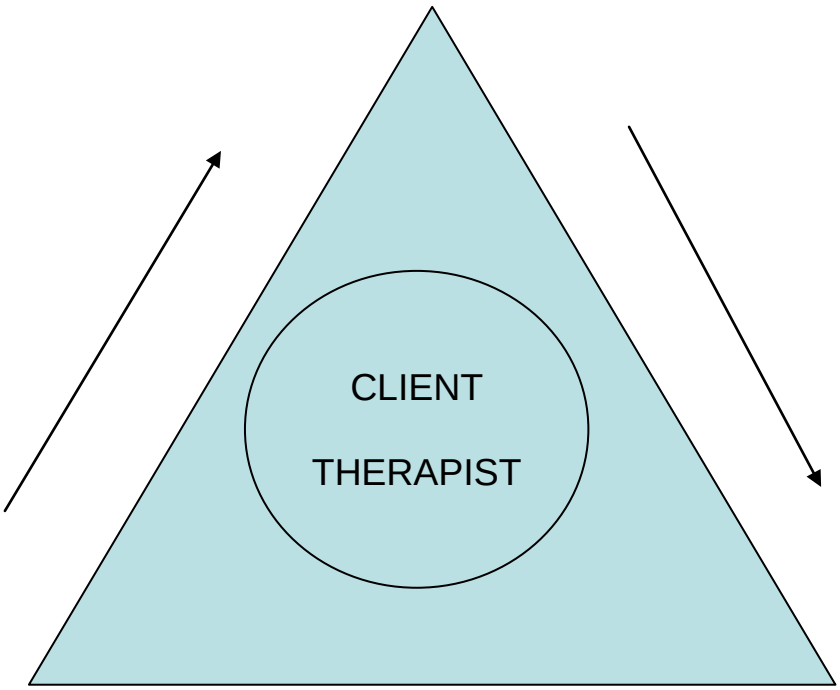
The final entry in my reflective journal illustrates the effects of the findings on a student music therapist at the end of one journey. This was not an action research paper, but on reflection, the evolution of my practice was inevitable and in fact – necessary.

> 'I am feeling so much more a part of the process here. Sessions seem to just flow – even if they are not "easy", I feel as if I am present and able to be with these kids and really sit back a bit and hear, see, observe, feel…. Without trying to constantly worry what the next thing is going to be – I think I am still thinking about it, but it is not coming from a place of panic and insecurity, it's coming from a place of knowledge and experience. My last supervision was today and I was asked to pick something out of a basket of assorted objects - something that represented me when I first began and something that

represents me now. I chose a broken mussel shell for my starting point. Fragile, brittle, broken, sharp… I chose a cats eye spiral and a stone with ‘patience’ and ‘trust’ written on it. The spiral represents to me a journey, a new beginning… and the stone is smooth, solid and I think the words ‘Trust’ and ‘Patience’ are two of my big lessons here. Trust the process and be patient with myself, the clients and with the process…’(Appendix 4, lines 294-308)

My Initial therapist model – Client and therapist centred

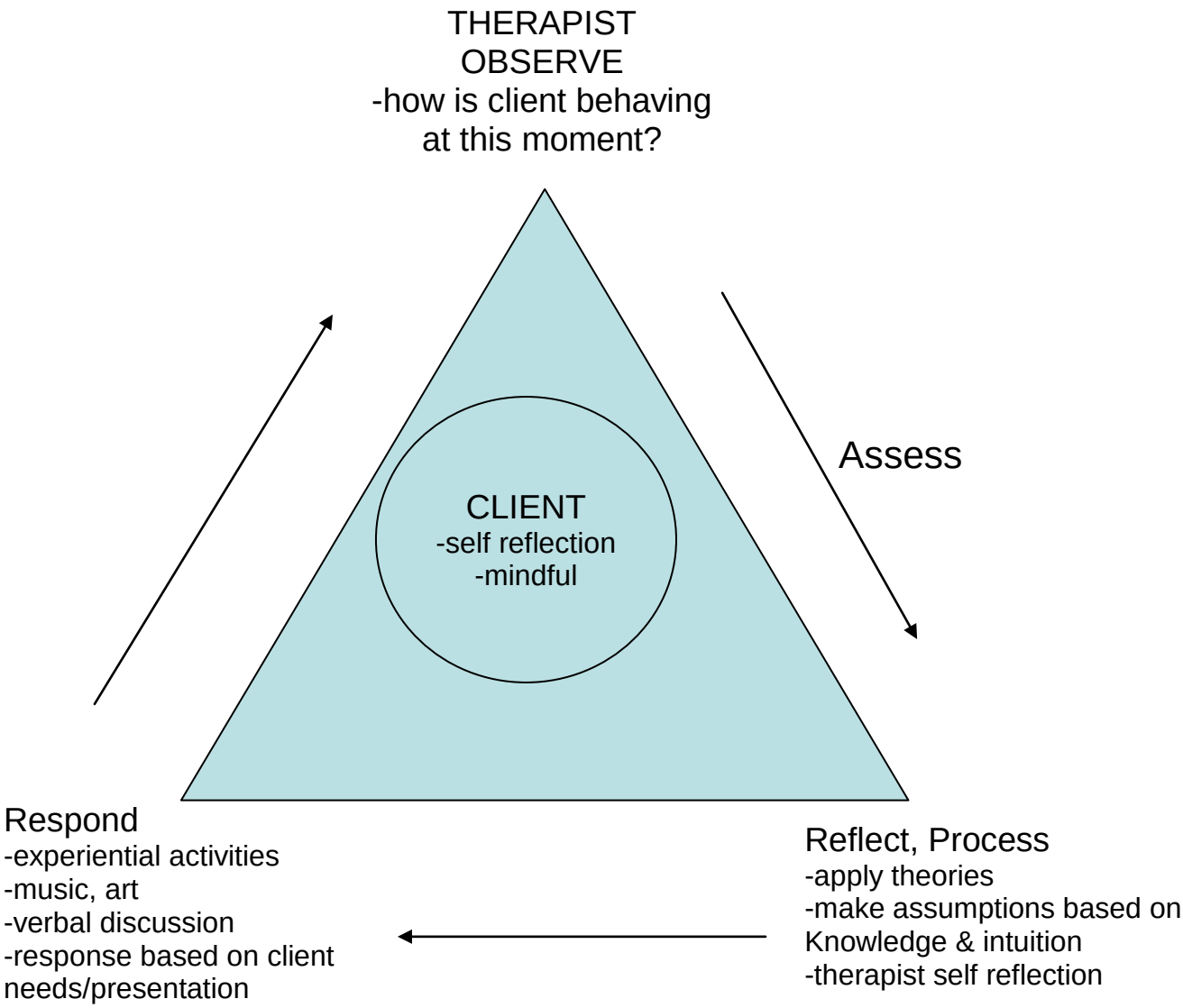
Therapist chooses activity
-based on session plan/goals/reactions



Therapist reacts
-thinks “oh no, that didn’t work, what can I do next?!”
-countertransferential response
-Therapist feels responsible, feels inadequate as a result of client response/lack of

Client responds
-involved in activity
-rejects activity
-not mindful of their response or activity purpose

My Present Model – Client Centred



In this model, the therapist is emotionally removed enough from the session to be objective. This does not mean he/she is not present or empathic, it is more a case of the therapist being mindful of her/his own reactions enough to be able to reflect on the clients' needs and process client response without being focused on themselves.

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Appendix #1: Interview #1: Occupational Therapist 09-10-2007

M: 10th of October, 2007- This will be the first interview with an Occupational Therapist from an acute psychiatric ward for adolescents

M: So you know the title of the research is, “Exploring processing and reflection methods and how they can be utilised in music therapy sessions?”

OT: Uh huh

M: So I just wanted to interview other professionals to get an idea of what they do – other than music therapists – since there are no music therapists here anyway other than me! Ok, so my first question is , are there any specific techniques that you use during your sessions with clients um, that you feel help you process and reflect what is occurring in the session?

OT: So this is about ME processing, not them processing

M: Yeah, well, actually both, we can start with you

OT: Mmm

M: Because I am kind of coming from the angle of wondering how you know what it is that the client is giving you during the sessions and how do you know during a session which way to go.

OT: Um Hum…Mmm, (clears throat) Cause I guess when I initially read that [The interview guidelines] or thought about what you were wanting to do,I was thinking it was about THEM processing their experience.

M: Yeah

OT: But you are also thinking about kind of MY processing what is going on for them.

M: Well, do you think it’s kind of, because do you think it is sort of tied into each other because you kind of need to process in some ways, or do you think that you need to process what their doing during a session in order to figure out how to help them?

OT: Absolutely! Yeah, I mean all the time as I’m, say to students who come in thinking about groups... I mean groups are about, um, learning new skills and you know, we’re giving them some structure and giving them some new experiences. But also, all the time I am assessing

M: Mmm

OT: Assessing where they are at with many many different things to give an indication of how well they are, what are the skills they need, what are the therapeutic techniques and strategies etc they need, so all the time I am processing

M: Yup

OT: How they are going, um and I guess in my own head, I have a vague structure around that, um, but a lot of that is based on formalized observation and assessment techniques that I have used in the past

M: Umm, and what might those be?

OT: (laughs) Ah…well there's a tool I was using the other day, which is one I use here. I haven't got one in front of me, but it's called, OTIS. You're gonna ask me what that means aren't you? (laughs)

M: Yeah

OT: Observational, I can tell you later! Basically, it's an observational tool

M: Yeah

OT: So unlike the "how am I doing" which I do, which is a self assessment, they don't fill it in, it's purely my observation of what their experience of the activity or their group and it's um, separated into 2 sections of task behaviour and social behaviour

M: So is that something you fill out after the session

OT: Yeah, yeah, yeah

M: OK

OT: Um, I mean, I don't always do them, but you know, I have those sort of categories in my mind when I am thinking about, when I am observing somebody and **I** am processing what **I** am observing.

M: Yup

OT: And it will be under the categories of specific task behaviour, you know, stuff like concentration, and ability to initiate, ability to follow directions and what sort of directions

M: Umm

OT: So all the time, while I'm kind of interacting with them, I'm also kind of **grading** my interactions to get a result, no not to get a result but, to challenge

M: Yup

OT: To do that challenge, so somebody who I know, maybe in the last session, managed simple instructions, I might up that a wee bit and make them a little more complex and then be observing and processing how they're dealing with that

M: And then based on how they react to the challenge you will then…

Ot: I can then make an assumption about their functioning basically, you know

M: And then that will change the way you do the rest of the session with that person? because of

OT: Potentially yeah, depends on the group really, as in how many people are in the group, whether it's an individual task that they are doing within the group, or whether it's a group activity

M: Yeah

OT: So all the time I guess, I am processing

M: Yup

OT: What's going on for each of the individuals as to kind of what are the challenges that I might put on them **or** ease off depending on what...

M: Yup

OT: I mean I guess when you are thinking about the adventure based principles is that thing of the "Just right challenge", one of which is them choosing their challenge, but also in this particular setting me as a therapist, I'm also having some control over what is a "just right challenge" for them because you're not wanting to completely overwhelm them with activities set being too difficult.

M: Umm

OT: And for them to feel incompetent and incapable and overwhelmed and distressed, but also you're wanting to provide enough of a challenge for them to feel a sense of mastery, and to build on capabilities.

M: Yup

OT: Does that make sense?

M: Yeah, it does. It's a fine line between feeling failure and feeling that they actually met the challenge and that they overcame difficulty

OT: Mmm, yeah

M: Yeah

OT: And then in amongst that I am also seeing what they can manage because ultimately, they are going to be leaving here

M: Yeah

OT: And if they are unable to, or if it they get completely distressed and overwhelmed by slightly complicated instructions that's an indication of what's going to be important outside of here. So again, that kind of me assessing the function.

M: Yeah

OT: Then there's all the social stuff as well. How they are interacting with others, how do they go about asking for things - whether they're able to assert their needs… etc.

M: Is a lot of that based on intuition? Because like, when you said you know, that the difference between them feeling failure or feeling success because they came to the challenge, is a lot of that based on your intuition on how you think they are going to meet that challenge?

OT: It's a real basis of my training that whole grading activities, task analysis, and analysing when I trained, you take very simple, everyday task or creative task, break it down break it down into many components. So it's something that we get drummed into us in training college, task analysis, grading activities to enhance abilities, learning and a sense of mastery and observing skill behaviour.

M: Ummm

OT: So, yeah, I wouldn't like to say it's strictly intuition. I think it's something we've done a lot of in our training.

M: Yeah

OT: About assessing functioning and task behaviour.

M: Yeah

OT: What we do a lot of

M: It's kind of, it seems like there's a lot of different kind of things that you're looking at to assess and to process and reflect on how they're you know, given how their reacting given their past and all sorts of things, and then you can

OT: Mmm

M: Observe and then you can come to a conclusion.

