Co-therapy in a Group Setting

Benefits and Challenges in Facilitating Co-Therapy

Music Therapy in a Small Group Setting

Exegesis submitted in partial fulfilment of the requirements for the degree of Masters of Music Therapy, New Zealand School of Music

Yair Katz

January 13 2012

Acknowledgments

I would like to sincerely thank the co-therapist who worked with me this year in my placement and the colleagues at the specialist centre.

A special thank you to my supervisor, Associate Professor Sarah Hoskyns, for her continuous encouragement and support.

Ethical approval was gained for this research as follows: HEC: Southern A Application - 11/41 NZSM Master of Music Therapy Programme Ethical Template for student research in NZSM 526 undertaken as observational studies, theoretical or case study research. Date awarded 15 August 2011.

Abstract

This study provides my findings on the issue of co-therapy in music therapy practice with children and young adults, based on my personal experience in placement during my final year as a student practitioner for music therapy. The study discusses co-therapy from the point of view that, like any other example of team work, co-therapy has advantages and benefits, as well as disadvantages, difficulties and challenges. The study looks at the practice of co-therapy in detail, to reach conclusions about those benefits and challenges. It uses examples of co-therapy with small groups of clients with a range of different needs, to provide a wide picture of how co-therapy could be used effectively in music therapy, but also to discuss the issues that occurred when co-facilitating. The results of the analysis are presented in the findings section and discussed in the subsequent section. It is important to note that these results, as in other qualitative research studies, are based on personal interpretations and should not be viewed as facts. They can, however, serve as recommendations and points for consideration for students, new and experienced practitioners who might consider co-therapy as a practice.

Table of Contents

Introduction

Overview of Thesis

This study examines a topic that was central to my practice mainly in the first half of the year, when I was on a nine-month music therapy placement as a Master of Music Therapy Student at a specialist therapy centre in New Zealand, working with children and adolescents, mostly out in community settings. My clinical work at this time largely involved co-facilitating therapy for small groups together with an experienced therapist (presented in this paper by the pseudonym name Naomi). As awareness of my professional growth and the learning involved in the co-therapy developed I also began paying attention to what might have restricted me in this practice, in comparison to other work I was doing as a single therapist. In addition I was interested in examining the relationship between the therapists as a team working together, in relation to my own practice and as a way of working in the profession. The research I went on to conduct began based on self-reflections (as a student, action research was not an option), however I wanted to be able to include a thorough examination of the topic of co-therapy, looking at what practitioners found beneficial about this practice but also its limitations and challenges.

The following study therefore includes a review of some of the main issues which are related to the practice of co-therapy. As the search for literature in the field of music therapy revealed only a small number of sources, I expanded my search to include examples from the field of psychotherapy, which I found relevant as I was examining the nature of co-therapy.

Using secondary analysis of data which I will explain on in the methodology section, I examined and analysed my experience in co-facilitating three groups. The results of the video analysis are described in the findings section, which is presented in a chronological order, from a group session early in the year (March 2011) to a later example (August 2011). The findings will show a variety of issues that occurred in the selected analysed sessions. However, I have also drawn on our clinical notes and on my reflective journal as sources of data to enrich my findings and support the argument I was making.

In the discussion section I look at the main findings in a focused way, connecting them to my sources of literature and adding Naomi's views, as well as key points from my reflective journal which related to the argument. I sum up bringing together my sources to understand my research topic and the findings around it and with the understanding I gained about my topic provide possible answers to my research question.

Background and Personal Assumptions

A research project that deals with co-work would ideally be carried by all the parties that made the team. Since the circumstances in the work presented here are different, being a university paper carried by one student, such balance in the presentation of the co-work is not possible. Indeed, I was very aware that this work involves my own assumptions on the experience of co-facilitating music therapy with another therapist, and is therefore not a complete picture of the whole experience. However, I have asked the therapist that I have worked with this year to add her thoughts in relation to final findings in the work, and these are included in the discussion section.

As a student music therapist co-working with an experienced therapist, I was aware of the gap in clinical experience between myself and the therapist that I worked with; Naomi has been a registered music therapist for five years. At the beginning of our work together I might have felt a little anxious about working with a more experienced therapist, and also realised I felt more self-conscious and perhaps a little less intuitive than I would normally be when facilitating sessions by myself. Looking back at our early sessions together I can now recognise 'weak points' in myself. In retrospect these could be explained perhaps as part of the process of learning; inexperience would undoubtedly have had a strong impact at the beginning of my placement. These issues will be discussed in depth later in this paper, however, I would like to mention in this section some of my background experience which related to my work this year.

Prior to studying music therapy, I had for years been engaged in group music making of very diverse nature. This continues. My background includes playing jazz music and participating in group free improvisation, which I find is close to music therapy in many ways as it leans heavily on the musicians' listening skills, and encourages and requires high levels of attention to others, relating and communicating. As in music therapy improvisation, in free improvisation being in the moment is an essential necessity in order for the music to be most true and reflect an honest intention. I find that the experience of improvising in a group has given me some tools that are also required in music therapy. I am particularly interested in free improvisation because of earlier experience, and draw on this approach in a central way in studying the literature, and in developing my practice. My co-therapist also used an improvisatory approach, and thus this was a natural way to develop and reflect on our practice.

Facilitating groups is another field that I have been practicing for a number of years, mainly in the context of a drum circle. While this is usually a more structured exercise, it has given me the opportunity to explore what it feels like to lead a group, something that I believe is essential for music therapists as well. Therefore it is safe to state that I was no stranger to the role of the leader nor to the concept of following (as in improvising jazz or free music), however the challenge that I believe is in the source of what this paper tries to examine and discuss lies within the concept of co-leading or co-facilitating groups; the actual experience of sharing the lead in facilitating group sessions.

The way improvisation is used as a method or approach the therapists take in the sessions seem to come from knowledge, experience and personal preference; improvisation can be seen as a style or attitude. Does the fact that the therapists work with a group of clients rather than with an individual mean a completely different approach is needed? Is it that any improvisation-based method should be avoided in favour of a structured activity that assures the group will connect and learn? These are issues in managing groups that I look at in the literature review.

The approach that I hold with regard to the practice of music therapy is holistic and humanistic. I strongly believe that an aspect of the work of a music therapist is to help shifting some of society's common and false past perceptions of people with disabilities and special needs, to a more inclusive humane attitude. As music therapists, I believe it is our duty to provide the people whom we work with the best tools and the highest quality conditions to help them to reach their personal goals and fulfil their highest potential as

human beings. I see music therapy as an empowering platform that holds an opportunity for self-exploration and self-expression, as well as meeting and dialoguing with other people. When working with clients I am aware of their personal space and respect it. I believe in treating each person with respect and dignity, seeing each client as an individual who has his or her own unique personality, qualities, desires and needs.

In this research I was curious to find how team work can be effective both for the clients and the therapists, and how I, personally, acted in this frame of work. Consequently I was interested in how I could improve my skills as a co-facilitator.

Research Question

Thus, the research question I proposed for this research was: What are the potential benefits and challenges in facilitating co-therapy music therapy in a small group setting?

Literature Review

In this section I will sum up some essential examples of co-therapy from the literature which I find relevant to my research, starting with a definition of the term, and proceeding with a focus on the psychotherapies from where co-therapy originated, followed by its use in music therapy specifically. In search for related literature, I used 'Discover', Massey Library's Ebsco Databases search Programme, through which I sourced 20 articles and book chapters, as well as other Journal Databases such as Jstor and Web of Science. Even though collaboration has been a key element in some traditions of music therapy (particularly in the pioneering practice of Paul Nordoff and Clive Robbins discussed in a following paragraph), the practice of two music therapists co-facilitating music therapy groups has not been widely examined. As my research focuses on group work I will also look at some key points in facilitating group music therapy, in particular focusing on the process of group improvisation. Coming from a background that includes personal experience of and special interest in free improvisation in group performance, I am also interested in finding links between that field and my practice to become a music therapist. Thus, the literature review will include references from the world of jazz and free improvisation outside the field of music therapy, and I will attempt to recognise some potential links between the fields.

Definition of Co-Therapy

In an influential book which thoroughly examines the practice of co-therapy in psychotherapy, Roller and Nelson (1991) define co-therapy as *'a special practice of psychotherapy in which two therapists treat a patient or patients in any mode of treatment at the same time and in the same place'* (Roller and Nelson, 1991, pp. 2). The relationship

between the therapists, they add in the introduction to their study, is fundamental to the treatment and becomes crucial in the healing process (Roller and Nelson, 1991).

Tradition of Co-Therapy in Psychotherapy

In the field of psychotherapy, it seems that co-therapy has been recognized as an essential and important method of treatment for quite some time, with papers discussing the topic dating back to the 1950s. I would like now to consider some historical aspects of the practice of co-therapy in psychotherapy, referring to Roller and Nelson's important study of the topic, in which they take a role of advocates for co-therapy.

According to Roller and Nelson, co-therapy is not a new practice; it was first used by Alfred Adler in his child guidance clinic in Vienna in the 1920s. Adler experimented with employing two counsellors instead of one, trying to break resistances in the treatment of children in the presence of their parents (Roller and Nelson, 1991). Furthermore, they claim that the first psychotherapy group with adults in a hospital setting in the United States was conducted and co-led by two therapists, Shilder and Shaskin, in 1936 at the Bellevue Hospital. (Shaskin and Roller, 1985 and Roller, 1986 in Roller and Nelson, 1991).

Between 1978-1990 Roller and Nelson conducted a thorough survey in which professionals were asked about their reasons for choosing co-therapy as a form of treatment. Psychotherapists answering the survey valued the experiential learning in co-therapy and mentioned the benefit of having widened perspectives when another therapist observed the same events of the therapy. However, they also recognize the challenge in this situation,

which requires therapists to be flexible and open to hearing other opinions from a co-therapist who might obtain a whole different attitude to theirs about the therapeutic process.

Co-Therapy in Psychotherapy and Other Therapies

Many state the effective use of co-therapy in psychotherapy and counselling education. The involvement of the trainees in the therapy process and the effectiveness of having immediate feedback from supervisors (Testony, 1994) and the two-way modelling between teacher and student in counselling training (Meyer, 1987) are amongst the reasons stated for using co-therapy in this context. In addition, co-therapy has often been used in family therapy (Eppler and Latty, 2001, Hart and Thomas, 2000), and couple therapy (Reese-Dukes and Reese-Dukes, 1983, Boles and Lewis, 2000).

