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FAMILY-BASED MUSIC THERAPY: FAMILY THERAPISTS' PERSPECTIVES

A DISSERTATION

Submitted by

BETH NEMESH

In partial fulfillment of the requirements
For the degree of
Doctor of Philosophy

LESLEY UNIVERSITY

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Lesley University
Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

DISSERTATION APPROVAL FORM

Student's Name: Beth Nemesh

Dissertation Title: **FAMILY-BASED MUSIC THERAPY: FAMILY THERAPIST'S PERSPECTIVES**

Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

Dissertation Committee Chairperson: *Roger King* 12/15/15
(date)

Internal Committee Member: *Michelle Ania* 12/15/15
(date)

External Committee Member: *Mtzy Bradt-Hills* 12/15/15
(date)

Director of the Ph.D. Program/External Examiner: *Barbara Bradt* 1.17.16
(date)

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Roger King
Dissertation Director

I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

Barbara Bradt
Dean, Graduate School of Arts and Social Sciences

STATEMENT BY AUTHOR

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SIGNED: Beth Nemesh

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“Music, uniquely among the arts, is both completely abstract and profoundly emotional. It has no power to represent anything particular or external, but it has a unique power to express inner states or feelings. Music can pierce the heart directly; it needs no mediation.”

Oliver Sacks, *Musicophilia*, (2008)

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ABSTRACT

The purpose of this mixed methods study was to explore the use of musical interventions borrowed from music therapy in a family therapy context. Furthermore, the study aimed to move beyond current application of family-music therapy that focuses on a child, a member with special needs, or families with additional diagnoses to non-clinical families seeking therapy, focusing on the family as an entity. This research was based on the premise that engaging in musical activities is a natural, common endeavor that does not require special musical skills. This does not replace the immense body of knowledge needed for conventional music therapy; rather, it intended to add a musical tool to the family therapist's toolbox, based on the family's natural playful activities. Thirty-five certified family therapists received a single workshop on implementing a structured musical intervention addressing family roles. Eighteen therapists implemented 38 musical interventions and offered insight into their experience concerning the applicability, the value for the families and therapists, and future implications for family-based music therapy. The findings demonstrated that incorporating musical interventions within a family therapy context offered family therapists (a) A practical and applicable musical intervention, (b) A potent family assessment opportunity, (c) New opportunities for families to find new possibilities, feel hope, and work toward change in a nonthreatening and playful experience; and (d) an intervention, which addressed diverse family objectives. These findings shed light on the benefits in the collaboration of music and family therapy and demonstrated the value of incorporating family-based music therapy interventions in family therapy practices, training and education.

CHAPTER 1

Introduction

Family-music therapy is a small but developing discipline in the field of music therapy. Family-music therapy is mainly addressed from a music therapy perspective in that it provides music therapy interventions to children and their families in a variety of clinical settings by trained *music* therapists. However, trained *family* therapists may also provide family-based musical interventions in a family therapy context.

From a music therapy perspective, with growing awareness of the advantages of focusing on the family as an entity on its own and the way it affects the individual's functioning, there is growing rationale for conducting music therapy with the whole family (Goldenberg & Goldenberg, 2008). A systems perspective acknowledges that "people and events are assumed to exist in a context of mutual influence and mutual interaction, as participants share in each other's destiny" (p. 13). It "takes a broader view that individual behavior is better understood as occurring within the primary network of a family's social system" (p. 23). Thus, a music therapist working from a system's perspective seeks to understand what, how, and when an incident occurs rather than why. The therapy sets out to replace dysfunctional family structure, interactions, belief systems, rules, and dynamics with new and more appropriate ones, thus affecting individual and family functioning and behavior.