OT: Yeah which helps to guide feedback that you're going to give to their team but also helps to guide the rest your treatment program, the treatment plan, your group or whatever

M: Yeah

OT: And I guess you saying about intuition, when I sit and talk about it, I think oh yeah that is based on my theoretical practice

M: Yeah

OT: and my assessments that I have a , formalized assessments that I have learned and there were many other ones as well, but when I am , sort of, doing it on an ongoing basis, I think I do take it for granted, and don't kind of formalize it enough, it is more informal when I'm doing that

M: Yeah

M: Probably because you've been doing it a while

OT: Yeeeah (both laugh)

M: As opposed to me who is going," what was that theory that I was supposed to…

OT: Yeah, well, that's where a lot of.. I mean, I should still be using these standardized formalized assessments and I still do at times but do less and less now and a lot of it is um, not go on intuition but based on that ..just a little less formalized.

M: Yeah… (pause)

M: But if clients, cause here, you're often… you're getting reactions that may not be what your client is actually ... what might be going on for the client, might not be what you're actually seeing?

OT: Um hum

M: You were saying how a client could get up and walk out the door but that might not necessarily, it might mean that they are done with the session or it might mean that they… some something else is going on...so how do you… I mean, do you...because you said you use all these observation skills and all these things to processes

OT: Um hum um hum

M: What happens if you have a client sitting in your session and they give you nothing

OT: Um hum

M: Or is that possible for them to give you nothing? Are you always finding something, even in what appears to be no reaction?
OT: Yeah, you're always trying to find something your always trying to find because as you know here, we talk about processing we don't kind of get very deep inflective self aware reflection. You know it may be that we're just looking for like facial expression
M: Yeah
OT: for some response, um yeah, so what was your question? What do I do if I get nothing or what…
M: Are you always… if you see that someone say is, sitting there and just sitting and not engaging,
OT: Um hum
M: Do you … do you attempt to think what might be going on for that person and does it concern you in a way that you feel you need to find a bit more about what's happening with the person that's sitting there doing nothing, or do you just think, " that person's having an off day today"
OT: Um hum
M: Or um
OT: I guess as an OT, um, my aim would be to get them involved in the activity in a meaningful way as much as possible, but also you do need to know about that person
M: Mmm
OT: Right down to you know, is this something they absolutely hate doing
M: Mmm
OT: You know and it's not one of their preferences, so obviously there's again back to your assessment, you know, is this an activity that this person is absolutely doesn't like and haven't chosen to be there.
M: Mmm
OT: Or what is going on for that person
M: Yeah
OT: Is it, that they react this way to all interventions
M: Yeah
OT: But ultimately, my aim would be to know a bit more about the reasons to what was underlying

M: Mmm
OT: But also then to know enough to then get them involved in some way
M: Some way, yeah
OT: Whether is was, just to get their opinion on something, to get them to choose something, to get them to, be involved in stuff enough to just be observing and getting secondary consequence from the experience, you especially do that in music, you know someone is just listening
M: Right
OT: and taking part in that by
M: being there
OT: Yeah, I suppose yeah, that in some ways it's about trying to work out how can I get this person involved in this activity
M: Umm
OT: if this activity is meaningful
M: Yeah
OT: Because it could be that it's not meaningful to them at all.
M: Yeah
M: So it's almost as if every session with this particular client group is almost like a new assessment. You almost have to assess, reassess them every time you see them?
OT: I think it is a lot here, because you know, every day is different.
M: Yeah (both chuckle)… everyday is different
M: Ok, so do you use anything in your sessions in particular, like other media, whether it's other types of tools that in particular can help you have some insight into what they might be thinking?
OT: Do you mean in regards kind of to the activity or about the processing of the activity?
M: I mean, like the Interactive Drawing Therapy,
OT: Um hum
M: Do you use that at all? I mean, is that something that you, does that help to give you insight into…
OT: Um
M: Or is it more to help them get insight?

OT: Yeah, I was going to say the IDT, I mean, of course you gain some insights, absolutely, but the idea of that is that they are gaining their own insights.

M: Yeah

OT: You know, sometimes you may not kind of know, and you don't want to go to any assumptions about what they are thinking

OT: Yeah you don't want to make any assumptions necessarily. So it's not a necessarily an assessment tool. It can be, you'll learn when you do the training, you can sort of make some assumptions even though it's about themselves and it's a mirror…you know, but there are some assumptions kind of made,

M: Yeah

OT: which are kind of natural, if they draw themselves really tiny in the corner, you know

M: they are probably not feeling great today

OT: You can probably have some assumption about it eh?

M: Mmm

OT: Concepts of self, but again it's not um, interpretative like that so…

M: Yup. Do you…would you think that any kind of reflection that you might have on anything they do whether it's the drawing or it's the way they do their pottery today

OT: Mmm

M: In some ways a lot of it can be an assumption.. on what they're..

OT: I guess it's…cause you were asking about their thoughts

M: Mmm

OT: Clearly observed task behaviours and social behaviours are much clearer than if your saying, you know, do I um… you know, what do I use to work out what they're thinking, I mean, that's

M: Yup

OT: different, because then that does become an assumption, unless they tell you what they are thinking

M: Right

OT: You know what I mean?

M: Yeah

OT: There are certain things I can say, “clearly I have observed that”
M: Yeah
OT: And in my observation skills, you know, I know that if they, if I give them a list of three instructions and they only do the first bit, then that tells me that they aren’t able to follow or they have a poor memory, you know, again, you might need to do some more assessment to work out **exactly,** but then when you are talking about what they are thinking..
M: Mmm
OT: Just because they are smiling you think they must be thinking happy thoughts, **that** is an assumption
M: Right
OT: As opposed to something else that’s going on for them.
M: So do you try to avoid those?
OT: Making the assumptions about thinking?
M: Yeah
OT: Yeah yeah. So obviously you’re wanting to get them to say, but that’s incredibly difficult here,
M: Yeah
OT: Accessing thoughts and self talk and feelings is really difficult for one this age group and than also for those who are acutely unwell
M: Yeah (both chuckle)
OT: Really really hard
M: “How do you feel? If I knew that, I wouldn’t be here”
OT: Yeah, cause I mean, even the coming up with the words, they may have a sense of um an internal body experience of emotions but then putting the words to that can be really really hard as well.
M: Mmmm, so is there anything that you ever do to help them?
OT: Yeah, I mean, there’s using the face cards, um, all the stuff I do in processing the big group activities like standing on a scale, that’s quite a simple one because they don’t have to speak.
M: Mmmm
OT: And there’s no sort of definites about it, you know, so you might want to ask a specific clear question, you know, about enjoyment of this particular activity.

M: Mmmm
OT: If you really really enjoyed it, stand at that end of the room and if you really really didn't enjoy it, stand at the other end of the room, if it's half way, stand half way and they stand somewhere along that scale.
M: Mmmm
OT: It's kind of an easy one to get them to think about how was this for me because they don't necessarily have to put it in words
M: Yeah
OT: So I've done that one to get a sense, but again, when they're just standing you know, you get people that will go and just stand with other people.. (chuckle) so, um they're all pretty arbitrary. And then of course there's the other ones you know, picking a face, picking a feeling. When we did abseiling the other week I did some processing in the car, van on the way back because there is a very limited tolerance to doing this, you know
M: Yeah
OT: I wanted to make time for doing it while we were there, we ran out of time, typically, but from my experience, I know if we had sat down on the grass and I had said can we have 15 minutes of getting together before we leave, I would have had a lot of "can we go now?" you know "I've finished this, " there'd be a lot of distractions so we actually did it in the van. I got someone else to drive and um, I sat amongst them and it is hard, because it is harder to listen to each other, but um, it was better in the van…captive audience (chuckle)
M: Yeah, they couldn't get away!
OT: They couldn't go anywhere
M: And was that for...that was to help them process wasn't it?
OT: Yeah, because it had been…I mean the processing starts at the beginning as well
M: Yeah
OT: for those sort of activities. I don't get a chance to do that a lot where you know, you have everyone for a specific activity… you know you are not going to lose anyone… they are all there and it is, in this case an adventure activity, you know
M: Mmm humm

OT: Where as before hand, actually, before we left here, I got them to think about what was going to be a challenge to them, so what goals they were going to set

M: Mmm hum

OT: What they wanted to do, what was within their comfort zone and what they needed help in, what was going to be a challenge, so I got them to sort of start thinking about the process for **them.** You know, what's the challenge what can I do, what do I need help with, and then um, while we were doing it as well, I guess, thinking about processing the experience and the adventure based therapy stuff while we were doing the experience I was constantly asking questions

M: Mmm

OT: You know about getting people to think about how they are feeling right now. Not necessarily getting them to state it at that point because other wise it would involve them sitting down and talking about it.. but jus throwing those questions out, you know, " think about how you are feeling right now..".. you know.. I did actually throw one out, " who's feeling really scared at the moment?" a couple people put their hands up and

M: Mmm

OT: A particular young man who told be that he was scared about two minutes before hand said, " I am not scared!..." (both chuckle)

OT: But then I kind of said to them that it was completely normal and natural to feel scared and that it would be really good if they could say it.

M: Yeah

OT: I asked them to tell us what they need to help them with that. So again it's that kind of getting them to constantly be reflecting so rather than just leaving them to get on with the experience,

M: Yup

OT: Getting them, as much as I could that was not really a pain for them, to get them to be reflecting on ,"how am I feeling?" and even some of the thinking stuff you know like, um, not so much as a group but .. be aware of what is going through your mind right now, you know

M: Yeah

OT: And be aware of what you need to ask for.. so to be constantly kind of prompting them with those questions

M: Yup

OT: You can think it's a pain in the ass to keep on shouting up to them! (chuckle)

M: Yeah

OT: But um, I guess normally in adventure based activities you wouldn't be giving them that many…

M: Prompts

OT: That many prompts to be thinking about, these guys are needing it.. or they would get to the end of it and be, "Oh, I don't know how I was feeling.." you know..

M: Right, so is it about helping them come back to the present or being present in..

OT: Yeah, yeah, and asking those sort of questions, "right, you're in it right now, I am not going to ask you afterwards how we were feeling when you were doing that…

M: Yeah

OT: Because they are more than likely to say, " I don't know, I can't remember"… so it's actually giving them the opportunity, " right so how are you right now?

M: Yeah

OT: Think about how you're feeling…how's your body feeling? All that stuff, and then obviously in some activities you can say, well name it, or give it a number or whatever.

M: Mmmm

OT: Umm…but in this instance, you know I just asked them to notice it and be aware

M: Yeah

OT: And in the van on the way home, I got them to pick the emotions cards

M: Mmm hum

OT: One for how they were feeling before, and one for how they are feeling now, you know, um, and then we did sentence completion as well. So, we got

them to pick their own topic randomly and it's sentence completion you know like, "something I was really proud of today was…."

M: Yeah

OT: And fill it in, or "something I wish I could do more of would be" you know, something to get them to sort of think about… rather than just doing it and then going back...And so some of the stuff they would say like, the young man – not naming names… his was very basic , you know like, "something I was scared of today...and it was something like…going up that tower… " you know, something very basic . But them someone else would say, "today I felt really proud of my achievement"

M: Yeah

OT: Which was…and then we can kind of carry on… so it kind of varies. So if you do the sentence completion it can give people an opportunity just to give **something** or a large amount of self-reflection.

M: So you're not asking them to come up with a concept of something… you're pointing out, "what are you proud of?" you're not asking them to name

OT: Yeah. Cause if you had said, "tell me how it was for you today?"

M: "I don't know.."

OT: Yeah, it's too big, it's too broad

M: Yeah

OT: And I've used the sentence completion thing before with another group that I worked with in the community who were sort of limited in their ability to self reflect and express as well, you know that kind of expressing the same way you or I might do

M: Yeah

OT: About how we felt, what we noticed, um, what it was like

M: Yeah… so obviously, adventure based activities really warrent themselves to doing that kind of reflection

OT: Umm

M: But what about say, your pottery group… do you, go into a group like that and have them reflect as much during their activities

OT: No…I don't… I mean, you could… if the system was set up so that you could, you know,… you started with everyone, and you finished with

everyone… and they stayed for the whole time, I mean you could just as easily do that,

M: Yeah… do you think it is always necessary to um to have such a deliberate reflection process for the clients?

OT: (pause)… I think it's good to the degree of which it is going to be useful, I mean it can seem painful to the youth, and I know they find it painful at times

M: Mmm

OT: And I have done it on outings before where I have wanted to stop, "we are not going anywhere til we are all in the van, and then we've had a think about it!" ...They often say, "oh do we have to do that again!"... you know… so I try to make it as pain free as possible…

M: Humm

OT: And also explaining to them why it's good to do it as well.