Deluca, Boyes, Furer, Grayston and Hiebert-Murphy (1992, in Hendrix, Fornier and Briggs, 2001) argue that two therapists have more resources than a single therapist. The shared responsibilities between the therapists reduce the workload for each other, and in addition the two therapists are able to role-model appropriate behaviours in relationships, that clients can observe closely. However, Haley (1987, in Hendrix, Fornier and Briggs, 2001) interestingly views co-therapy as primarily for the security of the clinician, rather than for the client's value. Later in the same text, Napier and Whitaker (1978) mention the potentially effective use of the symbolic nature of co-therapy, where the therapists take the role of therapeutic parents, while Haley (1987) proposes the possibility that clients could get trapped in a struggle between their therapists.

The mixed views about using co-therapy are well presented in a text by Cividini-Strani and Klain (1984) titled 'Advantages and Disadvantages of Co-Therapy'. While stating that many agree that co-therapy is useful as an educational model, and mentioning the positive effect of mirroring between therapists, they also quote Napolitani's (1980) and Foulkes' (1975), who found no significant advantages to group co-therapy in comparison with single-lead therapy, and mentioned the risks of having interpersonal complications between therapists (Napolitani, 1980, in Cividini-Strani and Klain, 1984). An additional challenge for co-therapists might occur when disagreeing with the other therapist's views yet deciding not to voice the disagreement, a phenomenon they call 'the control of one's narcissism' (Cividini-Strani and Klain, 1984, pp. 157).

Co-Therapy in Music Therapy

The term 'co-therapy' might not have initially been used by Nordoff and Robbins with regard to describing their pioneering practice of music therapy. However, when summoning together music therapy literature related to this research, referring back to their celebrated partnership seemed essential as a starting point for referencing, as well as looking back at some of the historical importance and on-going influence of Nordoff and Robbins' therapeutic teamwork.

Nordoff and Robbins (2007), state that the benefits of working as a team rather than individually are especially evident when working with severely disabled clients. In their model of practice, the two therapists have specific roles, as stated; a primary therapist, who sits at the piano, and is therefore considered to be in charge of the initial musical content of

the session, and a co-therapist, whose focus is more directly on the clients' physical needs and responses. Nordoff and Robbins believe the relationship between the therapists to be based on 'mutual attentiveness, support, exploration, discovery, and caring service' (Nordoff and Robbins, 2007, pp. 190). They also suggest that the therapists' age, gender, experience and skills are all essential influences on the character of the teamwork.

It seems as if Nordoff and Robbins provide reasons to justify co-therapy; specifically they mention the effectiveness of having the co-therapist's physical support of the client, and the additional sense of security that the clients get from what they describe as the 'mutuality' that comes from having two therapists. However, Nordoff and Robbins do not provide a real discussion on the nature of the co-therapy. Instead, the distinction between the therapists' roles is being described, and I would like to take a further look at that clear division, which I find to be an interesting point when comparing to my practice. The co-therapist's role in the Nordoff-Robbins model is being described as complimenting the work of the primary therapist by providing the necessary support. In other words, they do not seem to be perceived as equals in the music-making process. According to Nordoff and Robbins the co-therapist needs to be very attentive to the way that the primary therapist is working, as well as to the client's responsiveness. He can even, they go on, bring meaning and clinical intentions to the primary therapist's playing, and assist the client to find a meaningful musical language (Nordoff and Robbins, 2007).

Fachner (2007) further examines the role of the co-therapist in Nordoff and Robbins music therapy. In his article, Fachner clarifies that the co-therapist is a supporter of the therapist and thus has to follow the therapist's leadership; *'A co-therapist furthers the relationship*

between therapist and child and assists the process of relation between music and child' (Fachner, 2007, pp. 39). It is sometimes inevitable for the co-therapist to find himself struggling in this mediator role between the therapist and the client while trying to support; thus, Fachner describes the challenge in a situation where the co-therapist needs to recognise the right moment and avoid intervention, allowing the client to respond directly to the main therapist, in contrast to his otherwise supporting and intervening role.

In theory, the Nordoff-Robbins model of work did not exactly fit with the practice of group co-therapy that I have been involved with at my placement and discuss in this paper, however, situations in which a similar approach to Nordoff and Robbins was used did occur and will be addressed in the findings section.

Case Studies of Co-Therapy with Individuals

In a description of a case study with a child, in which they compare individual and group therapy, Robbins and Robbins (1991) avoid using the terms 'primary therapist' and 'co-therapist'. Their overall presentation is more of a united team working around the clients' needs in a direct way (this might derive from them being a couple). While not using the same terminology as the previous Nordoff-Robbins example, it occurs throughout their text that the set roles remains; while one therapist sits at the piano, the other takes a more physical and technical role and is in charge of, for instance, placing music instruments and objects within certain distance from the client and removing them as needed to fit the client's needs.

Describing their method of work, Robbins and Robbins make an interesting statement about the different approaches taken when working individually in comparison with group work. A music therapy session with an individual client is based on improvisation and is clearly client-lead; the therapist(s) respond directly to the client's behaviour, expressions or gestures by providing matching sounds, thus giving a musical context and meaning to the client's acts (Nordoff & Robbins, 1971 in Robbins and Robbins, 1991). However, the approach they use for the group music therapy process is altogether different and is more structured; focusing on learning and performing pre-composed songs rather than improvisation.

Salas and Gonzalez (1991), in their description of a case study seem to take a slightly different approach. In their work with a single child there seemed to be a natural, free flow, in which they allow for a lot of improvisation, alongside established songs they have created with and for the client, and with leadership shifting between both therapists and the client. The therapists, like Nordoff and Robbins, also complement each other, but the way they do that is different; they both use music equally to engage with the client, and this seems like an effective tool in their assessment as the child responds to both therapists' music. This is an example of how the richness of having two music-based therapists (i.e. therapists who both primarily use music as a mean of communication) can benefit the child. Salas and Gonzalez's use of voice over piano playing, and their use of different instruments as well, such as the violin, created a rich world of sound. Their client response suggest that for her the bigger and richer the music was, the more safe and secure she felt, thus suggesting that for this child having two therapists aided the feeling of being held by the music and allowed

for more opportunities to connect. This is also the approach that appeared to be in accordance with my own way of working and experience of co-therapy.

More recently, Cooper and Molyneux (2009) documented their experience of co-facilitating therapy sessions for three individual children to support a change of therapist. Co-therapy in their case was short term and the focus was to introduce the child to the new therapist via co-working. This way the new therapist could familiarise herself with the way the clients have experienced music therapy to date, and gain knowledge about the clients that most likely could not be learnt from notes or verbal handover. Cooper and Molyneux were aware of the chance that a co-therapy period might confuse the clients, who might not fully understand the concepts of ending therapy with one therapist and beginning with the other, yet, they concluded, they felt the clients will benefit from additional 'holding' in the critical time of transition.

Cooper and Molyneux's experience of co-therapy relates to my own as it discusses some of the issues I dealt with this year when co-facilitating music therapy with a more experienced therapist. As a student, I also related to the way Cooper described the effect of the positive experience of co-therapy on her as a professional. Having open discussions with the more experienced therapist aided her to gain confidence in her practice, a value that can never be underrated for a new therapist.

Multidisciplinary Co-Therapy

Often in the music therapy literature it occurs that the term co-therapy is used when describing a multidisciplinary approach, where a music therapist is working together with a specialist from another field. Examples of this are many and I would like to mention a couple here, as I believe that their conclusions on the overall effect of working as a team of two therapists are related to my own experience of co-therapy.

Twyford and Watson's book 'Integrated Team Working' (2008) was dedicated to multidisciplinary collaborations between music therapists and other therapists, parents, teachers, nurses and other professionals. In one of the many case studies described in the book, Miller and Guarnieri, a music therapist and a drama therapist reflected on their work of facilitating a group together. They state that the group members gravitated towards free musical expression and had difficulties managing structure or dramatic play. This, they believe, suggested the clients' emotional need to be held, and led to a group process that allowed a lot of what they call 'play space'. With regards to their own relationship, they concluded that as therapists they needed to have open discussions, be flexible and not be too protective about their mediums. By not carrying a lead role a joint energy was formed that seemed to aid what they describe as a creative experience of working together (Miller and Guarnieri, in Twyford and Watson, 2008).

Bull and Roberts (2005) considered group co-therapy consisting of a music therapist with a non music-therapist (also called 'an assistant'). The term co-therapist as they use it, refers to an assistant who, even though is not a trained therapist attends regular supervision, and is therefore seen as equally responsible for leading the group work. This suggests that Bull and

Roberts value seeing the co-therapists as equals in facilitating the group regardless of the gap in clinical knowledge and experience they carry. They conclude that there were many advantages for the use of co-therapy in their group work, which lead to a greater sense of containment. They also mention the potential of members of the group experiencing the therapists in different parental roles. A challenge they faced was a feeling of being exposed or threatened, acting in a defensive way and the chance of each partner feeling resentful of the other when splitting occurs (Bull and Roberts, 2005).

Co-Therapy in Groups Facilitated by Two Music Therapists

Davies and Richards (1998) reflect on their experience of co-facilitating group improvisation in an acute ward. Besides the music improvisation, the therapists also supported members of the group to express themselves verbally in the sessions.

The therapists shared roles in the sessions; as one would play the piano in a way that contained and allowed interactions, the other's role was to support and engage with individuals in the group. A similar approach was taken with regard to the group's conversations. The Nordoff-Robbins' framework is evident here, however, Davies and Richards seemed to swap roles between them, and mention the importance of being flexible and not being stuck in one role. Similarly, they were aware of the potential of holding parental or maternal roles for the clients, and needed to work hard to avoid feeling stuck on either a feminine or masculine role. Davies and Richards state that having mutual support in the difficult setting was an advantage, and found that for clients, having two therapists paying attention to their needs was helpful. The therapists' different clinical

backgrounds were, in their experience, another advantage as their learning and understanding of certain behaviours presented by clients had widened.

A challenge they mention is responding differently to a difficult situation with a client; in the example they provide one therapist's response to the client was verbal and in a way confrontational, trying to assist the client using her own way of communicating, while the other therapist struggled with this approach and remained silent, thus their approaches polarised. By openly discussing the issue in supervision, the therapists were able to avoid getting stuck in defending their stances and thus their relationship grew.