On the other hand, from a family therapy perspective, there is developing rationale and advantages for employing expressive arts in family therapy. Using creative arts can provide a playful experience that promotes mutual family pleasure and cooperation. It is an opportunity to creatively express emotions and conflicts, by means of connecting to positive life energy. The arts act as catalysts, significantly

enhancing and augmenting family dynamics, authenticity, and communication patterns. They tap into the unconscious and bypass habitual and conscious censors, affording opportunities to grow awareness and insight into family dynamics and promote change (Kerr, Hoshini, Sutherland, Parashak, & McCarley, 2008; Lowenstein 2010; Malchiodi, 2003; Satir, Banmen, Gerber, & Gomori, 1991). Although the use of creative arts in family therapy is gaining validity, a place for music in those arts has appeared absent. Specifically, among the variety of artistic techniques and therapeutic modalities mentioned in family therapy research, musical directives and the use of music has been scant. Decuir (1991), Hibben (1992), and Miller (1994) are among the few who studied family-music interventions from a family therapy perspective. Miller noted that the qualities of music and family therapy complement each other in many respects. Primarily, music "is a medium of communication composed of the elements of language (tones and rhythms), yet it does not carry the specific association of words" (p. 43). Borrowing from Lowenstein's (2010) advice on family-art therapy, clinicians practicing family-music therapy need, in addition to their training as music therapists, training and perspective in family-systems.

Considering the lack of literature on family therapists' use of musical interventions, a pilot study (Nemesh, 2014) explored the applicability and therapeutic value of musical interventions implemented by a dual expertise therapist (family and music therapist) with three families in a family therapy setting. The pilot study found family-based music therapy to be a viable and potent intervention with non-clinical families. Non-clinical families, were defined as families who apply for family therapy or counseling that does not focus on a single member—child or adult—or on a member with special needs or a disability, or who have not been identified with an

additional identified pathology or as "at risk" (Mackenzie & Hamlett, 2005). The outcomes of the pilot study noted that musical sessions had a significant therapeutic impact as a clinical family assessment and diagnostic tool and in addressing diverse family objectives. Family-based music therapy promoted family interactions, facilitated communication, quality of emotional interactions, and congruence on many levels. The musical sessions emphasized the "here and now" in the family reality and offered ongoing opportunities for change and growth.

Based on the results demonstrated in the pilot study, the author set out to explore the applicability and value of family therapists' use of musical interventions in clinical settings. The purpose of this study is to fill the gap in the literature concerning the use of musical directives borrowed from the music therapy field in a family therapy context. Furthermore, the study aims to provide a better understanding of the potential of music as a family therapy creative technique with non-clinical families seeking therapy. This research is based on the premise that engaging in musical activities is a natural, common endeavor that does not require special musical skills. It is based on inherent human communicative musicality (Malloch & Trevarthen, 2009) and affect attunement (Stern, 1985), which can be exercised for the benefit of family therapy. It does not intend to replace the immense body of knowledge needed for professional music therapy. Rather, it intends to add a musical tool to the family therapist's toolbox, based on the family's natural and playful abilities. The study expands the existing family-music therapy interventions by *music* therapists to interventions by *family* therapists focused on the family as a unit.

Mapping the Field of Family-Music Therapy

The historical roots of music therapy in its modern form developed after World War II (Bunt, 1994) in parallel with the development of modern family therapy

(Goldenberg & Goldenberg, 2008). Although studies independently have found family therapy and music therapy to act as potent vehicles for healing supported by literature and theories substantiating their healing powers, the interdisciplinary field of family-music therapy is still formulating. Despite the apparent benefits and advantages of combining family and music therapy, few have practiced, researched, or published in this area.

At present, family-music therapy is a small professional niche in the field of music therapy, attracting interest and research mostly in the last 15 years. An overview of existing family-music therapy literature situated rare early publications in the 1980s and 1990s. The current literature in family-music therapy has explored the subject mainly from a music therapy professional perspective. Most literature maintains a child-oriented angle, whereas families are included in music therapy sessions to fulfill the child's needs. Rare studies employed a family-based approach that did not focus on a single member, whether child or adult, rather than on the family as a unit (Pasiali, 2012).