M: Mmmm

OT: To explain it's good to kind of notice good stuff…or notice difficult stuff and not just let it pass on by so we know for the next time… but yeah, back to your question, do I think it's necessary... I think it's really useful to… I mean pottery, most of the time they are working individually as well which is difficult, so if I had all the time in the word and didn't have other things to do I could go to each person and talk with them individually about all sorts of things to do with the pottery that would get them to reflect on," what did I just do?" and cause I think a lot of them do just go through the motions

M: Mmm

OT: And don't allow themselves the opportunity to go, "hey, I just made something " I just did something"… I could say it to them, but to actually give them the opportunity to notice it for themselves is much more effective.

M: Yeah

OT: You know "yeah, I did do something that was quite fiddley and took lots of concentration and I did complete it" OR "yeah, I struggled but I asked for help and that was good that I asked for help" you know, so I think that there can be those opportunities but you don't want to make it long and drawn out… M:

OT: I have limited tolerance to that also

M: Yeah

OT: It needs to be quick and not an hour long therapy session everyone else has to listen to…

M: Everyone else's thing

OT: everyone else's thing. Sometimes how I get around this that is to get them to think about each other. You know, to for example, some of the Survivor things… um, I think last week when you and Cat had gone, and I was staying there, I had the café cards ready for them to pick out the café card that says "something about how it was for me today" …that was not going to work with those particular clients. So what I did was, it was prize time and for them to actually get their prize, is they had to themselves state one thing that **they** thought that they did that was good

M: Mmm

OT: And then also I asked other people to shout out their ideas about what that person did that was really good… so it was basic as that and it was very concrete you know, "you did really good blowing that balloon…" for example.

OT: Another time with other clients, I could have said, "that fact that you did that, what does that say about you?" and there are all those open questions you can do when someone has the cognitive capacity to … be able to reflect and come up with the words for that. But, with that particular group last week, the fact that they were having to say something that they were proud of themselves that they did that they think was good, and that other people were thinking about them and saying those things... that was about as much as you were going to get, and you get a prize if you do that…so I think it is always good, sometimes it can be painful if it is too drawn out and you do it and if you do it in the same old ways each time, it doesn't fit. But I think there's always an opportunity to , which I can't always take because of time, but there could always be an opportunity to be with that person and just do a really quick you know, reflection. And some of the things that… I mean… asking a really closed question, "are you really proud of what you made today?" you know,

M: because maybe that's all they can answer is a yes or no

OT: yeah and that kind of gives me an indication of where they're at but also gets them to think, " yeah, I am proud…

M: and then do you tend to take the information that happens during any sessions and maybe because it sounds like your sessions are very client

based in the processing I mean you're kind of there to help them make decisions about themselves and to come up with things about themselves during the session.

OT: Mmm

M: And then do you then take that afterwards and look at it in your own mind and think, "oh, so and so did this today and that um, means this..." or "I wonder if I should next time do this with that person"

OT: Mmm humm. Yeah, well I guess this goes back to what I was talking about earlier, if I am observing what they are doing. What they are doing is then giving me information about what then I will do as a therapist.

M: Yeah

OT: Ultimately with the goal of helping them to gain skills, gain independence , gain wellness.

M: Yeah. Because that's very OT, as in OT, that is what your goal is. Skill oriented isn't it?

OT: Yeah, I am not going to do it for them but I will then, based on what I am seeing them do, I will make sure that my next intervention is slightly more challenging or fitting with them to enable them to be able to..

M: To do stuff

OT: Yeah to do stuff

M: And um do you consult with… do you go to supervision?

OT: Yeah

M: And does that help you to process what happens in your sessions with the kids and to get some insight into what they're thinking?

OT: Yeah, ah, yeah it does but to be honest, my supervision, I mean I have it once a month and it's not so much um talking specifically about specific clients

M: Yeah

OT: I guess that's pretty typical for someone who's been practicing for a long time that it tends to become more managerial type process. My own process and system things that are talked about

M: Yeah

OT: Having said that, we have peer supervision with a group facilitator that we just started which I have had a lot of in the past as well um, even through outside facilitators

M: Yup

OT: But now we are doing it our selves…so that's an opportunity to kind of think about those things. Um

M: Cause do you ever find when you are talking with a colleague and doing peer supervision and you say ,"this happened with so and so in my session and I sort of felt that this is what that meant" do you ever find that they might think,

OT: Umm

M: "Well actually I would have read it this way or I think…"

OT: Probably that sort of stuff goes on in MDT more than anything else and informally – those sort of specific things like I might talk with [the clinical psychologist] about you know, stuff to do with a client in regards to **my** assessment

M: Yeah

OT: You know because I am often doing functional assessments. Which is all that task behaviour and social behaviour and how are they currently functioning

M: Yeah

OT: She may have a different spin, " when I observed them doing this, this is what I assessed that to be." Again, although a lot of this is observed rather than assumptions, yes you still…

M: You have to process your observations don't you?

OT: Yeah, yeah…

M: Do you think that, I could see something happening, and you could see the exact same thing happening and we both could come to different conclusions?

OT: Um Hum...we could and I am sure some of that is based on training, you know… your theoretical approach that you come from

M: Yeah

OT: I would worry if there was too many opposites all the time because …

M: (?)

OT: A lot of that is basic mental health assessment often as well so, so yes I think there is often different opinions but um, yeah I would worry if there were too many complete opposites because somebody is off track

M: Right

OT: Somebody is off the mark here. For example somebody goes storming out and “fuck fuck!” As they are going out the door and somebody says “oh they needed the toilet” you know, and someone else is sort of like well, “actually I was observing them becoming quite agitated”

M: Yeah

OT: So those are sort of fairly, well, actually, lets talk together about

M: What that meant

OT: Yeah yeah because if someone is consistently minimizing…no, minimizing is not the right word… not really kind of noticing stuff and just thinking because they left the room they either did not like my group or they needed the toilet, when actually

M: There was something else

OT: It’s, you know consistently this other thing, somehow…someone’s observation and mental health assessment skills need to be sharpened up probably…

M: Yeah

OT: Do you know what I mean?

M: Yeah that makes sense.

OT: Yeah, so there can be some differences in interpretation but I think if they kind of completely opposite ends of the scale there’s something missing

M: Yeah, yeah..it’s striking my now that actually, assessment and processing and reflection is all very similar here in mental health? It’s almost as if you’re assessing the situation and processing it at the same time and that you process the situation to come up with the assessment

OT: Um hum… yeah, I guess so. I guess from their client perspective individually, they wouldn’t say they were assessing themselves

M: But from the therapist’s perspective

OT: Mmm

M: You I mean they're processing and reflecting…as the therapist or the facilitator of the groups it's kind as if you're processing with the intent to assess

OT: Umm

M: The situation

OT: With the intent to set new treatment goals and interventions and etc.

M: And just last question. Um, since this is bicultural here, do you find that changes the way you um process what's happening? Are there cultural differences that would make you kind of see a client's actions different than another's because culturally that's a different..

OT: Oh yeah. I mean I know that I have become aware of that like when we have Whakapai forums um, she talks about case studies where someone they are presenting with psychotic symptoms and western medicine as such making an assessment and assumptions. I mean there are always assumptions due to psychotic processes um, and where as these may be altered by cultural beliefs and ideas and experiences going on for that person as well in relation to… um I think the example she gave was may be that somebody at home, somebody has died and they really are believing or experiencing kind of the whole, I don't know what the Maori term for it is, but ghosts and some … basically that say for example an area hasn't been blessed … needing to have it in the context of the cultural stuff rather than taking stuff completely on the face value. But I guess it's back down to knowing that person and that person's experiences and preferences and stuff

M: Yeah so it's also on the same line as having to know, I mean if you are working in this area you need to be quite well versed in what the indications of various illnesses are so, you know, if you see someone laughing at something you do,

OT: Mmm

M: You might they thought that was funny but in actual fact they're responding to an NAS of something or

OT: Or it could be something else, you know that they are so socially inappropriate, you know, like the guy we got at the moment, so we are still again not completely clear what behind what goes on for him, because he is

unwilling to engage in any discussion about it or is suspicious about your motives
M: Yeah
OT: You know but when he laughs at stuff, you know, we ‘re wonder is this because he really doesn’t know what is a socially appropriate cue? Yeah, so I guess with adolescents as well, in that whole, very often in early stages of mental health stuff, along side some of the very developmentally, not delayed but somebody may be individuating and more mature at 16 rather than responding as a 12, 11 year old level socially and all the hormone stuff...there’s all sorts of stuff going on that often leads us to be not be completely clear about diagnostics and assessment and stuff. You know and if someone is prodromal and in the early stages of psychosis then they present as being kind of withdrawn and depressed. Or even kind of odd, socially anxious and then 2 years later they present as really psychotic and that was some early stuff going on. So you can’t always say exactly or definitely they are socially anxious or depressed or whatever..
M: Because there’s too much else happening in this age group to say..
OT: Yeah, the brain’s still growing, still growing up, still finding who they are and depending on their family background as to whether they have a little bit more of a sense of who they are and where they fit in the world or culturally. Or may have none of that depending on their social support system.
M: Yeah
OT: And I guess thinking culturally again, how well integrated into their culture and how much time in that culture can effect all sorts of things, assessment and them how they process experiences for themselves
M: Yeah… it’s very complicated! Why did I choose this?! (both chuckle)
OT: I guess, what would your definition of processing be, you know when you think about it for your research.. I should have asked at the beginning..
M: Well I think, I mean I look at it as the ability to think about what’s just occurred or what is occurring and the ability to look at um well, if we’re looking at me as a therapist, how I would,..how I am feeling in the situation also how I think the client is dealing with the situation. So that’s how I look at the therapeutic therapist processing. I look at the client as processing as basically

having the ability to look and perhaps discuss what is happening for them during an activity.

OT: Its kind of like “so what’s going on?”

M: Yeah, “what’s going on for you here?”

OT: Yeah

M: You know, more than just “oh, we played a song” but even, like you said, it could be as basic as “I liked that” song. But also, for me as a therapist, I was mostly coming from my side of how do I process what they’re giving me. For instance if they are writing lyrics that are, seem to indicate um, which has happened to me in the past, which **seemed** to indicate suicide note, so how do I process. Do I look at them and think, ok, they are quite suicidal and they don’t normally write this sort of thing so maybe I need to look at it as .. for face value?

OT: Um humm

M: Look at their body language and what they’re doing and say, “yup, this all fits into what I think it is?”

OT: Mmm

M: And because, again, I find if I ask them, if I ask the client that, the client will say, “nah, it’s just a song”

OT: Mmmm. But then there’s pulling all the other bits and pieces together, like you say, the non verbals, the context, the previous plan… I mean with suicidal stuff that’s like slightly different sort of thing really…I guess with that as you know, you make sure you get other peoples assessments and processing that as well

M: Yeah, I suppose so would you say… do you use the team a lot when you are coming up with the assessments or

OT: Mmm, Mmm, because you can’t pick up everything and there is such um...you know, the guy that has just gone AWOL, it’s really unclear as to how capable he is because verbally he is so so limited

M: Mmm

OT: And it’s unclear as to then does he have intellectual capacity and understanding and even kind of formal testing because of his verbal skills… so you have to take information from all over the place, and from what

everyone is observing and noticing. You can't get an awful lot from him but, with me, I got him to do a task – a non verbal task

M: Yeah

OT: And made him know clearly that I was wanting to see how he was going with following directions and concentrating

M: Yeah

OT: Because often what happens with him, I think, is he can't be bothered, doesn't see the need to

M: Yeah

OT: Listen or you know, some of it's that so when we articulate clearly what he was doing it for, he actually can be

M: Higher functioning?

OT: Potentially onto it, then what we had assumed, but then also for him, it is so unclear, you have to get information from others

M: Yeah

OT: I guess the other processing thing that we haven't talked about too much is the process or the dynamics between a group.

M: Mmm

OT: Which is kind of a different level again you know… like that you might want to do if you are doing team building with a group, you are assuming that they have a certain degree of self-knowledge and awareness and though they are still reflecting on that they are also reflecting on what's going on with everyone else and how "I reacted to them and they reacted to me" and all that sort of stuff. I don't tend to do a lot of that here

M: Mmmm

OT: But given any opportunity, I think it's good to, you know.." what do we notice when so and so does, well you don't do that when he's in the room, and so and so is getting really angry what happen to everyone else? And then they may notice what happens to other people as well

M: And do you think that would help them perhaps do some personal reflection without it being so personal? By reflecting what other people are doing they might go, "ok, when I get angry in group, that's how it can effect..

OT: Umm humm

M: Do you think it can help them make that..