Fearn and O'Connor (2003) hold a different approach to their roles as co-therapists. In their long-term work with a group of children with special needs, they found it to be most important to keep specific roles in order to maintain a safe, secure feeling for the children. Even though this seems quite similar to Nordoff-Robbins, Fearn and O'Connor wish to avoid the terms 'therapist' and 'co-therapist', and their approach towards the roles is in fact very different; the static person, who sits by the piano and provides the musical 'glue' to the session is perceived as the supporter, while the other, who is more fluid and can move around the children, is seen as more of a leader, and can engage more closely with the participants both physically and by playing a portable instrument. The latter is also the one in charge of facilitating cues in the session, i.e. beginnings, breaks and endings, as well as facilitating difficult behaviours. It seems that for Fearn and O'Connor keeping those roles consistent was essential, and the examples they provide from the sessions suggests its effectiveness; by keeping the fluidity of the music (provided by the piano) the other therapist was able to deal with a destructive behaviour without this affecting the group. The

fact that the music continued while negotiating with the disruptive child helped both the group and the therapist who were not playing to remain focused and keep safe boundaries (Fearn and O'Connor, 2003).

Turry and Marcus (2003, 2005) discuss how teamwork in the Nordoff-Robbins tradition uses modelling to minimize the chances of significant clinical transference in comparison with one-on-one therapy where such transference more easily occurs[1]. In their analysis of a music therapy session in which they use improvisation with a group of young adults, it is evident that the therapist in their teamwork drew on mutuality, flexibility within certain roles and their ability to be spontaneously responsive to one another and to changes that might occur in the music.

Free Improvisation and Group Work

The topic of improvisation in group music therapy is thoroughly examined by Gardstrom (2007). She classifies two main types of improvisation: referential and non-referential. Referential improvisation is also known as programmatic or theme-based improvisation, and is an improvisation created around a theme that the clients or the therapist have chosen in advance, which can be a title or story, a feeling or work of art (Gardstrom, 2007).

The music in this type of improvisation, therefore, refers to something outside itself, and is not entirely autonomous as a 'thing' in its own right.

[1] In psychodynamic music therapy traditions, the development of transference would not be seen as an obstacle, but within this work the authors choose this particular approach to avoid the development of transference.

Non-referential improvisation is what we also call free improvisation. Gardstrom, however, chooses not to confuse the terms, stating that 'free improvisation' is also a clinical model attributed to Juliette Alvin (1982). In the Alvin model the improvisation is free from structure, while in Gardstrom's approach, nonreferential improvisation often uses parameters to put some structure and limitation to the improvisation, and add focus or direction to the group. She states that Bruscia (1987) called these parameters 'givens', while Wigram (2004) preferred the term 'play rules' which he describes as some structure design to give a sense of meaning to the improvisation (Wigram, 2004, in Gardstrom, 2007). I will return to this point of 'parameters' later, when discussing the issue of space in free improvisation.

I feel intrigued by the concepts that Gardstrom points out, and fascinated by the way she perceives the idea of free improvisation. Coming from a background practising improvisation regularly as a means of performance, I have also had the chance to apply it in my music therapy practice. I am aware that in experiencing group free improvisation one often confronts levels of understanding toward one's own feeling, as well as of other members of the group who share the experience, that is beyond what they can achieve without the aid of the music. The structure-free approach allows the bending of specific rules of music practice, such as harmony rules, playing in tune or in time and follow repeating patterns in the song structure (this will be discussed further in a following paragraph). Even though this spontaneous way of playing music can be experienced as confronting and challenging for some people at first, it has the potential to set the participants free in their minds and open the door to self-expression in an environment that is judgement-free.

Interestingly, Gardstrom goes on to explain about the way even a non-referential improvisation is never completely unstructured, nor it is unplanned. While I agree with the idea of the therapist spending time preparing for a session, I find that in many ways one has to remember that the nature of the session is unknown until it actually happens; the clients and therapists' states of mind and mood, the environment and ambiance all take important roles in how a session starts and progresses. These are not things we can always prepare for, and when working with improvisation as a method, being open to experiencing things as they are is essential. The work of two therapists in that context can be more complicated and challenging.

An interesting description of free improvisation with a group of three elderly men is provided by Freeman (in Twyford and Watson, 2008). In Freeman's description she mentions that the music had a purposeful quality, and that it also led to a conversation in which the clients mentioned specific images conveyed by the music which symbolised a sense of connection. The discussion that seemed to derive from and relate to the music brings another meaning and purpose for the use of free improvisation in this example, and is thus related to Gardstrom's idea of referential improvisation, however though, in Freeman's case the music was the trigger to the theme-based discussion that followed, and not the other way.

There are several different approaches towards group free improvisation, and I shall not attempt to cover them all here. However I would like to use this place to consider some interesting issues that the literature discusses with regard to free improvisation.

In a study that focuses on gestures and flow in free jazz collaborations, Mazzola and Cherlin (2009) state that in any collaboration, the first question to be considered is the space; where the collaboration takes place. It is the connection that Einstein saw between time and space that leads Mazzola and Cherlin to discuss the term space as not only a fact but also something that can be made, or an aspect of the making.

Mazzola and Cherlin differentiate two types of spaces in the context of musical free improvisation: closed spaces and open spaces. Closed spaces are given and un-changeable, and can be tonalities, consonances and dissonances as categories of intervals, framework for improvisation such as the 32 bar song and 12 bar scheme, and the concept of time as a hierarchical clockwork, suggested by the conductor's baton or the count-down "a-one, a-two, a-one-two-three-four", which, they claim, *"imprisons the band in a clockwork machine and destroys internal timing"* (Mazzola and Cherlin, 2009, pp. 42). In contrast, they list typical open spaces, which can include variation and extension of perceptual spaces, suspension of structures, the creation of empty spaces and negation of instrumental limits*; "This highly unstable elasticity of open space creation enforces a very different behaviour of collaborative musicians (and other collaborators)"* (Mazzola and Cherlin, 2009, pp. 44).

Elaine Streeter from the Guildhall School of Music and Drama provides a contrasting example to the above statement, talking about the experience of group improvisation with music therapy students. Streeter does state the effect and significance that the improvisation had on the group, but also mentions some challenges that occurred; the random nature of the music, she says, led to the emergence of leaders within the group who tried to make order in the chaos and control it. The more static or repetitive musical

form that might have emerged from such 'leadership' intervention sometimes prevented some creativity from occurring; this was possibly the result of some participants experiencing frustration in the non-structured free improvisation (Streeter, in Davies and Richards, 2002).The polarity in the approach to group free improvisation is clearly evident from those two examples.

Summary of Main Issues

Reviewing the literature, it is evident that there is a range of opinions and mixed views about the value of co-therapy. As pointed out earlier, the belief that co-therapy advantages the therapists more than the clients themselves is not uncommon amongst psychotherapists. Cost related issues and the availability of two therapists to work together for a long term treatment are also potentially problematic parameters when considering co-therapy. Yet the key to evaluate co-therapy in a most peculiar way lies within the actual relationship that is formed between the therapists when facilitating co-therapy; I believe that in order to judge the effectiveness of co-therapy one has to look into the details of the practice; how the therapists act and what they do in a session. Thus, a clearer picture of the nature of co-therapy can be drawn and it is possible to evaluate the work more convincingly.

While there is a limited number of co-therapy case studies in music therapy, they do convey a range of practices, from co-therapy with individuals to group work; from the specific roles in the tradition of the Nordoff-Robbins practice, to a more free flowing structure in which the therapists co-facilitate equally, using an improvisational approach (and the range of style within that wide spectrum). Each team of co-therapists will have their own agendas,

advantages and difficulties; however, like in any relationship, the open discussions between the therapists remain crucial to the way they function as a team.

The following sections will examine these issues further, based on my personal experience, and will bring my findings with regard to the benefits and challenges in co-therapy.

Methodology

This work is the result of qualitative research in which secondary analysis of data was the main methodology taken. Ansdell and Pavlicevic (2001) identify two sorts of data in qualitative research; Naturally-occurring data and Research-generated data. In my qualitative research I have used the former, which is described as products that derived directly and naturally from the therapeutic process, such as tapes, conversations and notes. Heaton (2004) describes secondary analysis of data as a methodology to investigate new or additional research questions. Heaton recognises three main secondary analysis modes, in one of which the data is re-used by its original author, a method that was previously referred to as 'auto-data'. In other words, the researcher makes further use of material which he gathered previously for different purposes. As a researcher, using secondary analysis of data meant looking back at footage and notes I have taken earlier on in the year as a music therapy student practitioner, and making a further use of them, trying to develop a theory from that data with the aim of gaining new understandings or adding new discussion to the existing data on the topic that I investigated.

Data sources and procedures for sampling

My main source of data in this research was video footage, as well as the clinical notes taken by myself and the therapist I co-worked with. In addition, this year I kept a reflective journal, and notes from it aided my analysis process too. Other influential tools were discussions and peer debriefs with the co-facilitating therapist, discussions that found their way to influence my clinical thinking and thus I could reflect upon these when interpreting my data at a later stage.

Video footage of clinical sessions was the main source for my secondary analysis, and I looked at in several stages: I have chosen extracts from three different sessions of three different groups in three different stages of my clinical practice (early – march, middle – may, later – august). The single aspect that remained the same in all sessions was the therapists' identity. Each video is approximately six minutes long. The criteria for choosing the video clips was as follows: I identified clips that showed both the complementing relationship between the therapists, in which I could recognise and point out the benefits and positive aspects of co-working, and moments from which I can draw on some of the potential challenges in this way of working. In the analysis I aimed to explain how and why I see the nature of co-therapy as both beneficial (for clients and therapists) and challenging.

Data Analysis

I have adopted a model from Ansdell and Pavlicevic (2001) called the 'Observing – describing – interpreting' (O-D-I) cycle as a method for analysing my video data. In addition, I was influenced by Ulla Holck's ethnographic descriptive approach to video analysis. Holck describes the approach as '*very useful in recognizing small indicators of communication and social interaction in music therapy with clients with severe communicative limitations*' (Holck, in Wosch and Wigram, 2007, pp. 29). This approach also matched the attitude which Turry and Marcus (2005) used to describe a session in a case study on co-therapy, and I found it effective as a guide in the early stages of the analysis.

I would like now to outline the stages in which I looked at my video extracts, using parts of the O-D-I cycle as a frame.

In stage 1 I take a general look at the footage to get a first impression. This is actually when I decide whether that part of the video is appropriate to analyse or not; if I believe that it has the potential to teach me about the nature of the co-therapy practice or not, and also to try and identify moments that link to my research question regarding the benefits and challenges in co-therapy. Ansdell and Pavlicevic (2001) state that the observation part is the central principle of qualitative research; controlled observation in which the researcher looks for evidence rather than having a ready-made decision on his findings beforehand, they claim, is the basis to theory building.

In stage 2, after I have selected the video clip and decided on the length of it, I note down in a descriptive way a list of what I believe are significant moments within the chosen clip; these can be, for example, a gesture or movement from a child that the therapists respond to, musically or clinically, or a musical cue - often a spontaneous one - that suggested some change in the direction and the dynamics of the music. I then index the precise timing when these moments took place, using the indexing method which I became exposed to at my place of clinical placement. In many case notes that I have read I noticed the use of indexing, in particular in the clinical description of the consultation session (usually taken by music therapist and head of clinical practice). In the O-D-I cycle this stage is described as 'identifying'; a subsidiary activity which is a result of the observation part, and leads to the next key process in the cycle – describing.

After recognising and indexing those moments of changes or significance in the music session I can take further notice of what was happening in each time frame, and note what each participant was doing at the time. This is stage 3, which requires several more views, in

order to see the coherent continuity of events and responses. This is where I note down in detail the actions related to each participant and describe them in parallel columns. This detailed description of action as seen in the footage can be described as transcription. Transcribing the chosen clips in such a way has aided me in drawing a clearer picture of the relationship between the group members and in particular of the therapists.

Having looked in detail at my video extracts, and coded and indexed video for 'benefits' and 'challenges', I then returned to our joint clinical notes from each session to review the impressions we had documented as co-therapists, check if I had missed anything, and compare any observations that were particularly prevalent at the time. These observations had been in my mind when choosing the extracts, but I wished to return to them at this point, for a fuller perspective.

Ethical considerations

I was aware that to write about co-therapy with several groups will involve considering ethical issues not only with all the clients but also with the co-therapist. Naturally, writing about co-therapy involved observations about the work of two therapists, yet the research was carried only by me rather than by the two of us. Thus it is important to clarify that these are only one practitioner's interpretations of co-therapy. As mentioned above, a pseudonym was used for the therapist who worked with me to protect her identity. The sessions I analysed for this project took place in two facilities: a school and a specialized centre. The school's deputy principal was given an information sheet regarding the research. The existing system in the school was that parents chose in advance whether to give or not

to give permission for the school to use information from classes for reasons of research or education. Since my project did not reveal students names and its main discussion did not detail specific students' behaviours but dealt with the professional work relationship of two therapists, I was informed that a special consent was not necessary, however it was confirmed by the deputy principal that parents of all five children who participated in sessions that I analysed gave permission to use material from the sessions. Consent forms were given to and signed by the head of the clinical services in the specialist centre where an additional co-therapy session took place, and by the parents of both children who participated in the session analysed in this project.

Copies of the information and consent forms are included in appendices of this exegesis.

Findings

In this section I look at my findings from the completed analysis of my data. As mentioned, the frame of stages that I used in analysing my data was adapted from Ansdell and Pavlicevic's O-D-I cycle (see p.22). I then coded and categorised my data to clarify my findings to the maximum. My presentation of the findings is in the chronological order of the video footage that I have used in my analysis. Some of the points I stress in the first two excerpts may have occurred in the final one as well, but I wished to avoid repeating myself; instead of mentioning the same patterns again, I will discuss the findings in a more detailed manner in a following section.

Excerpt one

Background of the group

This group was a short term one, involving 11 sessions over one school Term. It consisted of three children aged 8-12 years old with profound physical and intellectual disabilities. The children shared the same classroom at school and were thus familiar with each other. One of the children had a vocabulary of a few words, the other two were non-verbal. The music therapy sessions took place in the music therapy room in a weekly basis throughout one school Term, and each session length was approximately 30 minutes.

Because of the children's different presentation, it was a particularly difficult group; the children seemed to have very different levels of wakefulness, participation and anxiety. They all needed some physical assistance at various times.

Findings from the analysis

Benefits:

1. Physical assistance and presence

   Description: *The therapists' physical proximity to the clients and presence in the room is a practical prompt and has a grounding feeling for them.*

The beginning of the video excerpt that I analysed shows both therapists working closely with the clients: I sit between two children, holding one of them by the hand (or being held by the child), while Naomi is located in front of the third child, strumming on a guitar and offering it to the child too. This picture in itself shows already how useful it is having two therapists in the room, as it enables more direct contact with the clients.

2. Safety[2]:

Safety may not be an issue directly linked to the musical process, but it is an essential one which needs to be considered in music therapy practice. Here again, having the two therapists was extremely helpful towards maintaining safety. Two children especially required assistance; one, who has limited control of his arm movements, needed help holding bells. Without the help of the therapist there is a chance for him to either throw the bells which might hit and hurt someone in the room, or lose balance and fall (in this particular session, unlike usually, the child was neither on a wheelchair nor on a standing frame, but was given a chance to sit on a stool, which meant that the therapist's aid was

[2] Safety was an issue that was relevant to excerpt two and three as well, however it seemed most crucial for the group discussed in excerpt one. Instead of repeating myself by mentioning it again on the following excerpts findings, I refer to it in with more detail in the discussion section.

even more necessary). The other child required immediate assistance as she kept pulling the wind chimes towards her to the point that the stand was constantly about to collapse on her. The therapist had to remove the stand when her engagement with it became too unsafe and dangerous. While a single person could possibly attend to those needs by himself when a safety matter occurs, it is unlikely that he could keep a steady music flow in such circumstances. This leads us to the next point of benefit.

3. Musical flow

Description: *The two therapists work together to help the music be continuous and to keep the students focussed on the sounds*

Having two therapists in that group meant that whilst one attends to those matters of physical assistance and safety, there is not necessarily a pause in the music. Even if all the clients are not actually engaged with the music at that moment, a therapist is still available to give musical offering, listen and respond and thus the potential to draw the clients' attention to the sound is greater.

4. Maximizing the clients experience

   Description: *Having two therapists helps keep the clients focussed positively on participation*

While having two therapists present in a room helps to create a safer practice, as point #2 argues, it subsequently also has the potential to increase clients' levels of participation. If the client is safer, he or she is capable of extending their engagement and bringing their

levels of awareness to the maximum. This can normalise the group session experience for them, making it more positive and secure.

Challenges:

1. Therapists' different awareness levels

   Description: *The different level of experience and sensitivity as therapists sometimes impeded the musical flow - which became more fluent as the student gained experience.*

The session took place in the first month of my placement. Looking back at the video footage I was aware of being the less experienced facilitator. This shows in the way I was not always responsive to Naomi's music, having almost all my attention paid to the clients. I also recall feeling somewhat overwhelmed by the group in those early weeks, trying to figure out what to do and how to connect. I believe that this slight anxiety could have had a negative effect on my musical interaction, until I felt that I understood the nature of the group and could trust myself more. Naomi, on the other hand, being more experienced in this situation, was able to respond not only to the client's but also to my music. The challenge that occurred was that, for instance, at the beginning of the clip I was responding directly to one child, and during my interaction with her (a short vocal dialogue), was unaware of Naomi's music; she was strumming on the guitar in front of another child, occasionally holding the child's hand against the guitar strings, assisting her to strum. When Naomi heard the vocal dialogue I was having with the child opposite her, she matched the rhythm of her strumming to our voices. Then I changed my vocals to shorter, sharper 'hey he'' calls, and Naomi began to play a similar sharp rhythm. I was oblivious to that change in

her strum as I was fully attentive to the child, waiting for more vocals responses from her (which did not come, perhaps she heard the guitar herself and got distracted?). It took me about half a minute to join the music that Naomi began and 'lock in' with her.

2. Negotiating change/the challenge of non-verbal communication:

   Description*: Negotiating musical changes in improvisation while working with non-verbal clients*

This more general challenge is relevant to this group as it was facilitated, as mentioned, early in my placement. I was aware that, while working with mainly non-verbal clients, it felt important to keep verbal communication between the therapists to the minimum. This is not to say that we restricted ourselves from talking, but suggest that, as communication within the group took place in the shape of sounds more than words, it felt natural to try and minimize our own verbal dialogue while facilitating the group. There were still situations when we did not hesitate to speak (which has its positive aspects as well i.e. modelling), in particular in a directive way, for instance when one therapist asked the other to pass an instrument. However, when 'musicing' took shape, our intentions were to keep our communication within the music. The challenge occurred when, at times, one therapist decided to change the direction of the improvisation and take the music elsewhere. How he or she can be sure that it is the 'right' moment for such change is down to the therapist's own experience, intuition and intention, but the important question that arises when co-facilitating a group is: how can the therapist know that he or she is not clashing with the music and/or the intentions of the other therapist?

Excerpt two

Background of the group

The group consisted of two 18-year-old young men who both have cerebral palsy. Even though they were not from the same class, the boys knew each other from school. They both used wheelchairs, and were able to use their hands. It seemed that music was quite an essential part of their lives, and each had his own way of responding to music and expressing themselves in music. In school Term two the group was co-facilitated by both Naomi and me and in Term three I took the pair by myself. Sessions were 30 minutes long.

The session I analysed was from our co-work, but looking back in a later stage after my experience of facilitating the group without Naomi gave me another angle, and the opportunity to compare the two experiences. Matters related to that comparison will be discussed in the following section. The analysed example was a remarkable session in our group work; during that session one of the boys (Mani, pseudonym) used his voice to sing for the first time in our group work.

Findings from my analysis

Benefits:

1. Modelling:

   Description: *The use of modelling to encourage and enhance clients' actions and vocalisation*

Don and Mani's (pseudonyms) clear responsiveness to music and sound made it quite an expressive session, with a lot of explorations from the four of us. Don always used his voice for extensive singing in the sessions, with a vocal range that went from very high falsetto to a lower register, which he used less frequently. When I began working with Naomi in this group I used my voice to respond to Don's singing, much like Naomi had done in the past. However, being a male with a baritone voice, I could also model to him singing range and styles that he was less familiar with. Subsequently Don started to copy my singing style, using his lower register much more often than before. The juxtaposition of our voices together (Naomi's, mine, and his own) gave Don a richer experience and inspired him to continue and widen his musical explorations. It also inspired Mani to use his voice, as the next point will also show.

2. The intensity of having mutual intentions and focus:

   Description: *How a focused, intent interaction facilitated by two therapists can intensify the clients' experience*

Case Vignette

Presented is a case vignette of a significant session in the co-therapy with Don and Mani (which also illustrates my argument for point #2 in the findings for benefits of the co-therapy in this group). Firstly I will provide more background details about the clients.

Don and Mani are both 18 years of age, and both have cerebral palsy, as well as epilepsy. Both young men have limited expressive language (able to say very few words); however

Don uses his voice more than Mani, for singing and occasionally copying words he hears. Mani uses eye contact and facial expressions to communicate. A specific goal for both Mani and Don in their pair work this year was to increase their levels of interactions with their peer, as well with the therapists.