OT: Um humm,Yes, I think it is good to do and it's good for them to kind of see things from other peoples perspective

M: Yeah

OT: I mean, it is another processing technique that you can use, I have used it a couple of times, but not an awful lot, um is when you are doing a group experience working together, so like working on a problem solving task together or a group task, is to perhaps example is to do the continuum but not necessarily enjoyment but where you place someone else where **you** think they are

M: Ahh

OT: Do you know what I mean?

M: Yeah

OT: Or you're thinking how this experience might have been for Melissa, do you think it was a positive experience for Melissa or an unpositive , because obviously the opposite of positive is negative

M: Yeah

OT: So I might then think, " well, ok, I am going to put Melissa here" and then it's just another way of doing it because it gives you a chance to see how, what I am thinking about you, gives me a chance to have noticed how things were for you. It just sort of gives a chance to do that reflecting. It can be quite difficult to do here.

M: Yeah, again, it depends on the wellness doesn't it?

OT: Yeah

M: The group right now wouldn't be able to do that

OT: Yeah, they can't even notice much for themselves let alone

M: Other people in the group

OT: But that is another, and I have done it myself in adult groups and it can be really eye opening as well. And it can be quite good for that sort of… for that person to think of how they come across to other people too

M: Mmm yeah. I often do that with the emotion cards in music. One person plays angry and one person plays happy and trying to have a conversation with that and asking the others what it looked like. But again, that takes quite a well group of people to look and say well, what's it like to be happy and have a conversation with someone who's angry…

OT: Mmm

M: Does it look like it’s enjoyable, does it look like it’s working. But that’s not so much based on… that’s creating a scenario as opposed to reflecting on the actual experience

OT: Mmm, yeah, it’s a more artificial sense of it but you still getting them to think about it

M: Well thank you very much for your time

OT: I am sure I could go on and on and on

M: Please do!

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Appendix #2: Interview #2 – Clinical Psychologist Oct 17, 2007

M: Ok, thank you very much for doing this today. My first question is," are there any specific techniques that you use with your clients here at the unit that you think would help you process and reflect what is occurring during the sessions?

P: I think I need to check with you, do you mean particular psychotherapeutic techniques? Or broader techniques?

M: Well, it could be either, because anything you feel that you personally find useful. So they could be specific therapeutic techniques, it could just be something that you personally find useful

P: Ok. You know what a lot of us do, including myself, is follow what is called an eclectic approach. You know I was trained in what is called systems theory just broadly means the person is functioning within a system, a school system, a societal system, a family system… where they are influenced by cultural and other issues around them so it's to see whatever client you have in context so it's a broad way of understanding

M: So the system here would be acute mental health?

P: Acute mental health – yes but also ok, that they are presenting with depression. So yeah we can see that there is bullying at the school or whatever. What's happening in the family? Is there divorce? Did the grandmother die, did the pet die? Is there conflict at home?

M: Right

P: is everybody smoking pot? So you have to see that in context as well

M: It's very holistic

P: Yes. Because very often what happens in families, I mean all families are dysfunctional to some extent or another, it's just how it is, And very often with children they think things are their fault, so, especially a vulnerable child who is acting up, with aggression and anxiety and sometimes they are presented to mental health. Families tend to have the idea that we are all ok, we are just dropping this kid off who is a problem at our household either smashing things or sitting in the room and won't talk to anybody. Please fix child and we will come and collect him from you. Well it's not exactly – well, it doesn't work that

way because we can do things here but if there's stuff at home that upset them. If we put them back into that family system and nothing has changed they will respond in the same way because that's the only skills that they have to show their distress. Very often they don't have the language

M: Yeah

P: The young child or even adolescent can't tell you, "Well, it's because my parents were divorced and because they were fighting and because of this, that is why I am depressed" - they'll just say, "things don't feel right." They don't know.

M: So it's really helpful for then, to have a knowledge family background

P: Yes

M: Because I mean, they can come in as depressed and you have no idea where that has come from

P: Some people can view it very simplistically... the family history of possibly depression – that's been looked at, there's been bullying at school or whatever else… you can have a simplistic approach and say well we'll put the kid on some Prozac, he'll improve and we'll send him home. But if you miss a whole lot of the stuff that is happening at home, after 6 months they can develop depression again and then back in the unit. You can have that repeated cycle of these things that you haven't picked up on

M: Would it be your assumption that that is probably why the depression has come about? If say the adolescent can't tell you that's why they're depressed but you see that there's divorce or, like you said, "the dog died" and all of that, can you assume that's a likely cause of it. Is that just where you have to…

P: It's just one of the things you need to factor in. Psychological problems are never that simple and it's not about, or the reason why we try to find out what the possible causes are, it's not that we can change that

M: yeah

P: and it's often combination of some kind of genetic predisposition. It's like diabetes or cancer. Some people with diabetes can eat anything they like, they don't develop diabetes. But if you come from a family where there's a genetic predisposition, if you become over weight, eat lots of sugar, starches that your body can't handle you might develop it, so there's often a whole

array of things, so it's just to look at all the possibilities because it gives you avenues for intervention

M: Right

P: You know, like I say, if there's conflict in the family you need to address that, if there's a genetic predisposition the young person in the family needs to understand they are likely to react to stressful events by becoming depressed like somebody else might get into drinking. It's their disposition.

M: Right

P: You know they look at other things- are they happy at school. Do they have the social skills to interact with peers. That is something that you need to address and it's not to find fault or anything like that or to lay blame. It's just to … it's a combination of factors and it's not we can't like with medical procedures pin point a particular thing. It's all these factors interacting to bring the young person to this position so we address all of those as far as we can to try and maximize the chances that they will become well and stay well.

M: and when your…because in the sort of angle of reflecting and processing what the child or adolescent is giving you.. is it, do you find you are doing this because you want **them** to be able to reflect themselves and get some insight? Or is it often for you to get some insight so that you can then say, "yes I think you are depressed because blah blah?"

P: It starts with me first trying to make some sense of what I'm seeing here.

M: Yeah

P: Once you have an understanding of what could be going on, you normally supply that information with informed psych education back to the family or the support structure of the young person - And they can understand. The young people are often at varying levels of their understanding but they find it very helpful to try find out "how did I end up in this place where I am now?" because often they are quite perplexed. You know, "How did I land here?" but like I said there are variable levels. Often we interact with community teams so when we do we supply them with the kind of information we think they will be able to understand, and then the community team can elaborate on that and as they get better and they're understanding…

M: Are there particular things that you can do that can do that help you – particular techniques that you are using?

P: yeah, like I say, a lot of people really don't use the old, no I wouldn't really say the old fashioned, the psychodynamic approach you know that Freud started where you look back at the history of a person and they reflect back on their past and how that influenced them. That is very important , you know, we don't ..

Interviewer pauses tape briefly to check sound while drums play in background

P: Like I said the old psychodynamic approach is to look at the background history and how you grew up and the relationship with the parents. We use that information still, but the modern approach is due to time restraints, I focus more on the current

M:Yup

P: Because even though you know the past, you can't change the past. What has happened, happened. So it's just information to try and figure it out. A lot of us use CBT – cognitive behaviour therapy. Because it is believed that the way you think about things drives your emotional sort of life and it drives your actions

M: Yeah

P: So it's very much a perception of your life. I mean some people live in a war zone and they still have the opinion they have a good life and some people live in upmarket houses and they are desperately unhappy. You know, especially with things like depression and anxiety people over exaggerate. You know, "things always go wrong with me, nobody cares for me, I'm always a failure" – it's that kind of thinking that drives the negative thinking and the negative behaviour." Well, I'm not even going to try, what's the use of that" That's the kind of thinking we try to challenge. Because they have had bad experiences before

M: Yup

P: And they just repeat that kind of thinking into all of the situations they go. Of course if you always depressed and you never want to do anything of course your friends don't want to be with you anymore…

M: Ummm

P: or if you start acting up and breaking things in the house because you you think nobody cares about you, eventually parents say, "well we can't keep this

young person that keeps destroying the house" and they say "we need support with accommodation" – " you see may parents don't care for me!"
M: Yeah
P: It becomes a vicious cycle. So we use a lot of CBT. We use quite a bit of DBT, which is dialectical behaviour therapy which is behaviour therapy with an added component of mindfulness. And this developed to deal with suicidal and self-harming young people
M: Right
P: Young people with borderline personality disorder have repeated cycles of depression, anxiety, suicidality, and self harm with repeated hospital admissions. And the idea is that they don't have, well they are emotionally quite sensitive, but they also don't have the skills how to deal with stress on the outside, so we combine skills training. How to deal with emotional distress- give them interpersonal skills and then also individual therapy to try and minimize hospitalisation and take on a "patient" role.
M: So with those models, the DBT or CBT, do you use those as a line of attack so to speak so when you are with a client one day and you find they are reacting a certain way, or they are doing.. and you try those techniques with them, do you then sit back and think, "well that doesn't actually appear to be working or that does appear to be working" and then do you continue along that same line or do you often change tack?
P: You have to be quite adaptable. As I say, working the DBT model that's a specific model that was sort of developed, and if we do skills training we've got a particular model that we follow. Well, if you do therapy with a person, you don't sit and think, " ok, I am going to use the CBT technique"
M: yeah
P: What we initially do with a client we follow what we would call a narrative approach. We just sit down and you forget about all the stuff that you learned – ok I am sitting here with a **person.** A full person. Let me hear what their story is, where they are coming from, what's happening for them at the moment.
M: yeah
P: So you try and connect up with your client – never mind all your techniques and what you are.

M: Right
P: You try and find out where they **are.** When you run a therapy session you have your goals. You think well I need to work on their relationship with parents and maybe their kind of thinking, so you have an idea
M: Yeah
P: Sometimes when the client walks in they throw your idea out the window because just now somebody down the corridor has smacked them in the face and they are very upset
M: Yeah
P: So it doesn't then help to say "well actually lets get along with that. Never mind that you have a bleeding nose, but I thought we would discuss today your relationship with your father" … they'll say "well, I don't wanna talk about that today"
M: Yeah
P: So it is also joining them where they are today- And seeing what is happening with them. You have to be quite adaptable to see what is working
M: mmm
P: but also to be quite aware of when they are trying to always avoid the difficult issue
M: Right
P: People in a session tend to tell you the important stuff inn the last 3 minutes of the session when they **know** that you don't have much time. " Ok, I just want to tell you I beat up my mother last night on home leave" It's sort of as they
M: Open the door!
P: Or avoiding issues like grieving you know by just avoiding school, not wanting to go there because it is too difficult. Always coming in with **other** issues like, "my dog got sick" and "I had a fight with my school teacher" and they never want to go to that difficult place. Sometimes you have to start pushing that as well.
M: Right. And do you after a session… I mean do you use your intuition to say "I think that they're avoiding something?"
P: Very much so. You can be quite open about it. Like I say, (sigh)… there's more to doing therapy than using techniques and having approaches. It's to

be able, like I said, to have an intuitive feel and sometimes what you need to do is practice your own mindfulness with the clients…is to stop the conversation in your own head.

M: mmm

P: Just to sit and say “to shut up in your head” because what we tend to do when a client’s talking is we’re already formulating a response

M: Yeah

P: What we are thinking. You can miss out. You can hear the words, but you can miss out on the undertone because you are very cognitive. And sometimes, what I personally do, I just stop everything in my head and I tune in very closely. You pick up subtle things. And therapists that have been doing work for a long time experience a lot of what we call transference and countertransference in psychodynamic terms. But it comes through in different ways. I personally, I react physically. I would work with a client for instance who might have been abused and suddenly I would feel quite dizzy or get a tummy ache. A tummy ache is quite useful I think. You get a feeling this is not your physiological response but you pick up on their anxiety but it’s almost, it’s not on a cognitive level.

P: It’s an intuitive and you sort of think , or you suddenly feel very anxious and I think “there’s no reason why I should be feeling anxious. I am not tired we are talking… What is going on?!”

M: Mmm

P: And it gives... you can either just sit with it and think there’s an underlying anxiety that my physiology is physically picking up… “this doesn’t feel like me” you know? Obviously if later on you get sick you think, “oh it was a tummy bug” but if you just use it as information – sometimes I will say, “ you know what, I am feeling quite anxious at the moment” you know “ you look a bit pale. Do you have a headache or a tummy ache? Or is there something going on?” and sometimes they will respond, “I am not feeling very well” or “ actually yes, I am feeling quite anxious” But they are trying to keep it together. So again, you can use that as information. You have to be quite present and have to open yourself up. It’s a risk that you are taking, it’s much easier to very cognitive and very intellectual and “this is what I want to do and this is what I am seeing and that’s what we are going to do” But it sets you apart –

it's that art of moving in and experiencing all the darkness and the stuff that's going around but not to get so deeply into the client's stuff that you can't disengage.