Towards the middle of the school Term, both Naomi and I started discussing what could be done to enable Mani to use his voice. We felt that while he always participated readily by beating on a drum and a cymbal, there was another level of communication that he so far avoided – singing. While that was his peer's favourite idiom of expression, we have learnt from Mani's teacher that Mani was able to use his voice in the classroom in response to his teacher's prompts. In the music therapy session, we hoped that by using musical cues we could prompt a musical response from Mani. In our discussions prior to the session we simply raised the issue and brought it to our awareness, but we did not have a set plan for the following sessions. During the session, it seemed that both Naomi and I thought about that issue (how to 'make' Mani sing) as we were 'musicing' with the boys. The improvisation was flowing with both Don and Mani participating in their usual manner; Don was extremely expressive with his vocals and Mani drummed with a lot of drive, passion and intention. Looking back at the video I noticed that from the beginning of the session there was quite an upbeat, energetic exchange of musical ideas and sounds between us. What was also evident from viewing the video was that at approximately 10 minutes into the session both Naomi and I began looking more and more directly at Mani, who looked back at us quite intensely. We were still using our voices as way of responding to Don, but at one moment it felt like the three of us were singing to Mani, as if inviting him to join in the singing with us.

At some point there was a gap in the music, and Mani filled it by calling out in a rusty voice, that sounded like it has not been used for singing for quite some time. Naomi and I immediately sang back, wearing a big, perhaps somewhat relieved smile. Don, on the other hand appeared quite shocked as he looked at Mani in disbelief and paused his singing for a while, giving Mani a chance to fully express himself vocally, which he did. When Don finally used his voice again, it was as if he took a second violin role; he sang more at the background, and allowed Mani to take the lead.

Interpretation

I chose this session for a case vignette as it provides a good example of how the therapists were able to hold the clients in the music and, using shared attention, consciously tried to make the group interact together. Both therapists were responsive to both clients, but after Mani began vocalising there was more response to him (Don also became less dominant, which was a change).

I would like to make the argument that, even though we had no set roles as two therapists working together, in the video excerpt I analysed Naomi was the leader. Her guitar playing provided a background drone, which was the main glue that brought us into the centre, connecting to Mani's drumming and making space for the vocals improvisation. I followed Naomi's guitar, playing rhythmically on the tambourine, mainly in response to Mani's drumming.

We both used our voices in an expressive way, exploring similarly to Don, but also often holding long notes (matching the guitar drone, providing a harmonic anchor, even if for a moment). We sat between the clients, who were facing each other. We both responded to the two of them constantly and simultaneously, using a lot of eye contact. There was no verbal interaction. Sometimes it occurred that the therapists connected more with the client that sat further from them rather than the one next to them; this was a conscious decision in order to avoid falling into sub-groups (see 'challenges' below), and was done through body language, facing the client and using direct, sometimes animated facial expressions.

In the clinical notes, both therapists wrote an entry for the session (something we tried to do as much as possible so to present both our opinions and thus have a wider scope of the experience). There was an agreement between the therapists that the session was special and significant because of Mani's vocalisation. I mentioned that it felt like we were able to connect through relating to each other's music. I stated that we sat closely, and that there was 'a lot of looking between the group members, as if we all felt excited about singing together'. Naomi noted that we all sang in harmony at several points, and she was aware of the contrasts in our voices, which, she stated, helped everyone to be heard.

I believe that the fact that the therapists had more discussion about our music prior to the session and shared the particular intention and goal – to create the right atmosphere and environment that might help Mani use his voice, made it more possible to happen. The versatility in the vocal qualities and the way the voices were used was powerful and thus

highly effective to get the most from the clients; the intensity of our engagement that session, with the singing modelling from both therapists and his peer, seemed to have inspired Mani and encourage him to sing.

Challenges:

1. The tendency to break into two sub-groups:

   Description: *A situation where each of therapists attends more directly to one of the clients, thus dividing the group*

With a group of two therapists and two clients this tended to happen at times, especially as each one of the clients had his unique way of communicating. Don's singing often seemed to be directed at one of the therapists, seeking communication, so when one therapist was then musically 'answering' him there would become a dialogue between them. To ensure that Mani was not left aside, the other therapist often directed his music and respond more directly to him, so two sub-groups or pairs subsequently emerged. I was aware of this issue and discussed it with Naomi. However it continued to occur.

In the Term that followed I worked with the pair by myself and noticed that it was easier to get Don and Mani to look at each other and relate to each other when there was only one therapist in the room with them. I will elaborate on this in the discussion section.

Excerpt three

Background of the group

The group consisted of two girls aged three years old, both with Down syndrome. The girls were both mobile and active, and began using words to communicate. Previous to the formation of the group, Ellie (pseudonym) had experienced one on one music therapy with Naomi over a period of a little less than a year, so a strong relationship already existed between them. When music therapy began for Maya (pseudonym) I had the chance to have two individual sessions with her, before we all got together as a group. While that could have led to another example of two pairs within one group, and at times this did occur, the girls' natural curiosity about each other had mostly lead to a more playful, often adventurous kind of interaction in the group.

The session I analysed took place in August, after five months of co-working with Naomi. Looking back I could identify areas of growth and development in our teamwork in comparison to the first video excerpt from March. Out of the three analysed groups, this one existed for the longest time; over six months from our first joint session until the end of my placement when we facilitated our last. Sessions occurred weekly and were 40 minutes long.

Findings from my analysis

Benefits:

1. Group joint attention

Description: *Enabling the clients to focus on one activity and on each other*

The session began with a five minutes improvisation on glockenspiels and xylophones; we tended not to sing a 'hello' song in this group; the girls were often 'ready to go' and wanted to explore the instruments as soon as they entered the room and we did not want to break that. After about five minutes Ellie, whose concentration span was usually quite short, started to lose interest. She was looking to her side and it seemed like she was about to move away from the rest of us. Naomi noticed that and tried to draw Ellie's attention by offering her small percussion instruments which she often played, but Ellie remained uninterested. Naomi could have simply followed Ellie's interest (to explore and break away from the others, at that moment) but chose not to; instead, she insisted that Ellie try and stay focused on what was going on. This firm attitude was not very usual in our sessions, and the reason for insisting was that at that particular moment Maya seemed extremely focused and musically active as she played a fast lively rhythm on a xylophone and a tambourine at once, using beaters in both her hands. I was engaged in 'musicing' with Maya, providing a steady beat to accompany her improvisation. Naomi knew that if Ellie moved away from the centre of what was happening (we sat closely in a circle on a mat at the centre of the room), it would most likely distract Maya from her playing. Thus, when Ellie stood on her feet and started moving away, Naomi affectionately grabbed her and sat her on her knees, facing Maya. Ellie, a very affectionate child, did not resist and giggled. She then noticed Maya's music, which at that point increased in tempo and volume in a dramatic crescendo, laughed and grabbed a beater in one hand to join the joyful noise.

2. Holding the clients in the music

Description: *Calming and grounding the clients and keeping them focussed together.*

Because of the girls' playfulness and sense of curiosity and adventure sessions had the potential to become unfocused and a bit scattered. A way to centre us all was sometimes provided by the therapist's playing; at times it was Naomi's piano playing and at other times my guitar playing. As one therapist was playing, the other followed the children's 'adventures', which were often not necessarily musical by nature; hiding behind the piano or the gathering drum, putting instruments inside a basket, rolling a drum on the floor and other activities as such. The musical background helped us keep a sense of security and created a certain atmosphere, even if just for a short time. It tended to be quite reflective and accompany the activity more than guide it. Naomi and I later discussed those moments in the session and we realised that we both associated it with the traditional Nordoff-Robbins approach. It was not a consistent approach to work this way, but we found that the 'background' music had a calming, grounding effect on both the clients and the therapists.

3. Psychological support:

   Description: *The therapists provide back-up for each other, particularly the experienced therapist for the student therapist.*

This might seem like an obvious point yet I would like to mention it here as it was not mentioned before: personally, the presence of another therapist in the sessions had a great supportive effect on me.

In this group we often played games ‘around’ the music, making use of instruments but not always musically, following the children’s imagination and initiatives. For a single therapist this kind of interaction with a child in music therapy contains a potential problem: the therapist might ask himself the inevitable question: ‘is what I am doing here considered music therapy at all?’ There is also the potential for such an experience to become a frustrating one for the therapist who is trying to make the maximum use of his musical and therapeutic skills but finds himself (and this could be a process of months) playing hardly any music and spending entire sessions engaged in activities which arguably relate more to drama than to music.

Having another therapist to facilitate the sessions with made me worry less about that process and trust it more. I could learn ways in which we, the therapists, could involve music in games the children initiated, even if in a non-directive way (for instance using our voices to sing into a drum or to accompany a game in which the child lifted a percussion instrument in the air before bringing it back down). These are things one therapist can do by himself yet to do it in a group was perhaps more comforting. As a student therapist in particular, this made a lot of difference in my experience of facilitating music therapy.

In addition, mirroring and modelling were both important in this group. When looking at the video excerpt I noticed plenty of mutual play in which the therapists seemed to simply mirror the clients’ actions, which motivated them to continue their exploration of the instrument. Having two therapists augmented the modelling or mirroring effect.

Challenges:

Once again, the challenge that occurred in excerpt two - the tendency to break into two pairs - did occur in this group as well. However the nature of the group was very different to that of the previous excerpt, and the girls' mobility often made it possible for the therapists to change roles between themselves. This flexibility aided a sense of flow in the sessions and without it we could have experienced more challenges.

We also discussed early in the group experience the fact that Ellie was more attached to Naomi and Maya more attached to me. This was evident when, for example I would offer Ellie instruments and she would ignore or say 'no', and then respond positively and readily to Naomi. On the other hand if Maya was struggling with something she was doing such as putting her shoes on she mostly rejected Naomi's offer to assist her and came to me instead. Bringing our awareness to the issue made us try and connect - each therapist with the other child - as much as possible. This would have been a potential challenge but we found that as the sessions progressed Ellie became less reluctant in her interactions towards me and finally happily made contact, and Maya was more comfortable with asking Naomi to assist her.

An additional issue was that it was not always a possibility for us to facilitate sessions together. Due to other commitment, Naomi had to miss a series of sessions, which I facilitated by myself. This had an interesting effect on the group; on one hand, there seemed to have been more freedom for the girls during those sessions (perhaps they enjoyed the additional space in the room?), and they appeared to grow personally closer to

each other during those sessions. On the other hand, the intensity that occurred in the co-therapy sessions was not possible to obtain on my own. I felt that there were pros and cons to working on my own with the pair.

The table below sums up the findings' headings from the three excerpts:

	Excerpt 1	**Excerpt 2**	**Excerpt 3**
Benefits	Physical assistance and presence	Modelling	Enabling clients to focus on one activity
	Safety	The effect of mutual intentions and focus	Holding clients in the music
	Musical flow	Safety	Modelling, mirroring
	Maximizing clients Experience		Psychological support for therapists
Challenges	Therapist's different awareness levels	Tendency to break into two sub-groups	Tendency to break into two sub-groups
	Negotiating change/ the challenge of non-verbal communication		

Discussion

In this section I aim to discuss further some of the matters that were mentioned in the preceding findings section. Main points of benefits and challenges from the co-therapy will be discussed, and juxtaposed with the literature. In addition I wish to discuss other issues that were relevant to my experience during my practice this year, and came up when reviewing my reflective journal. Thus I will compare my experience of working as a single therapist to the co-therapy work with the same clients. Thoughts from the therapist who I worked with will also be included in this section in relation to my findings. Finally I will be looking at the limitations on the research, discuss ethical considerations and include thoughts about future research.

Mutuality and support for each other

One of the benefits that come across as central in music therapy co-therapy is mutuality and support between the therapists. Nordoff and Robbins mention mutuality and support as key elements in the success of a teamwork, and Turry and Marcus further discuss this phenomenon, but is that always the case? As Napolitani (1980) states, interpersonal complications between the therapists do occur, and can become an issue, especially when clients get trapped in a struggle between the therapists, as Haley (1987) warns. It is also valid to argue that the effectiveness and usefulness of the mutuality and support are actually for the sake of the therapists and not necessarily the clients, as Haley (*ibid*) proposes. In most co-therapy case studies from the field of music therapy, therapists do mention that they felt more secure with another therapist co-facilitating alongside them, as the Cooper and Molyneux (2009) and Miller and Guarnieri (2008) examples suggest.

However, evidence of the advantages for the sake of the clients can be drawn from the case studies examples of both Robbins and Robbins (1991), and Salas and Gonzalez (1991). The findings suggest 'support for therapists' as a benefit in the co-therapy, but can we argue that this has also had a positive effect on the clients?

Naomi had kindly agreed to express her thoughts in response to some of the issues present in this paper; she comments in her notes about how we supported each other musically in the sessions, in such way that would not be possible when working with an assistant who is not a music therapist. Naomi states that she particularly enjoyed being able to use an improvisational approach more consistently and thus give the clients a deeper experience of being in the music – compared to some of the group work she led with the assistance of teacher aides, which tended to be more structured, so that the assistant can have a clear role and understanding.

In addition, Naomi states that even though as co-therapists we did not plan in detail, we agreed on a music-centred approach, focusing on improvisation. Debriefing after each session enabled us to share observations, experiences and interpretations of the client's responses, and these were built upon in subsequent sessions.

All of the above created a certain framework that I argue can be viewed as mutual and supportive, and in the experience we had, this was first and most, for the sake of enriching our clients' experience through co-therapy, and not just to make us, the therapists, feel more secured or supported.

Student learning

As mentioned in the literature, co-therapy is commonly used for education, in both counselling and psychotherapy. Having a student as a co-therapist practitioner means that the treatment is cost effective, which can suggest that a co-therapists team that is made of a student and an experienced therapist is probably one of the most likely places where co-therapy occurs. Drawing from my reflective journal, I would like to stress my experience as a student practicing co-therapy and discuss some of this practice's pros and cons. I believe that my experience holds relevance to any experience of co-therapy, and that the thoughts and impressions expressed here should be shared with other students, new practitioners or any therapists experiencing co-therapy.

One of the first things that occurs when working alongside another professional (let alone if you are the least experienced of the two) is one's tendency to become more self-conscious. I see myself as an open minded person, usually not holding back my thoughts and considering open and honest discussions to be an integral part of a healthy practice. When starting co-facilitating groups with Naomi this year, I was conscious of initially becoming a little bit reserved and more observant. We did not have set roles or rules to how we co-facilitate, though initially it made sense that I would be taking more of a following role to familiarise myself with the group's dynamics (in a group that Naomi had taken by herself previously).

As stated before, improvisation was a central method in our groups. In the past when using improvisation, whether when facilitating music therapy sessions or when playing music with professional musicians, I felt that intuition was the essence of my experience. I tried to have

no restrictions on myself in terms of sounds and structure, while remaining in control of my musical contribution. Listening and responding were the main values and means of communication.

Looking back at the early sessions of co-therapy I am now aware of feeling a bit limited, less intuitive and thus participating in a way that was not completely natural for me. I realise I restricted myself a bit, as I perhaps was sometimes wondering what was appropriate to do. It certainly is a challenge for some people to fully expose themselves in front of people they are not very familiar with as Bull and Roberts (2005) also suggest. Exposure is a part of what we do in music therapy as we allow ourselves to be musically expressive. Questions like 'how much do I show of my musicality?' and 'If I play more fully on the drum now and use my technical skills will it help the client?' were at the back of my mind as I was considering the other therapist's view, and leadership. Debriefs and discussions between the therapists were helpful in realising some of the answers to those queries and as the experience grew so did the trust and understanding, and a more mutual and natural relationship evolved.

As a student, it is important to state that learning is definitely in the core of the co-therapy experience, and having the opportunity to work alongside an experienced therapist was without doubt a great learning process. Naomi, on the other hand, commented that she enjoyed seeing the clients through new eyes as she had experienced facilitating music therapy with those clients on her own previous to the co-therapy period.

Safety as a main benefit for co-therapy

Safety occurred in the findings as one of the benefits from the co-therapy in the group from excerpt one, but as I stated earlier, it was relevant for the other two groups as well. In the example from excerpt one, children with limited control over their movement could be assisted by a therapist, while the music continued. In the notes from Naomi, she comments that she found the co-therapy with this group to be the most valuable, as she had worked with this group previous to our co-work and was aware of their difficulty in becoming a group of contributing participants. The physical needs of the clients were crucial to that difficulty, and with another therapist in hand more could be achieved with regard to their levels of participation, keeping a safer practice while maintaining musical flow.

The young men from excerpt two both have the risk of experiencing seizures, as they both have epilepsy, as well as cerebral palsy. Having another therapist can be reassuring and helpful in a situation when a client is experiencing a seizure, as one of the therapists can stay with the clients while the other calls for medical assistance. The girls in the third excerpt were not physically disabled, but as young girls with Down syndrome, their development was slower than that of most children their age, and thus, especially at the beginning, their mobility has not been perfected yet. One of the focuses suggested by their parents was to work on increasing independent participation, which involved some anxiety from the girls at times. Here again, both Naomi and I agreed that having two therapists helped maintaining a safe practice and a remaining focus on the musical activity, which I argue would have been harder to do as a single therapist.

The benefit of the co-therapy in creating a safer practice and thus a safer experience for the clients links directly to other points of benefits from the findings, including the maintenance and continuance of musical flow, holding clients in the music and in particular the maximization of the clients' experience.

Comparing co-therapy to sessions led by a single therapist

Excerpt two in the findings section describes the experience of co-facilitating sessions with two teenage boys. The session that is described in the case vignette occurred in the second half of the co-therapy work. In the following Term I led the sessions by myself, which gave me the opportunity to view how things worked in comparison to the previous Term's co-led sessions.

I stated this group's tendency to break into two pairs or sub-groups, and the challenge in bringing us together as one group, which both therapists were aware of. Looking back at my reflective journal I found many speculations about the group's nature, one of which was that the nature of the clients themselves seemed to invite a personal one-on-one interaction, thus perhaps doubting the effectiveness of the group as it existed.

In the following term, however, when I facilitated on my own, I stated in the journal feeling that there was a chance of becoming more focused as a group; there was somehow a new balance in the way sessions were conducted: I situated myself in the centre, between the two clients who were facing each other. I felt that this way I was able to share my attention

equally between them. The aim was to try and raise their awareness of each other (hence their location facing each other) and bring our musical contributions together.

It occurred to me that, as a single therapist, I became more aware of the two clients, and somewhat less distracted and more focused. In my notes I stated that the fact that there was no need to consider another person's approach or music somehow freed me a bit. There was also perhaps a feeling of professional growth as a result of the increase in my responsibility, from co-therapist to singularly being responsible for the small group. I was using enthusiasm, affection and empathy as I was trying to encourage the clients to look at each other and see what the other was doing, making comments about their acts. As a result they became more aware of the music, which perhaps was more focused than in the co-therapy experience, and were more motivated to contribute.

As a single therapist, I was able to avoid responding to potentially distracting behaviours, and focus on what was mostly motivating for the clients. For instance, Don always used to reach his arm out to the therapist beside him, trying to grab it, shake it or simply bring the therapist's attention to him. When working with another therapist, it was easy to respond to his gesture, knowing that the music does not have to stop, but then sometimes hard to release the shake. Don's strong grip limited both him and the therapist in their contribution to the music for that moment, and it seemed like an obsessive routine for him. The therapist would then have to aim his hand back and return to the music. When working solo, it felt more natural to avoid this contact, and so as I was standing playing the guitar or sitting at the piano I would acknowledge Don's gesture with a nod or by singing about it, for example:

'I can see your hand, Don, waving hello', or 'I can see your hand, Don, and I say hello, too'. Thus I remained focused on the music, and Don could move on too.

Limitations to the research and ethical considerations

As stated in the introduction section of this paper, ideally a research project that deals with co-therapy would have been carried out by both therapists. As this is a university paper, there was a particular way of facilitating the research which meant it was not a possibility. Thus, the research was carried by myself only and therefore reflects only my perspective on the experience of co-therapy. This is a big limitation that needs to be considered; some questions I raise in this paper cannot fully be answered by one person's assumptions. Some of the presented data cannot be generalised about at this level of work and should be viewed as thoughts and ideas that are drawn from experience rather than actual facts about the practice of co-therapy. Thus I find it important to state that for future researchers on co-therapy, a joint study with both therapists involved, if possible, would be recommended.

Should there have been a possibility to conduct a participatory action research, results and findings from such research could potentially show more complete and rounded aspects of the practice, however, I had to be ethically considerate with regards to how to carry out the research. It would have been difficult to gain ethical approval to conduct such research with the clients I worked with in the groups that are considered in this exegesis, as they are mostly non-verbal, and appropriate data gathering in the time frame for this study would have been a challenge. For future researchers on the topic of co-therapy, who might work with clients with different presentation, however, a participatory action research study should be considered.