M: right

P: It's moving in and moving out. Especially when you do family work. When you move into a system like that they will try and make you one of the family. You're with **us lot** against that lot. So the women may pull you in, or what we call the "gate keeper" who person speaks for the family. The one that's pulling the strings and that person will try and engage you as part of the power structure. And to allow yourself to experience it and see what it feels like and pulling back…and being pulled in by someone else. We call it therapeutic maneuverability. You have to allow that push and pull. Because if you don't you miss out on a lot of the information but it's also dangerous because some therapists get pulled in. And to know when you've been pulled in…and it's extremely …

M: Is that where your own personal reflective processing would come in? is going perhaps afterwards, "ooh I got pulled into that…

P: Yes

M: situation" Because I imagine, would it be hard to do that on the spot? I mean that's experience…

P: It is. It just takes experience. You know, when you you've been trained or the way we were trained is that you work in your room and you have a one way mirror and you've got your supervisor behind the glass so when you work with the client in the room when you are training, you've got the client stuff going on and your stuff going on. You have to develop towards the end, three sets of information. The client stuff, me, and the supervisor sitting behind me checking me being with a client (all in your head)…

M: Mmm

P: and the interesting thing is when you become a supervisor yourself you have to have the supervisor watching the supervisor watching the therapist watching the client. So you have multiple processes and it takes a period of time to develop the observer observing someone else. So you can see the sequence.

M: So do you almost, over time, become that observer yourself. You observing yourself…
P: Yes, you observe yourself. It's almost as… if you still got the supervisor behind the glass checking your behaviour - Because early on in your training you don't notice what you do in a session. When you see yourself on video you say, "did I do that?", "do I always make that comment?" I remember one student talking about the "stiff board syndrome" because he always sat like this in a session (P makes a gesture of stiffening up her body in the chair).. (both laugh)
P: When you look at yourself it's ,"Oh my goodness!" so it's becoming aware of your physical position because if a client doesn't talk loud enough you tend to lean forward but you need to watch yourself because if I lean forward the client becomes more quiet and moves back. Watch your tone of voice. How you speak… Repeated statements that you are using… So you need to become quite aware of what you are doing.
M: Yup… you have to be quite quick cause this is one of the reasons I was coming up with this question is that I was realizing during sessions I might be… I might have come upon a situation and my brain is just going so quickly thinking, "what should I be doing" and I am thinking "I should be doing this, oh no, I should be doing that" and having this whole argument in my brain the whole time and then I do something and I think,"oh I shouldn't have done that!" and it's sort of like constantly processing what's happening, but yet for me, I am realizing, I research into this, that actually, it's almost as if I am trying to process what the client is thinking for them.
P: Uh huh
M: I want to help them so much, to figure out where they are, that I need to know exactly where they are, so I can tell them.
P: Oh…yeah
M: and that's not really what it's about – is it?
P: People often have that in the beginning." I will go in there, I need to fix things." And there is still a push in any service - fix them get them out because there's a long waiting list…
M: Mmm

P: and when you make peace with it that you can't fix anything for anybody, they say with therapy the most valuable thing is the relationship with the person and not so much the technique that you are using. That you are in a situation that is correct for them- that they feel listened to and validated before you do **anything**. That is almost the most valuable gift that you can give anybody… And that you can't fix things for people before they are ready to have things undone. They can only take onboard what they are ready to take onboard. It's like a child learning to walk, if they are not ready, their muscles are not strong, you can lift them up and put them on their little legs all you like, it's just not going to happen. With people especially if they have quite severe defence mechanisms that they've built up, it's there for a reason. And you can try and fix all you like but it won't work.

M: Right

P: To be totally there for them and listen. And to be quite open.. . for me it took a long time to recognize when I make an error, and not to just, you know, (sigh) cover it up. You know. I was with a client, telling a little story in one of the sessions and right in the middle of the story I thought, "Oh my goodness, this is not a good example, this might be quite offensive." Now this is the middle of the story in the middle of a group. So I just quickly finished it off, but I could see on her face, you know there seemed to be quite a frown and at the end I said to her, " I just want to check with you – that story, right in the middle I sort of thought this was not a good story. Was that your experience?" and she said "yup" and I said " was it better for you that I talk about it and bring it out in the open and said I'm sorry or would it have been better if I had just carried on and … and she said "no, actually it was very valuable that you recognized that I didn't like your story and that you brought it up." So… when you work with a client and you do say something and you think, "oops, that didn't go too well" what to do about it is actually part of their validation so, when I was saying "that you felt uncomfortable during the story you might think what is this, what am I talking about!" - it gives them a lot of freedom in the relationship that they can say,"yes that was the stupidest story that I ever heard" or "I can see that would be valuable" …so it's not a technique – it's "this person is really there with me, she's listening, she's

watching me, she doesn't push her ideas or whatever onto me…she's really there just with me and quite aware of what's going on with me… "

M: So it's very much about being with them more so than being this facilitator or being this person that running the group – it's more about actually **being** in the group and being a part of…

P: It's creating a context where people can heal. That is all you can do. So in the music room, I would imagine you create a place where people are relaxed where they can experiment, where they can do things they don't normally do, where they're not being teased, where their limited abilities are being understood…and within that context, what is ready to come up and what is ready to heal, comes up.

M: Right…(pause) and so, when you get to the point, my second question about the media in session and working with other media. So let's say you get to a point and you realize, ok, this person is really ready to start doing some self reflection, is doing quite well… is there anything you use to help them…

P: Especially with adolescents, they're almost the trickiest people to work with because with kids, they like play therapy. So, you just put a bunch of toys on the floor and.. I always say that kids fix themselves. You are just there with them and you observe and .. they will play out their anxieties and their depression in the toys. **Structurally** you can **see** it… and they somehow sort it out for themselves in their own minds and you don't have to use a lot of language. With adults you can put them on a chair and you can have a discussion about a problem… teenagers fall somewhere in the middle. They don't like playing anymore because it's childish and some **don't want to talk to you!** You know it 's typical of teenagers .They seem to enjoy activities and that's what makes our work difficult. You also have to understand where they are. You get adolescents who are more intellectually inclined and don't mind having a discussion and expressing themselves verbally. Especially the girls

M: yeah

P: Boys are more inclined if you run around and play ball with them or whatever, in between , you know… shooting hoops they'll say to you, "oh well my parents don't want me back". But if you put them in a room and say, "what do you think about your parents and being discharged?"...(low mumble voice)

“I don’t know..” So we use a lot of other things like drawing therapy or drama therapy.
M: Mmm. And are those therapies used so that **you** can see what’s going on for them or is it more so that they can see what’s going?
P: It’s both but it’s to do it in a form that’s not so challenging for them. some of the adolescents find it quite challenging, almost invasive. They don’t always understand, I find, the real reason for talking therapies. Because really for them they’re in an inpatient unit and to them it is, “you better keep your mouth shut or you’ll never get out of here”. So it’s more stressful for them to share it and also to have a person that sits on the chair looking at you and listening to what you’re saying. I’ll check with them,” we think very often it’s quite validating to have someone listening to you” but to them it feels quite like they are on the spot. I suppose it feels like parents. (Low authoritative voice) “so tell me what your day was like at school today”...”Well I’m not telling you nothing!”
M: Yeah
P: So it’s a more indirect way because if you are quite anxious or if you’re cross with your mother you can always make a drawing of a monster or whatever else and afterwards they can always deny it and say “no, no it’s just a picture or I was joking or no no it’s not my mother it’s just something I saw on tv”
M: Mmm
P: or they can like I say, draw it in a way and see how you respond to it and what you understand from that. It’s just an easier way for them to do it and gives them an opportunity to put on paper what they are ready to disclose to you. I actually found that through drawings they actually tell you more than what they would in words because with adolescents… the brain is not fully developed so for them, especially if they are emotionally distressed, to take the turmoil on the inside and translate that into words and full sentences to explain it… how do you explain to someone when feel yuck? Or what is the yuck all about? Is it angry, sad?
M: Yeah
P: who knows? But yuck can be put on paper. You know, if it is a pile of rubbish, or whatever and from that and from the colors and the way it’s

positioned and the words that they add to that then the information comes out**.** **You** understand better and when you reflect back to them,"Ah!" ok, that is what is busy happening… you can help them develop the language…" And what I am seeing for instance using a lot of black...what does black feel like?" …(lowered moody voice)"Oh, dark "…is it like the night which is quite protective? What is that about?

M: Mmm. Ok. So it really does help both you… When you are reflecting on them is it more like you are testing to see... where they are- verbally…while they are there and you are reflecting back … "does it appear to be safe?" or "it appears that you're angry" ... is it more because you are testing your theory? … a thought that you have?

P: Yeah, it enhances the understanding and for them to expand on what they have done as well because what I have found with the kids very often if I have a discussion afterwards, and again sitting on the floor which works better for them than at a table... they would pick up a crayon by themselves … if I say to them, " that's quite interesting what I notice down there" they will pick up something and add to the picture, as we go along and it also makes them feel more calm because they don't need to look at you…

M: Right

P: and the crayon, even if they just scratch it helps with the distressed clients because the hand is busy doing something. Like I say, as the discussion grows and their understanding grows, they would sometimes add something…I might say "that is quite separate from that, I am wondering how that relates to this?" they would sometimes grab a crayon and draw something else with it. So you start with an initial picture and as both of you explore, they will add and expand on their own picture.

M: Right. Ok. Do you find that, I mean, you have been practicing for a while so I don't know if you would still do this but do you still after the session not only reflect on them but reflect on yourself? … and on how you were in the session?

P: Yeah, that's a process that continues. Yeah, you don't always, well…You do do during the session as well but that's something that I personally do when I am a little bit quieter. Obviously you do that in supervision as well.

M: Yeah

P: you need to check that the whole time. “What was going on for me, what was going on for the client?” … do I get stuck in a rigid way of seeing things?
M: Yup. So, supervision – do you find that quite helpful for you… To help you process what’s going on? Do you ever go there and think “there’s a thing happening with a client … or I do this…” does it help **you** to process what’s going on?
P: It does.. but it depends on the kind of supervision you have and the approach of your particular supervisor.
M: yeah
P: Some supervisors are quite psychodynamic orientated so their questions tend to be a lot of, “ well how does that relate to experiences in your life?” say you are with a client and you become quite irritated because they wouldn’t engage, you know, they won’t talk to you … and then it’s a repeated thing… the supervisor might say, “ I wonder what the irritation is about when people don’t speak to you? Does that relate to anything else in your life? Your own kids or when you were a child?”… so they push you to reflect on that, but not all supervisors do that.
M: Right
P: A lot of supervisors are into the more practical kind of things. What is happening with the client, what other techniques could you possibly use, who in the team can you pull in to assist you with that?
M: Yeah
P: So, for me personally, a lot of the reflection I do on my own. Or not just rely on my supervision. I’ll just talk to one of my colleagues.
M: Yeah
P: That I often work with and say, “I am having this kind of response. Are you having that as well? Do you wonder…” so often in a very informal way, over coffee, just reflect on ….
M: So you can actually use your co-workers… also for a particular client say, you’ve come out of the session with a feeling of … something the client’s feeling… do you then go to your co-workers formally at MDT or informally over coffee and say, “so and so did this today…I think this is what that means…” Do you do that?

P: Yes, but it depends how urgent it is. If there is a safety issue … if a client, say we were applying for weekend leave and they said all the right words but something just didn't feel right, you know, I'll go to the team leader if it is serious enough or I'll go to the shift coordinator and say, "look we were planning for leave , I spoke to the person, but I have a sense of discomfort. That's just my… or what do you think? Will you do an assessment from your side before she goes on leave? And I will note it down in the file as well."
M: Yeah
P: If it's just my personal stuff… think, what is that about? Did you get enough sleep? Do you have other stuff going on? Does this relate to something else in your life? I sort of process a lot of that in my own head, so it's a continuous reflection. You get to know yourself...of course you have to know if there's a pattern being established .
M: Yeah
P: Towards burnout or whatever… that you seek your own therapy…
M: Mmm. Were there other things that you wanted to add?
P: Yes…to process the session or to help with my future therapy planning for the client, like I said, I speak to my supervisor, I will also speak with the keyworker here on the unit who very often works with the family and arrange weekend leave, work on the discharge plan… if there are things that bother me or things that need to be put in place I often ask to be part of family meetings.
M: Yup
P: Either to do an assessment of the family and see what sort of patterns I pick up or to address particular issues for the family that I think need to be addressed… maybe there's something I feel quite strongly about..
M: Mmmm
P: I'll work together with the OT if I'm asked to do an intellectual assessment.
M: Oh ok
P: Because very often they do a functional assessment first. You know, practical stuff like cooking and cleaning… so to give me a broad idea of where there might be neurological fallout…so that I can structure my assessments accordingly.