The use of secondary analysis of data is somewhat problematic too. It involves looking back at one's own experiences in clinical practice and reflecting back and thus, as I have experienced in the process of analysing, there is a strong sense of self-critic that is unavoidable. While self-doubt can be healthy, it is always recommended, in particularly for students, to consult with peers and supervisors.

Theorising about a subject when dialoguing mainly with one's old data and notes can also be problematic. One can find new meanings in one's old words and therefore there is a risk of distorting original intentions when revisiting the old notes and thus limit its authenticity. However, I do feel that the research project in its current structure is appropriate for a student to carry; the self-examination and the process of questioning one's own decision making and actions in the clinical practice are important tools which help evaluate what we do in music therapy, and I will carry them with me as I begin my professional career.

Challenges and difficulties in co-therapy and how we can work around them

As some of the literature suggests, co-therapy can involve a clash of interests between therapists. An interesting point Cividini-Strani and Klain (1984) refer to is the 'control of narcissism' that one might need to consider when meeting with opposing strategies form the co-therapist and wishing to avoid conflict. 'Holding back' is perhaps a more adequate term to describe the attitude some music therapists would prefer. Holding polar positions in co-therapy is described in an article by Davies and Richards' (1998); in their case, the conflicts were addressed by openly discussing their feelings towards the difficult situation which occurred in the session. If the therapists' approaches towards a client's behaviour or

their attitudes and methods in the facilitation of sessions do not match, they face a serious dilemma, and need to reconsider the continuous use of co-therapy. As Cividini-Strani and Klain (1984) also stress, such conflict might disadvantage the clients, who might feel trapped between rather than embraced by the co-therapists. In my practice no such dramatic scenario occurred, yet looking back at my reflective journal I recognized being less confident at first in taking a strong or leading role; early in my practice I might have preferred at times to follow, which I found quite natural, as Naomi had had more experience and also knew the clients already. Yet I found that when my confidence grew and I was less shy in expressing my musical self, not only the relationship between the therapists expanded, but also the sessions became more balanced. Thus I would like to suggest that a co-therapy team in which therapists are able to be expressive despite their differences, and perhaps even celebrate those differences by combining methods and styles, holds a potential to give clients more; modelling has occurred as an important point in the study's findings, and I would like to suggest that the term can include therapists modelling a respectful relationship where even polar opinions can co-exist side by side.

In a music-centred music therapy practice, I was aware of the sometimes difficult situation in which the therapists wished not to break the music by speaking between themselves (this was perhaps more felt when working with non-verbal clients).I found that as we progressed in the therapeutic process, our rapport as co-therapists also grew, and we became more familiar with each other's musical vocabulary. The possible challenge of having different cultural backgrounds, together with our different experiences in music practice and music

‘language’ as we express it became something we could draw on to create a richer, more interesting world of sounds.

Conclusion

The focus of this study was a topic that is neither thoroughly examined in music therapy, nor often discussed in the music therapy literature, despite being an integral part of the music therapy tradition and a method that is arguably not uncommon. Thus, I hope it can serve as a modest contribution to the growing literature. Whilst leaning heavily on personal experience, and presenting personal interpretations on findings from self-analysed sources (secondary analysis of data), the aim of this research was to discuss general issues which occurred when facilitating co-therapy music therapy in small group settings. As a student I was aware of the growth and learning that the co-therapy work involved for me, and stressed it as a point of value for practicing co-therapy; interestingly, I have found out that co-therapy is often used for educational reasons in the fields of psychotherapy and counselling. It might be of interest to see if there is a place for the use of co-therapy in education in the field of music therapy too. Co-therapy might not work for all practitioners, and it remains debatable whether the costs, availability, and complications that might be involved in such practice are worth the effort. However, this study argues that the benefits of co-therapy outweigh its challenges.

References

Ansdell, G. & Pavlicevic, M. (2001).*Beginning research in the arts therapies*. London: Jessica Kingsley Publishers.

Bruscia, K. (Ed.) (2001). *Case studies in music therapy*. Philadelphia: Barcelona Publishers.

Bull, R. & Roberts, C. (2005). The odd couple. A Model of co-working with non-music therapists. In *No Man is an Island – groups, partnerships and teams in music therapy.* Papers from the BSMT/APMT Annual Conference. (pp. 23-25). London: BSMT Publications.

Cividini-Strani, E. & Klain, E. (1984).Advantages and disadvantages of co-therapy. *Group Analysis*, 17, 156-159.

Cooper, A. & Molyneux, C. (2009). Singing the same tune? Co-therapy to support clients experiencing a change of music therapist. *The New Zealand Journal of Music Therapy* 7, 32-60.

Davies, A. & Richards, E. (1998).Music therapy in acute psychiatry. Our experience of working as co-therapists with a group for patients from two neighbouring wards. *British Journal of Music Therapy* 12(2), 53-59.

Davies, A. & Richards, E. (2002).*Music therapy and group work*. London: Jessica Kingsley Publishers.

Eppler, C. & Latty, C. (2001). Filial therapy with co-therapists. *Journal of Family Psychotherapy* 12(3), 89-95.

Fachner, J. (2007). Co-therapists in Nordoff-Robbins music therapy, *Music Therapy Today* 8(1), 39-55. Retrieved December 8, 2011, from http://www.musictherapyworld.de/modules/mmmagazine/showarticle.php?articletoshow=197

Fearn, M. & O'Connor, R. (2003). The whole is greater than the sum of its parts: Experiences of co-working as music therapists. *British Journal of Music Therapy* 17(2), 67-75.

Freeman, A. (2008). Groupwork, the team and spirituality. In K. Twyford & T. Watson (Eds.), *Integrated team working: music therapy as part of transdisciplinary and collaborative approaches* (pp. 195-200). London: Jessica Kingsley Publishers.

Gardstrom, S. C. (2007). *Music therapy improvisation for groups*. Barcelona Publishers.

Hart, A. & Thomas, H. (2000).Controversial attachments: The indirect treatment of fostered and adopted children via parent co-therapy. *Attachment & Human Development* 2(3), 306-327.

Heaton, J. (2004). *What is secondary analysis? Reworking qualitative data*. London: SAGE Publications.

Hendrix, C. C., Fornier, D. G. & Briggs, K. (2001). Impacts of co-therapy teams on client outcomes and therapist training in marriage and family therapy. *Contemporary Family Therapy* 23(1), 63-82.

Holck, U. (2007). An ethnographic descriptive approach to video microanalysis. In T. Wosch and T. Wigram (Eds.), *Microanalysis in music therapy. Methods, techniques and applications for clinicians, researchers, educators and students*. (pp. 29-45). London: Jessica Kingsley Publishers.

Mazzola, G. & Cherlin, P. B. (2009).*Flow, gesture, and spaces in free jazz*. *Towards a theory of collaboration*. Minnesota, USA: Springer.

Meyer, M. (1987, May).Consultation and co-therapy as teaching devices. Paper presented at The Annual Children's Center Spring Conference, Detroit, USA. Retrieved January 2, 2012 from http://ezproxy.massey.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=eric&AN=ED290987&site=eds-live

Miller, C. & Guarnieri, M. (2008). Integrating two different disciplines: a music and drama therapy group. In K. Twyford & T. Watson (Eds.), *Integrated team working: Music therapy as part of transdisciplinary and collaborative approaches* (pp. 146-151). London: Jessica Kingsley Publishers.

Nordoff, P. & Robbins, C. (2007).*Creative music therapy: A guide to fostering clinical musicianship.* Barcelona Publishers.

Reese-Dukes, J. & Reese-Dukes, C. (1983).Pairs for pairs: A theoretical base for co-therapy as a nonsexist process in couple counselling. *Personnel & Guidance Journal* 62(2), 99-101.

Robbins, C. & Robbins, C. (1991).Self-communicating in creative music therapy. In K. Bruscia (Ed.), *Case studies in music therapy (*pp. 55-72). Philadelphia: Barcelona Publishers.

Roller, B. & Nelson V. (1991).*The art of co-therapy. How therapists work together*. New York: Guilford Press.

Salas, J. & Gonzalez, D. (1991). Like singing with a bird: Improvisational music therapy with a blind four-year-old. In K. Bruscia (Ed.), *Case studies in music therapy (*pp. 17-27). Philadelphia: Barcelona Publishers.

Streeter, E. (2002).Some observations on music therapy training groups. In A. Davies & E. Richards (Eds.), *Music therapy and group work* (pp. 262-273). London: Jessica Kingsley Publishers.

Testony, S. C. (1994, August).Using co-therapy in the training of therapists. Paper presented at The Annual Convention of the American Psychological Association, Los Angeles. Retrieved January 1, 2012 from http://ezproxy.massey.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=eric&AN=ED372317&site=eds-live

Turry, A. & Marcus, D. (2005). Teamwork: Therapist and cotherapist in the Nordoff-Robbins approach to music therapy. *Music Therapy Perspectives* 23, 53-69.

Twyford, K. & Watson, T. (Eds.) (2008).*Integrated team working: Music therapy as part of transdisciplinary and collaborative approaches*. London: Jessica Kingsley Publishers.

Wosch, T. & Wigram, T. (Eds.) (2007).*Microanalysis in music therapy. Methods, techniques and applications for clinicians, researchers, educators and students*. London: Jessica Kingsley Publishers.

Appendix One

Music Therapy Programme (MMusTher)

Research Title:

What are the benefits and the potential challenges of facilitating co-therapy music therapy in a small group setting?

Information Sheet

Dear.....,

As you know I am a second year Master of Music Therapy student undertaking a clinical placement at the Raukatauri Music Therapy Centre (RMTC). As part of my training I am required to research an aspect of my practice by undertaking secondary review of clinical practice data. The purpose of the research is to improve my learning and to inform other music therapy students and practitioners of particular issues involved in the work. With informed consent from all affected parties, I would choose an aspect of music therapy work that particularly interests me, and would closely observe and critically reflect on this practice, and produce my interpretation of its value. My research project this year focuses on co-facilitating music therapy group sessions, and the title that I am currently using for it is: 'Co-therapy in a group setting; Benefits and potential challenges in facilitating co-therapy music therapy in a small group setting'. My research process will involve looking back (secondary review) over the clinical notes that I have written following music therapy sessions, re-examining notes that I have written in my reflective journal, and reviewing video footage. The reflective journal is part of a music therapists' usual practice and is a way to document personal reflections, learning process, critical thinking and the like. As part of my clinical evaluation I regularly review footage of music therapy sessions, and in the context of my research I will be looking particularly at the relations between the two therapists in facilitation of small group sessions.