M: Do you find that with your assessments, that, because I thought that sometimes here, I am almost doing an assessment every session with the same client because from week to week they are so different.
P: Yes - obviously, there's different kinds of assessments. One is just a psychological assessment what is happening for them. But we also use formal psychometric testing where you pick a particular test to do either an intellectual assessment or short and long term memory, test frontal lobe function which is your brain's ability to manage emotions …to follow a step wise approach. So if I have a referral saying there's something intellectually not right with this person , we don't know if it's concentration or memory or whatever it is… the OT will do a functional assessment. She'll say to me, the person has a problem concentrating for longer than 5 minutes. I give instructions and 10 minutes later the person can't remember it… they have problem following a step wise approach. I mean there's 5 steps written and they get it all confused. I think, ok, so, possible intellectual assessment, I need to assess memory, the frontal lobe there seems to be a problem…
M: Yeah
P: So I know exactly from the broad testing what other tests… because often I have to book it with other centers. We don't have all the formal testing instruments here.
M: Ahhh
P: That I can do an assessment that follows or covers all the bases of the things that we are concerned about. I work quite closely with them and have a discussion about what we found. I also work quite closely with the health school teacher here on school related issues. Again if it's related to concentration or memory, we might have to do an assessment here that would relate to maybe their school placement. Maybe they can't go back to their current school, maybe they need a teacher assistant in the school to help with the person if there is a concentration problem. Also, that the teachers know what to expect of the client.
M: Sure
P: And also the school transition part of that is how to be with their peers. Answer difficult questions at school, " where have you been for the last 6 months? " How to keep their boundaries and how to make that transition. So

that is something that I do. The team leader will be consulted if there are serious issues about confidentiality, for example, people wanting to have information from the files, like reports, if there are boundary issues, anything that concerns me about ethics or safety either of staff members or clients. And there's the very practical issues- I am dealing with the client, what have you observed, especially with eating disorder clients. What did you observe during meal time, what did they do. What makes them feel anxious, what else have you seen on the ward going on? And also to realize when you're work together with the family, do you think the mother will be able to handle this? What would be our goals for this week when a parent comes to visit?
M: right, so that would change how your session goes because this is happening this week.
P: yeah. And then addressing the clients…"tI've spoken to them and this is what we think your mum will be able to do this week, do you agree with this?"…that kind of thing
M: yup.
P: With the kaumatua – the Maori cultural workers, what would be appropriate for a client? Maybe, sometimes they would also discuss with me their responses to a client and they were wondering if the kid swears, how to manage that and what would be the meaning of that and having a discussion about that…
M: do you find that that changes depending on culturally what the client is? I mean, if they are Maori, do you have different issues that you …. Like you said, if they swear, or if they do something, do you think well maybe that's a cultural reaction?
P: I just consider that it could be a cultural thing …it could be the way they were brought up and cultural issues you need to be quite sensitive it doesn't mean if they are Maori they necessarily believe in these cultural values. People are very mixed cultures and they might adhere to one part of a cultural belief system and not to another one. Someone can't make assumptions but it is something you have to consider.
M: Yeah

P: If the kid swears, maybe they grew up in a household where everyone swears. So it doesn't necessarily carry the same sort of viciousness that it would … it's just the way that they talk

M: Yeah

P: You might not agree with it or endorse that, but it's not because they are necessarily …

M: So that would be something different as opposed to someone who doesn't normal swear then is suddenly swearing...and so the reflection would be quite different wouldn't it?

P: Yah…that's right.. and their religious beliefs, their spiritual beliefs.. that sort of stuff

M: Right

P: And last but not least – **The community team**! That is vitally important.

M: Right!

P: They visit us here during hospitalisation and we give them frequent feedback, especially the community teams that are close to Wellington. They need to know the process. What has been happening. They need to know what's happening and I need to know what's happening out there – especially with family work being done because we've had conflict before that they sort of say, "well we will start with family work once the young person is discharged"…well that is too late – when we work with the young person, you need address family issues out there so that we can put the two together.

M: Yeah

P: And then they understand why we are emphasizing that, why we are so worried about the family, what needs to be done. Because very often they get an early referral, it's an acute thing, they meet the family very briefly, and the person comes down here and they don't have a lot of contact with the family in between so they really on us. I also need to know from them what is available out there. If they don't have APOC[acute package of care] nurses available and the person is in a rural area were ambulance services are far away, it influences whether we can send somebody with suicidal tendencies away on weekend leave. If the ambulance is ½ hr away that's gonna cause a problem.

M: MMmm

P: If APOC nurses are not available to assist the family, other decisions need to be made. So those strategies need to be firmly in place for us to be able to start working towards discharge.
M: Right. Which I suppose all of those factors will effect how the actual sessions – whether you are with a group, whether you are with individuals – how they're being structured… because you have to process all these external things because they very much effect the internal…
P: Yes. When you talk about …to them about their future… are they going back to school? Well, maybe they can't because of certain problems because of suicidality, cutting…
M: Yeah
P: There's only one school in town… or there's not the help available you can't say ok well, if they are concerned about home leave and can say, ok we will give you an APOC nurse if there's no APOC nurses available. It's not an appropriate discussion.
M: Mmm.. Ok excellent. Thank you for that!

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Appendix #3: Clinical Psychologist Interview Continued 7-11-07

M: These are some extra bits of information that the therapist decided needed to be added – thank you

P: Ok, with your questions, regarding question number one about the techniques used during sessions, I think I mentioned before that it's important to follow the eclectic approach – concentrating on the physical health, psychological health and the spiritual health. So for me personally what I do is follow a sort of wellness approach. Not to always necessarily see the person as a patient, but see them as a person who is presenting symptoms but who is trying to get balance, trying to get a solution to their problems. They are not necessarily the way they would like to be. What I also ask myself is what function the symptom serves in their life. Is it a way of asking for help? Is it a way of getting away from a dysfunctional family? Is it a way to get nurturing? And also if people's defences are up, you know, or they don't want to talk about stuff or are trying to argue things away or are becoming very intellectual whatever defence mechanisms they use, I try and not to break that down too quickly because if people are trying to protect themselves there's often a good reason.

M: Mmm

P: It can be quite dangerous to you know, just sort of wipe that away and exposing that person's vulnerability all in one shot…. Very open and fragile

M: Right, and do you use your intuition to sort that out or do you use all the other information that we talked about the other day… all that together get make you think, "oh they are… they have a defence mechanism up and I think it's because…"

P: I use the background information I have but also being with the person and if I try to bypass it a little bit, and see how they react…

M: mmm

P: and if they act quite severely with that I think ok well, they are trying to protect themselves. It might need a bit of time to build a relationship with them before I can start pushing… nurture and step over to their side of the fence… fight a good fight on their side before I can start introducing different ways of seeing things

M: So patience and waiting

P: Yes… (both chuckle)… ok also some people talk about a transmutation of energy. It's almost sometimes that emotions are just forms of energy so somebody reacts

with anger. Can that anger be turned, or can the energy of that anger be turned into determination? Or can the determination in someone with an eating disorder – “I won’t eat, I am restricting my food, I am doing this perfectly” – and that sense of perfection and drive changed into a drive to get well again or to achieve in other areas. So it’s just shifting the energy in a more constructive way.

M: Shifting the negative into a positive.

P: Yes. Rather than saying,”that’s bad, you shouldn’t be doing… that’s not a good thing. It’s shifting that energy.

M: Seeing it as a strength, instead of a weakness.

P: Yeah. Anger can be a good thing. Anger is what changes the world, but if you burn down the Parliament building because you are angry because you want to effect a change, that’s not going to get you anywhere

M: Well, it’ll probably get you in jail

P: Yes, but it probably won’t do much for your cause.(both laugh). So that’s question #1. With Q #2, you asked what media do I use in sessions, and how do they assist in understanding? I think with adolescents you have to use a whole number of things. With groups for instance, we can use videos, dvds, anything to stimulate the senses, like I said, things to look at , smells, sounds, things to taste. For instance you can use the senses, to illustrate the emotions and how intense emotions come and then they subside…you can have the group put a bit of wasabi paste on their tongue. It burns and burns and then you drink water and you sit with it and it dissipates and use that as a…

M: Ah!

P: Sort of experiential learning activity. Very often it is difficult, especially with adolescents especially in an inpatient unit, for them to concentrate for an extended period of time during group interaction. Music, games that they can participate in, drawings, discussions… one young person instructing someone else or acting as a sort of teacher or mentor for someone else. Not being a councillor but for instance if we use a training session for interpersonal skills, one person trying to convince someone of something else she will have somebody with her that can give her some guidelines. “Why don’t you try that – what about you ask…” In that helping somebody else, they learn as well.

M: Right
P: Rather than me telling them what to do…sometimes the young people will bring their own drawings, their own artwork or their own poems and we can use that for a discussion as well. We sometimes ask them to write letters. You know just write in your diary where you can keep it or we can send it to the person in whatever form they want to… make lists, pros and cons lists, lists of things that they need or that they want, requests that they might have for their treatment in the unit, writing little notes to their parent wanting to tell them something… oh and a mood continuum for them to start identifying where their mood is today. On a continuum. You know, is it bad is it average, how does it vary…
M: Is that a visual?
P: Yes, it is a visual. Just a line with" terrible" and "better than it's every been" and they can just make a cross on it - To create awareness. Because otherwise they may say, "so, so or I don't know, or Yuck". It teaches them the differentiation and the insight. "My mood is always yuck in the morning but if I get out of bed it does seem to improve…" and then they might think "oh that's interesting, I never realized that".. So instead of lying in bed until 12 o'clock, deciding in advance to get on with the day…if I get up, things will look better later on…
M: It's creating a bit more mindfulness, isn't it?
P: Yes. And it's better that they find that out for themselves than us saying it to them...sometimes they can make their own collage, cutting out pictures, sayings… take a big piece of paper, write their own stuff, taking it to get a theme, their journey, their future…that's useful… like I said, in general, they respond well to non-verbal techniques and there's a richness of information that comes through with that. And then they will start adding their own words in as well. As they cut out pictures, they cut out phrases…
P: Questions about the structure… does the structure change depending on what's occurring in the session? I talked about that before. There's often difficulty to engage them and you have to find all different ways to do that. Coming back to what it is that they need. Sometime what they need is an impromptu session. Sometimes I will be on my way down the corridor to do something else and somebody will be sitting somewhere in the corner and I will say,"Hey,what's up?" not planning a particular

session, but they are in the mood to talk now and it's to use that however difficult it is sitting in the corridor because it is not so confidential… Because if they are in the mood they will start talking because it might be something that might be happening right now. They might have had a meeting with their doctor or one of the nurses said something to them and it's still fresh in their memory.

M: Yup

P: Two three hours later or tomorrow when you have a session, all that stuff has either been suppressed or they don't want to talk about it.

M: Yeah - so it's very much going with the moment

P: Yes. Young people are very much like that and you utilize that moment and see if they will talk and that could become a session of an hour or longer – and you can sometimes shift it into another room but sometimes you loose the momentum.

M: Yup

P: If you change the context. Sometimes just me asking other people to move away and talking quietly…

M: I've done that with music. Sometimes I will have the door open here so that people come in and we will suddenly have a session…

P: which you can do here luckily. It's one of the advantages of an inpatient unit which you don't have with outpatients. You know, they've got particular sessions with you. They might just come in and they don't want to talk today, you know but that's the nature of sessions that creates difficulty.

P: The therapy I'm doing, whether it's individual or whether we are having a family meeting, to work on therapeutic issues or provide psycho-education or psych-communication for the family whether we are having a meeting with the school to talk about school transition or the community team and we having discussions… sometimes it is difficult to differentiate what is a planning meeting and what is therapy meeting...what is the…

Sometimes you might go into the session for a so called "discharge planning meeting" but give therapeutic input. Because if we invite parents in for a family therapy session they might be quite resistant. Why do we need therapy if it's about the young person?

M: Right

P: But if you call it a discharge planning meeting and you pick up patterns and things you want to comment on you can make your comments there.
M: Mmm
P: I notice this - you look a bit sad or dad looks a bit angry – what is that all about? so having the therapy meeting…
M: Subtly
P: Subtly without them noticing! (both laugh) - again, it's just using the opportunity… The core of the structure is to have a plan, know what sort of priorities you have and what you would like to address, but also to grab the opportunity …playing with both of them.
P: Ok and number 4, the other professionals we have addressed… everyone in the unit works together. The cultural aspects...
M: You did talk about that. You mentioned um, how it's good to know for example, it the client is doing a lot of swearing and it's something that happens at home a lot it's not something you would really take note of in this situation… only if it's unusual – so context…contextual aspects.
P: Well, we see mostly Pacific island people, but I think in the future we are going to see more people of other cultures. Chinese, we have had a South African client, and eventually we will end up with also refugee clients coming in. And I suppose the tricky thing is addressing all of these cultures we've had and also people of mixed origins and that makes it even more tricky. We had a client in here who was mixed European and Oriental sort of background. And how we pick up even in the family, the different viewpoints of illness especially psychiatric illness. How to address this. Mum was oriental and she was very protective. "We don't discuss stuff like that, I just want my kid to get better, I just want to get home, I don't want to talk about my marriage, my family, issues at home, I don't want to address that" she was very reluctant. The father …there were marital problems, and you could really see he wanted to address issues and he couldn't understand why she had such problems and the marriage was in trouble…It's difficult working with a mixed family like that and this young person seems to be torn between these two. You know, wanting to be with dad and actually getting on better with dad but looked more like mom and wanting to be close to mom. And so…(?)

P: That is the difficulty with a particular culture, it's not to assume for instance, that people from a Pacific Island culture will identify with it. Even though that is their full genetic background they may be in a school with mixed cultures and therefore may associate more with Pakeha. Pakeha lifestyle… it's important to know how this culture and the cultural beliefs fit into their own belief system and lifestyle. And into the family because there can be a rift there as well. Especially with people coming from the Pacific Islands where the parents are still very staunch believers in" the children must be quiet and the parents will decide what they are meant to do and where they go to school" but the children believe "I speak up, I speak my mind, I will do what it is that I want" and that can create huge problems and that needs to be addressed because otherwise it leads to problems- especially after a person is discharged.

M: That would effect the way you … because you are trying to empower the client and saying, "speak up for yourself and tell them what you feel"

P: Yes, and "they shouldn't be speaking to you like this and"

M: But culturally that doesn't work in the family so you have to be aware of this so you know how to help the whole picture.

P: That's right, they understand that maybe the father would see that as being very disrespectful so in speaking their own mind, how can they speak to their father and say you know, " I appreciate your view, it's not out of disrespect, but it's very important to me to tell you how I feel, I would really appreciate if you would just listen to me" which is a different way to, "no, no, I don't like that, and you never listen to me and …"starting to shout at each other…

P: So I think we will see a lot more of that, especially with the Chinese community…

M: So it will become more of an issue

P: Yeah, like I said it is more and more common for people to have mixed backgrounds and not to assume for instance, that if someone looks Maori that the whole family is Maori. Sometimes they walk in and say, I'm not Maori or we don't adhere to any of the Maori principles and don't speak Te Reo

M: Mmm

P: This is not what is happening for me. Or, sometimes there's a mixed system that they still believe in some of the old cultural beliefs… they hold that part but they want

a cellphone and to go drinking with their friends…and to assist them… help them to hold both - to hold on to their cultural background, their roots but also their modern beliefs and that's often what's…. especially with people and their religious belief systems… someone will say "that's old fashioned stuff I don't believe it" and someone else will say" no, no I am going to church…"

"I walked through a grave yard I am going to be in big trouble… I am not sure I believe that stuff"

M: And I guess for us, we're not here to judge those beliefs whether we …even if a child, the rangitahi doesn't believe that … we're not really there to take sides are we?

P: No it's what's important to them, what's their belief system… what is meaningful to them. Of course, if there's something in their belief system that can assist them to get **better**, or a misunderstanding that they have …something that they thought they did wrong, you can get people from the other culture like a Kaumatua to come in and maybe give them some good advice and if it was a misunderstanding then they can help them to understand this is not a permanent sin they have committed.. they can do a cleansing ritual or something that can be fixed up. People may be uncomfortable with self-harm or suicide attempts or whatever people may feel very uneasy with that part of the ward… somebody can come in a do a blessing and that is very helpful…

M: Yeah…

P: Well, that's it

M: Thanks that was excellent!

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Appendix #4: Reflective Journal

10/4/07- morning group

Very chaotic – loud! Had found objects from trash shop – hubcaps, tubes, metal barrel – everyone banging randomly. I stopped group – asked them to take shakers and form circle to do passing shaker exercise – worked well to unite group but LOST them after that. I asked them how it felt, if they felt together – "no"… very disruptive, several people combative, contrary…loud music. At one point I could feel myself getting frustrated and angry. We started to play quiet music and I asked them to notice what that was like. Then, I started banging loudly on the hubcaps because I wanted them to notice the difference. I felt really out of control and frustrated….

It was too chaotic! Too many choices within group…loud instruments too disruptive. I need to lessen choices and be very clear about activity…

30/04/07 – morning group

Once again, in a big group, I loose them… I can't seem to keep them all interested and actively involved. I felt very out of control and inexperienced. When X made comment re: [another music therapist's] sessions being better/more fun… that expressed my exact concerns. Session improved when M brought flute and many in the group had left.

Think I need to start w/ better activity… although I notice the same people (X, Y, Z) don't like my sessions, A is ok, but tends to get very low mood.

I don't' know how to get reflections going from work during session.

I feel so inadequate

What am I doing?!

30/04/07 – afternoon group- music relax

This session went well, but still quite "free form" – it was relaxing though and that was the point – all seemed in good spirits following group but I am not sure how much of that was me.

9/5/07 – individual session

I was very worried about X after session. I felt this was a "goodbye/suicide" song. I spoke to [the clinical psychologist and shift coordinator] about this – showed them the song. Neither seemed too worried… X hugged me goodbye and thanked me for everything…she later attempted to kill herself (hang herself)…while I was still in

unit…I heard the alarms and I just knew…I feel as if I let her down- didn't go w/my gut feelings that something was terribly wrong…

A lesson to be learned.

10/5/07… a message for X (this was not given to X – it was for me)

I tried to listen

I tried to help

Were you asking for me to stop you?

Did I let you down?

You spoke of a journey

I had a feeling

I knew

But the question for me was

What do I do?

I told other people

I gave them your song

I said I was worried

Everything felt wrong

Should I have kept you there?

Was the music session not long enough?

Should I have given you all my time?

What did I do wrong?

What didn't I do? To help you….

14/5/07

[X came to session, played chimes and zither very quietly and commented she was embarrassed -I told X she didn't need to be embarrassed] With X, instead of telling her she didn't need to be embarrassed, I might have asked why – or perhaps what she was concerned about….I shouldn't invalidate or brush off emotions!

I am so often here feeling inadequate – I was unable to hold her (Y). [Y climbed out 2nd story window trying to go AWOL- I held onto her, asked her to come inside/I needed help]

Needed [staff] to get her in, I back up and just don't know what to do.

I wasn't really prepared today and felt very apprehensive about being here…I must work on this – being unprepared won't make me more effective – that's for sure.

23/05/07

I felt odd about session because it was not what I normally do… felt unprepared. I know I was effected by kids telling me how cool it was to be in [other music therapist's] group where they sing songs…"he is so awesome" so I thought I would try…it does not feel right for me though, to only do that…even though all were ok, it didn't keep them engaged for entire session (there for 40 minutes)

30/5/07

I felt the group was not interested in what was going on. I think I am caught knowing how much they enjoy [the other music therapist's sessions]. Trying to emulate this… but I end up feeling out of control – inexperienced and basically that it's not a good session.

04/06/07

I wake up every Monday with dread – I don't want to go to placement. Luckily, it's a holiday today and I don't have to go. I feel so inadequate and out of my depths at R. I am told by professors that we are not psychotherapists – then what are we doing in an acute psych ward giving music therapy?!!!! I am told not to look into countertransference too deeply – but that is exactly what I think I need to do in order to understand why I am struggling to cope there...Or perhaps it's just that I would find these kids tough no matter what my background was…

I feel lost, over whelmed… confused…how do I make these sessions

meaningful???!

13/06/07

Group session today – many were initially quiet and flat. I had to fight with my mind to stop worrying about the next exercise and worrying that they were not enjoying the activity. They all stayed and they all participated. They smiled…and made "good sounding" music together (they said this)

Had individual session where very disturbing information arose. I spoke to psychologist and she asked if we could have 3 way conference. Client's mood plummeted and I felt as if I had betrayed her trust

Except that she spoke of wanting to kill herself when she goes home – about lying about her wellness…

But in this 3 way session she wouldn't speak and was extremely disturbed. I feel so bad – as if I had done the wrong thing – did I cause her to decline because I betrayed her trust? **BUT I HAD TO!!!**

14/06/07

Came from supervision and I feel a lot better about what happened on Wednesday. I realize a few things that I can do in the future and what was missing this time:

1) Psychologist and I should have discussed our plan for the session – what each of us expected and required from each other…
2) I would like to have spoken to my client before hand to discuss the fact that I had spoken to Psychiatrist and **ask** client whether it would be ok for the 3 of us to talk about what was said…
3) Realize that I can ask for what I need to happen and that I can choose not to participate if I don't feel that it would be beneficial…

17/06/07

I was uneasy about seeing the client from last week today…I wanted to talk about our session w/ counsellor – apologize for not asking if she would talk about it w/ us. When I saw client in morning meeting we didn't really make eye contact. I felt uneasy. At lunch, as I was entering building, client called out to me for a chat… I felt relief and said a few words about previous session. She seemed ok and requested to see me later…

Had group session this morning. My mood is flat because I am tired and sad due to my home life being very unsettled. I opened up to my partner about what's going on in my counselling sessions regarding my difficulties attaching to people and my history of not being able to trust in the security of relationships. He finished this chat by telling me he doesn't think we understand each other and that we should split…hum…

17/06/07 - morning group

I changed initial exercise because one client had a sore arm… Due to the acuity of the other participants the exercise didn't really work (shaker pass). Trying to keep everyone in time was very difficult. The session felt very flat – as if nothing

really was working and that the clients I had were not really able to focus. I felt very disorganized – although I did use different activities, I felt that it was really hard work.

22/7/07

Clients found song writing very amusing. Commented that this was their favourite song writing session. I think this may be because they were writing about themselves a lot today. Making jokes about their diagnosis' and also reflecting how they feel about the unit.

25/7/07

Kids were excited to song write again because Monday's song was so enjoyable. They had written about the unit and made jokes about their diagnosis' etc… they all laughed and felt really good. Written around song "beautiful" (C. Aguilera)… Today we wrote to "Oo oo Child…things are gonna get easier etc" Client X chose it because 2Pac has it in his song. Client wrote 1st set of words…they indicated child abuse and not being allowed to cry. Client immediately closed down –curled up on couch and eventually said "I don't want to do this anymore." Other client Y wrote more hopeful lines but said it was depressing song. Both were upset, so I suggested new song…Client Y suggested "stand by me" – but at this point I hadn't seen Y's distress and was focused on X. I chose the Bob Marley tune "3 little birds" (Don't worry…every little thing's gonna be alright) because I knew that X liked this song. X gently played djembe , Y left.

In hindsight I wish I had played "stand by me" – it would have been **perfect** – letting clients know that I was there for them – supporting… I just felt I needed to "fix" and make them feel better, but I chose wrong path – client Y had actually chosen correct song but I missed it!

22/8/07

Chaos today. I began session focused on one client (only one there) invited next member to join…then was thrown when new member said other [music therapist] is good and did cool stuff. I changed exercise to do the one had mentioned, this went ok although, not particularly well due to other clients in the group… I quickly switched to boomwhaker clap exercise (since we all standing) and 1st client said,"too confusing" others got distracted so I changed again….sat down to do

rhythm exercise – this went ok although everyone needed ++ encouragement and appeared bored. 3 clients were in and out of room, one other doesn't respond to verbal comments, one was asked to go to meeting and another tired. I KEPT SWITCHING ACTIVITES IN ORDER TO FIND SOMETHING SUITABLE – ADDING TO CONFUSION THAT THEY ALL FELT ALREADY

5/9/07 - group

We sang song "Boulevard of Broken Dreams" I think I should have sang it higher – it was too low for girls to really chime in and sing strongly.

One client who hadn't started out depressed (appearance wise) seemed to lower in mood after discussion of being alone began.

01/10/07- electronic music

Electronic music in morning – this went well with variety of people in again.

Client from last week wasn't doing well this week. Very "out of it" said due to medication. Y who has (eating disorder) worked with me – only 2nd time ever!

Wrote song that had really strong dance beat, but changed throughout and had very dissonant melody that rhythmically was very imprecise. I thought this was good because she is often so concerned with control and order that she was able to let go here and liked the sound/song she made…(she asked to play it for other kids and I asked if there was anything she needed to change etc and after a bit of listening and small changes, she said she liked it.)

Group – I didn't really have a plan. Very varied group – initially going well but then extremely disruptive client came, banging loudly on drum – completely disrupting group flow. I tried activity that could use this disruption – 1: lead group in improvisation and 2: have a conversation musically between client x and Y – talk about whether it worked…Y said "No!! Couldn't hear!" but by then we'd lost a few members and then client X became more disruptive , moving drum near door to watch/listen to client outside yelling..