I am writing to express my interest in reviewing and analysing my practice as a student music therapist in working with your child, ... As part of my research write up I am required to include a case vignette from my practice, i.e. an excerpt about my work with a client, to illustrate a particular point about my learning.

The research will not use real names of children, and in any publication or presentation arising from this research, pseudonym will be used. The secondary analysis of data will take place at the RMTC or at my private home computer. Consent forms will be kept for ten years from when the child turns 16 and will be stored at the New Zealand School of Music, Music Therapy Department, in a locked cupboard or filing cabinet, and files will be marked 'confidential'. The research supervisors would have access to the data and would be responsible for its safe-keeping.

A summary of the results of the study will be provided to RMTC, and I will provide copies of the summary and vignettes to your family and other team members who may be represented in the writing. I will present the practical case material to my examiners in a private session at the end of my University degree and I may also present the work, if appropriate, to RMTC, the facility where the research was undertaken. Findings may be published in the future in journals for music therapy or other professional journals, in collaboration with the research supervisor, Sarah Hoskyns.

If you are in agreement with your child's involvement in my research, please sign both copies of the enclosed consent form and return one to the Raukatauri Music Therapy Centre. If you decide not to allow data related to your child to be used in my research, this is fine, and I shall approach other families. There will be no change to your child's ongoing music therapy. Please do not hesitate to contact the following people if you have any questions or wish to discuss this further:

Sarah Hoskyns, Research supervisor and Music Therapy Programme leader at the New Zealand School of Music. Ph: (04) 8015799 x 6410 or email: sarah.hoskyns@nzsm.ac.nz

Claire Molyneux, Clinical Liaison and Head of Clinical Services at the Raukatauri Music Therapy Centre. Ph: (09) 360889 or email: Claire@rmtc.org.nz

Yours sincerely,

Yair Katz

Student Music Therapist

Email: yairkatz@hotmail.com or yair@rmtc.org.nz

Ph: (09) 8136243 or at RMTC (09) 3600889

Appendix Two

Research Title: What are the benefits and the potential challenges of facilitating co-therapy music therapy in a small group setting?

Consent Form

I am writing to express my interest in reviewing and analysing my practice as a student music therapist in working with your child,.....As part of my research I am required to include a case vignette from my practice, i.e. an excerpt about my work with a client, to illustrate a particular point about my learning.

The research will not use real names of children, and in any publication or presentation arising from this research, pseudonym will be used. The secondary analysis of data will take place at the RMTC or at my private home computer. Consent forms will be kept for ten years from when the child turns 16 and will be stored at the New Zealand School of Music, Music Therapy Department, in a locked cupboard or filing cabinet, and files will be marked 'confidential'. The research supervisors would have access to the data and would be responsible for its safe-keeping.

A summary of the results of the study will be provided to RMTC, and I will provide copies of the summary and vignettes to your family and other team members who may be represented in the writing. I will present the practical case material to my examiners in a private session at the end of my University degree and I may also present the work, if appropriate, to RMTC, the facility where the research was undertaken. Findings may be published in the future in journals for music therapy or other professional journals, in collaboration with the research supervisor, Sarah Hoskyns.

If you are in agreement with your child's involvement in my research, please sign both copies of the enclosed consent form and return one to the Raukatauri Music Therapy Centre. If you decide not to allow data related to your child to be used in my research, this is fine, and I shall approach other families. There will be no change to your child's ongoing music therapy. Please do not hesitate to contact the following people if you have any questions or wish to discuss this further:

Sarah Hoskyns, Research supervisor and Music Therapy Programme leader at the New Zealand School of Music. Ph: (04) 8015799 x 6410 or email: sarah.hoskyns@nzsm.ac.nz

Claire Molyneux, Clinical Liaison and Head of Clinical Services at the Raukatauri Music Therapy Centre. Ph: (09) 360889 or email: Claire@rmtc.org.nz

Yours sincerely,

Yair Katz

Student Music Therapist

Email: yairkatz@hotmail.com or yair@rmtc.org.nz

Ph: (09) 8136243 or at RMTC (09) 3600889

Appendix Three

Music Therapy Programme (MMusTher)

Research Title:

What are the benefits and the potential challenges of facilitating co-therapy music therapy in a small group setting?

Information Sheet

Dear Claire,

As you know I am a second year Master of Music Therapy student undertaking a clinical placement at the Raukatauri Music Therapy Centre (RMTC). As part of my training I am required to research an aspect of my practice by undertaking secondary review of clinical practice data. The purpose of the research is to improve my learning and to inform other music therapy students and practitioners of particular issues involved in the work. With informed consent from all affected parties, I would choose an aspect of music therapy work that particularly interests me, and would closely observe and critically reflect on this practice, and produce my interpretation of its value. My research project this year focuses on co-facilitating music therapy group sessions, and the title that I am currently using for it is: 'Co-therapy in a group setting; Benefits and potential challenges in facilitating co-therapy music therapy in a small group setting'.

I am required to include a case vignette from practice which will involve an analysis of my co-facilitation of a group in the facility (plus two groups from outreach) through data and video analysis, to illustrate a particular point in the exegesis. I will send consent forms to be signed by the parents of the children in this group. This preliminary communication is to ask permission for the research to take place in this facility. Subsequently I am also asking permission from Carlson School for the use of data analysis of groups taken place in the school.

I would like to inform you that this project has been reviewed and approved by the New Zealand School of Music Postgraduate Committee. The chairs of Massey University Human Ethics and Health and Disability Ethics Committee have given generic approval for music therapy students to conduct studies of this type. The music therapy projectshave been judged to be of low risk and, consequently, are not separately reviewed by any Human Ethics Committees. The supervisor named below is responsible for the ethical conduct of this research. If you have concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please contact Professor John O'Neill, Research Ethics, Ph: (06) 3505249 or email: humanethics@massey.ac.nz

If you are in agreement with this research taking place at RMTC, please sign both copies of the enclosed consent form and return to me. Please do not hesitate to contact my research supervisor, Sarah Hoskyns, if you have any questions or wish to discuss this further. Ph: (04) 8015799 x 6410 or email: sarah.hoskyns@nzsm.ac.nz

Yours sincerely,

Yair Katz

Student Music Therapist

Email: yairkatz@hotmail.com or yair@rmtc.org.nz

Ph: (09) 8136243 or at RMTC (09) 3600889

Appendix Four

Research Title: What are the benefits and the potential challenges of facilitating co-therapy music therapy in a small group setting?

Facility Consent Form

I,.....(name/position) give consent for data which has been collected for clinical purposes at the Raukatauri Music Therapy Centre (RMTC), to be used in the research project ***'What are the benefits and the potential challenges of facilitating co-therapy music therapy in a small group setting?*** to be carried out by Yair Katz (Student Music Therapist) as part of the requirements of the Masters of Music Therapy at the New Zealand School of Music.

I understand that clients' names will not be used in any publication or presentation arising from this research. I understand that clients' music therapy would occur in a standard way and there would be no expectation of extra attendance or sessions.

I understand that the secondary review and analysis will take place at the centre or, if the data is de-identified and kept on a password protected computer, at the student's place of study (home office). In accordance with RMTC policies, data will belong to the centre and all originals will be stored securely for five years after the case is closed and then destroyed. Any copies of the data, used for research purposes, will be destroyed upon completion of the research project, March 2012.

I understand that consent form will be kept for ten years from the age of 16 of each client, and will be stored at the New Zealand School of Music, Music Therapy Department, in a locked cupboard or filing cabinet, and files will be marked 'confidential'. The research supervisors would have access to the data and would be responsible for its safe-keeping.

I understand that the student music therapist will provide a summary of the results of the study to RMTC, and provide copies of the summary and vignettes to clients' families and team members who may be represented in the data.

I understand that the student music therapist may present the work, if appropriate, to RMTC, the facility where the research was undertaken, and/or to the New Zealand School of Music (MMusTher) staff/students. If the work is of suitable quality, findings may be published in suitable music therapy journals or other professional journals, in collaboration with the research supervisor, Sarah Hoskyns.

I understand that if I have any questions, concern, or wish to discuss this further I can contact the student music therapist's research supervisor, Sarah Hoskyns.

This has been discussed with me by Yair Katz (Student Music Therapist and researcher).

Signed.....

Print Name.....

Date.....

Appendix Five

Example of transcription of video analysis

Time	SMTh	MTh	D	N	A
5:57-7:10	Position between N & D, facing MTh & A. Holds guitar. Moves from sitting close to N to face D. Starts strumming a 2 chord sequence (G/Am) in a steady beat. Adding notes to 'colour' the improvised tune.	Position between D & A, facing SMTh and N. Looks at D. Holds shaker. Picks up djembe. Takes A's hand & places on djembe. Puts away A's shaker. Scratches drum with nails. Responds to N's voice with an 'oh'. Wipes A's fingers. Drums.	Looks at SMTh. Holds bells. Smiles. Moves hands to play bells. Vocalises – sounds agitated. Becomes quiet after MTh's vocal.	Looks down, and then looks up. Vocalises (6:38). And then again after MTh's vocal. The tone matches the guitar's harmonic scale.	Holds shakers. Looks down. Looks up. Appears to be engaged in listening. Puts hand to mouth. Moves right hand fingers on drum's surface.
7:10-8:35	Faces N and then A and looks at them. Continues the moderate, steady guitar strum.	Encourages A to play; Places A's hand on top of her palm on the drum & then holds her hand & drums. Looks at N, A & D. At 8:30 makes a low voice & looks at A. Continues to drum.	Appears to listen to the vocal dialogue between N and MTh. No hand movement. Looks at SMTh and then at N and A.	Continues to vocaliseconstant long sounds of 'Ohaaa', Ahhh' & 'Yaaaa'. Lifts hands, smiles. Vocalises 'Oh…oh…', pauses, then a high happy vocal call of 'Yay'. Head up. Stops vocalising at 8:03. Finger to mouth.	Looks up. Engages in active listening. Holds MTh's finger. Puts hand to mouth. Starts to sway body to the rhythm of the guitar.
8:35-9:45	Looks at N after she stops	Keeps the long note. Looks at D.	Laughs. Arms moving to play bells.Continues	Resumes vocalising in the same manner as	Rocks body to the beat. When the

	vocalising. Stays on the 'Am' chord. Repeats it with variations on the strumming style. Looks at D. Slows down pace to fade.	Smiles & turns to N when N resumes vocalising. Copies N voice & plays a fast roll on the drum after SMTh's strum faded.	this until right before guitar stops.	before. A big smile at 9:10. Says 'again!' as guitar playing slows down at 9:20. At 9:35 makes a big call followed by laughter. Opens mouth wide & lifts hands.	music stops raises her head & looks up.