10/10/07

I tried only improvisation today with my client Z…client responding to NAS [non apparent stimulus] throughout. Played xylophone – I tried to just be with client rather than think of activities because Z often seemed to not quite understand activity – or perhaps too caught up in NAS? Z was unable to see difference in

facial/ musical emotions. I tried activity of how we would play if we angry?.. happy?... Z unable to notice difference. Just said “yeah” for all (asked if it looked angry…etc) I felt a bit lost as to what to do to keep him interested, so I just followed his lead to play with him. Started playing xylophone very fast, with repetitive melody and notes… I mirrored this, then I slowed down as he did. Music became slow and sounded relaxed. X appeared to be caught up with NAS, then looked at me and asked if session over…

Was the fast playing the confusion in his head and did it slowly clear when music relaxed and had more gaps and silence?

The ward is very acute (my clients are anyway!) and I am finding sessions difficult to get inspired or organized for. Not too sure what to do with these folks…other than improvisation…

17/10/07 – group

Mixed today – started with improvisation but then thought I would try an activity to unite group. One individual Z, who in past didn’t do organized activity was briefly involved – stating “I can’t do this” I explained it’s fine to make mistakes – we all do. Client stayed for a while. Activity worked but then client laughed, got up and left (looked as if saying “this is ridiculous”)…rest of the group followed.

Did I make exercise go too long?

Was he embarrassed or did he just have enough?

Should I have stuck to improvisation?

How to integrate a very diverse group?

20/10/07 – IDT

Just finished a 2 day intensive IDT [interactive drawing therapy] workshop.

WOW! I had no idea I would get so much from this. A lot of experiential learning – we were both the client and the therapist. Many similar themes are starting to emerge: 1) the importance in SILENCE, 2) **Client** - centred processing – it’s about client processing for themselves – we there to support, provide safe environment and the tools (music or paper and crayons)

I think everyone involved in therapeutic work should take this course… Invaluable tools on client/counsellor relationships

29/10/07 – relax group

We played music – had a jam session. All going well, then one member had to go to meeting. All bar one left. Prior to session I had supervision with psychologist. Great to talk about things – reflect on how my mind is doing here. Learned that sometimes it's good to just sit back and observe, feel what's going on.

03/10/07

Thinking over why a particular client doesn't attend music group anymore. Took several sessions to build trust – individual sessions because nobody else scheduled for group. The next time (4th session) had other members. Client expressed inability to do activity, enforced idea that there were no right or wrongs. Client stayed briefly, then left group. Next time , client stayed on periphery of group only minimal contribution. Client now does not attend group stating he doesn't know how to play…hum…

Did he feel intimidated? embarrassed around group? disappointed that "our" time was being used by others too?

Note: he popped his head in to say good-bye today. I asked if he'd like to come next week because I'd missed him today, he said "no", turned and left.

31/10/07 group

I was initially nervous about group because it's been a while since I'd had many (past couple of weeks have been individual sessions due to clients being at school) This group I came in with a plan (rough) and decided to stick with it

initially. Opening “Salileo” went very well, laughing, singing – all participating in someway. One client suggested activity that she particularly likes – instead of going for it straight away, I decided that the group needed to get into the instruments first (2 of 4 were showing interest in playing) so did rhythm exercise. Talked about focus and how to help yourself to be mindful or focused while other stuff is going on around you.

Thought: It might be useful to have scale that kids could put themselves on (magnets?) to show how they’re doing or how activity was for them.

Did rhythm activity but I could see it waning so I ended it…and had quick debrief. Moved to face card activity which all participated – again, talked about how it was for all…. I felt it was time for song and then when heaps of kids had come in I thought “I can see clearly now” would be a good ending song… we all sang and played – called out to one as he headed for door, requesting he sing it’s gonna be a bright, bright sunshiny day” – he did and it felt good (this is client who in previous sessions could completely disrupt session)

I felt that I had read the situation well and that throughout the session I was more aware and open to what was going on with the clients.

07/11/07 –group

All boys… has been for a couple of weeks now…all improvisation – no structure so to speak but just flows as different people lead, come and go. I drifted with that today – changing activity/song depending on who was there. I found I focused on the activity happening rather than trying to think ahead to what would happen next. It seemed to suit this client group. I felt like I was floating down a river, navigating what was directly in front of me, riding waves not worrying about

what lay ahead. It went well – I was able to provide for each member well (I think) – and perhaps by chance, when different people chose to leave or arrive, instead of disrupting – it evolved…

Chance? Me?

12/11/07 relax group

Total improvisation - mostly guys…great jams interrupted by clients leaving and coming. One client sat in corner banging her head [against the wall]. I replicated rhythm on drum. [She looked at me], wrapped herself in curtain but stopped banging. Again, group moved, changed, evolved with each coming and going. This was not too disruptive though. Only problem was sometimes person that kept returning didn't know how to fit into group/activity – got frustrated and left.

Do I need to set more boundaries?

14/11/07

I still feel anxiety before coming into work here. Is it the unknown of everyday? Insecurity about what's going to happen?

19/11/07 – group

Began session with "Salileo" as per client M request. Had X in group, who was meant to be in school and in the past was INCREDIBLY disruptive… last week he'd been in group doing his usual banging and I turned and said, "I hear you" and continues playing. He calmed his playing and joined the group. It made me realize that if I could let him know I am listening that perhaps he won't need to be so disruptive to get attention. So, we were marching in circle singing song then I suggested someone take the lead and lead us around the room – X asked if we could march around the unit, so I said, "ok, we will march you over to school" Not

only did he lead the group, but he listened to directions and lead us to school and left the group without an incident. Yahoo!

21/11/07 last day!

I am feeling so much more a part of the process here. Sessions seem to just flow – even if they are not “easy”, I feel as if I am present and able to be with these kids and really sit back a bit and hear, see, observe, feel…. Without trying to constantly worry what the next thing is going to be – I think I am still thinking about it, but it is not coming from a place of panic and insecurity, it’s coming from a place of knowledge and experience. My last supervision was today and I was asked to pick something out of a basket of assorted objects something that represented me when I first began and something that represents me now. I chose a broken mussel shell for my starting point. Fragile, brittle, broken, sharp… I chose a cats eye spiral and a stone with patience and trust written on it. The spiral represents to me a journey, a new beginning… and the stone is smooth and solid and I think the words Trust and Patience are two of my big lessons here. Trust the process and be patient with myself, the clients and with the process.

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Appendix #5: Compilation of Categories and themes from data sources:

Literature:

- The client-therapist relationship is a primary focus in therapeutic sessions.
- Client self-reflection is an important issue in therapy and is a focus and goal for many therapists.
- The therapists' responsibility is to provide an environment conducive to client reflection and safety.
- A Therapist's empathetic response and the use of intuition are vitally important in trying to understand what feeling state the client is in.
- Affect attunement and non verbal communication are tools used in therapy to help clients feel understood and heard by their therapist.
- Adhering to a Psychotherapeutic theory can be of value to the therapist on various levels.
- Processing your (the therapist's) counter-transference is necessary in order to be helpful to the clients.
- Non-musical therapeutic techniques as a means for a music therapist to understand and help a client have been utilized in therapy.

Clinical Psychologist interview:

- The client-therapist relationship is a primary focus in therapeutic sessions.
- Meet the clients where they are rather than trying to fix them.
- Therapist mindfulness and their observation skills enable them to better provide for the client.
- Processing your (the therapist's) counter-transference is necessary in order to be helpful to the clients.
- Therapeutic experience and training influences a therapist's ability to process and reflect
- Client mindfulness and awareness is a goal that many therapists are trying to achieve

- Alternative media is often utilized in order to assist client reflection and processing
- Working with co-workers to reflect and process can be helpful for therapists.
- Knowledge of client's cultural influence can assist a therapist to reflect on observed behaviours/responses

Occupational Therapist interview:

- Observation and assessment are valuable skills used frequently during sessions.
- Meet the clients where they are and find activities that appropriately challenge them.
- Choose activities that are meaningful to the client.
- Intuition based on training can be used to process and reflection on a client's feeling state.
- Client self-reflection is a goal that many therapists try to achieve
- A variety of processing and reflection techniques can be used to assist clients to the experience.
- Therapeutic experience and training influences a therapist's ability to process and reflect
- There are a variety of possible reasons why people in this client group often have difficulty processing and reflecting.
- Clients cultural beliefs can effect their reflection and processing

Reflective Journal:

- Wanting to "fix" the client was an underlying goal of this new music therapist
- There were many reactions to sessions that were a result of countertransference that initially were not apparent to the journal writer.
- When initially reflecting and processing sessions, assumptions rather than observations were made.
- Focus of sessions began as both therapist and client centred and with experience and training they became client centred.

- Focusing ‘in the now’ and mindfulness was challenging for a new music therapist
- Through observation and experience, skills can be gained to make sessions more meaningful for clients.

Appendix #6 – Information sheet

Mt Cook Campus, P.O. Box 2332, Wellington.
Music Therapy Dept., Conservatorium of Music, Tel: 04 801 5799 x 6410/6979

Exploring Processing and Reflection Methods and How They Can be Utilized in Music Therapy Sessions at an Adolescent Acute Psychiatric Ward

Information Sheet

Researcher: Melissa Garber

Supervisor: Daphne Rickson
Music Therapy Lecturer and Clinical Placement coordinator
New Zealand School of Music

Thank you for taking time to read this information sheet and for considering participating in this research project.

This research project is asking the question, "What techniques have music therapists and other professionals used to help them process and reflect on their sessions with psychiatric patients? How can I use these techniques to assist me when endeavouring to better understand my adolescent acute psychiatric clients?"

Through interviews with other professionals and a thorough search and analysis of literature I plan to explore the different methods other professionals use for reflection and processing of their session. I will be looking at how I may be able to use some of

these methods and those found in the literature for future Music Therapy sessions at [this acute psychiatric ward for adolescents]. The unit will not be identified by name nor will any clients or staff however, the number of adolescent mental health units in New Zealand is small, so there is a chance for the unit/staff to be identified.

Participant Recruitment:

I would like to interview three staff members on the unit. I would prefer professionals from three disciplines. The criteria for selection is that the therapist has worked as a licensed therapist with this client population for at least 2 years. Another criteria for inclusion is that this person facilitates both individual and group sessions at the unit. I do not intend to use their actual names in this study. I will not need to recruit any of the [clients at the unit] for this research, clinical notes will not be used and this study will not alter their therapy sessions and therefore, there is minimal risk to them as a result of this study. However, the journal that I am keeping, though no specific client will be mentioned, will contain reflections of sessions that have occurred at the unit without mentioning client names.

Project Procedures:

I will be audio taping the interviews and these will be transcribed and used as data for the research. Transcripts will be returned for editing and approval. I may eventually choose to use some of the information/methods provided to reflect on my music therapy sessions. I will be keeping a journal of my reflections of these methods following my sessions. This journal will contain my thoughts about how the sessions proceeded and how I responded/did not respond to clients. Clients will be referred to as, “the client” or “client A, B, C etc” and their diagnoses will not be identified in any way, nor will their identity, staff identity, or the unit identity.

All raw data will be stored at the New Zealand School of Music in the Music Therapy Department for 5 years.

Participant Involvement:

Interviews will last for approximately 30-45 minutes and will be audio taped.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;

- ask for the audio tape to be turned off at any time during the interview;
- withdraw from the study at any time up until you have reviewed the tape transcripts or to request certain information not be included in the study.

If you have any questions or concerns about this project please feel free to contact:

Melissa Garber: 04 904 0041 or email melissagarber@clear.net.nz
Daphne Rickson: New Zealand School of Music, Mt. Cook Campus, PO Box 2332

04 801 5799 x 6979

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 07/43.

If you have any concerns about the conduct of this research, please contact:

Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 8771, email humanethicsoutha@massey.ac.nz

Appendix #7 – Interview consent form

Mt Cook Campus, P.O. Box 2332, Wellington.
Music Therapy Dept., Conservatorium of Music, Tel: 04 801 5799 x 6410/6979

Exploring Processing and Reflection Methods and How They Can be Utilized in Music Therapy Sessions at an Adolescent Acute Psychiatric Ward

Researcher: Melissa Garber

Participant Consent Form

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have my tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix #8 – Cultural consent form

Mt Cook Campus, P.O. Box 2332, Wellington.
Music Therapy Dept., Conservatorium of Music, Tel: 04 801 5799 x 6410/6979

Exploring Processing and Reflection Methods and How They Can be Utilized in Music Therapy Sessions at an Adolescent Acute Psychiatric Ward

Researcher: Melissa Garber

Consent Form

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree that this study is consistent with the provisions of the Treaty of Waitangi

I agree/do not agree that a consultation has taken place and I support this research taking place at [this acute psychiatric unit for adolescents].

Other Comments:

Signature: ..... **Date:** .....

Full Name - printed .....