From a family therapy perspective, however, there is scant literature (Decuir, 1991; Hibben, 1992; Miller, 1994). It brings to light a perspective from over two decades ago presenting music therapy practices by music therapists in a family therapy context. The literature noted the compatibility of musical interventions with the main schools of family therapy (Miller, 1994), as well as the unique value of musical techniques for promoting family communication and interaction on many levels. Hibben (1992) who noted family therapists' reluctance to involve young children in family sessions stressed that music was especially effective when used with young children. Musical interventions provided an opportunity for a playful, nonverbal technique engaging children and adults in family therapy.

Although most family-music therapy studies were child centered, they demonstrated the benefits of family-music therapy in addressing the family needs as a single entity. The outcomes of the studies exhibited the family-music therapy impact on improving the family's physical and emotional wellbeing, relations, dynamics, overall interaction, communication, parental functioning, and attunement. The studies also showed improvements in building mutual trust, setting boundaries, and promoting congruence and quality of life.

Research regarding the application of family-music therapy with non-clinical families is minimal. In a unique paper, Mackenzie and Hamlett (2005) adapted music therapy techniques traditionally used for children with special needs and their families "to address the needs of 'well' families" (p. 48) and investigated an early intervention program for families and young children.

Purpose of the Study

The need for additional literature concerning family-based music therapy employed by family therapists with non-clinical families is the basis for this study. The purpose of this study is to assess the potential of a music therapy intervention in family therapy and its applicability and value for family therapists working with non-clinical families. This study was inspired by a preceding pilot study (Nemesh, 2014) that found family-based music therapy to be a viable and potent practice with non-clinical families seeking family therapy when applied by a dual expertise; family and music therapist. In the pilot study, short-term family-based music therapy offered an audiovisual display of family dynamics and functioning that served as an accurate family assessment tool. Additionally, the musical interventions offered families a therapeutic experience promoting family functioning and congruence. The interventions augmented the family dynamics, which the musical representations

accurately accentuated. The musical experience and its exploration through verbal reflections provoked a heightened awareness of family issues. The participants used musical instruments and mutual music improvisations to explore new possibilities, affording them a more congruent and attuned experience with other family members. The directness and precision conveyed through music therapy improvisations motivated the participants to make prompt changes and improvements throughout the sessions in an ongoing positive process of change.

This current study addresses limitations noted in the pilot study (Nemesh, 2014), where the interventions were performed by a dual expertise (family and music) therapist. Expanding on the pilot study, this study aims to explore the applicability and value of family-based music therapy interventions provided by a certified family therapist who is not a trained music therapist, and facilitated the session subsequent to a single training workshop. Introducing musical interventions borrowed from music therapists as additional techniques in traditional family therapy may broaden the family therapist's toolbox with a potent experiential vehicle for assessment and intervention.

Theoretical Foundations

Two theoretical paradigms are at the foundation of the family-based music therapy model. From the *family therapy* perspective, experiential family therapy emphasizing Virginia Satir's humanistic model is at the heart of the model. From the *music therapy* perspective, the model is inspired by Juliette Alvin's free improvisation model. Additionally, family-based music therapy builds on experience gathered from the field of family-art therapy, group music therapy and musical improvisations, knowledge obtained from musical communication theories and developmental theories that offer insight into the inherent and developmental aspects of family-based

music therapy. Finally, innovations in neuromusicology offer a new dimension to understanding the phenomenon of mutual family music improvisation.

Research Questions

The guiding questions of this study were:

- What are family therapists' initial perspectives on using musical techniques in family therapy? How do they change after a single family-based music therapy training session and after implementing family-based music interventions in a family therapy setting?
- Based on the family therapists' experiences of implementing family musical interventions, what are the family therapists' perspectives on the applicability, therapeutic, and professional value of family-based music therapy interventions in family therapy?
- Null Hypothesis: There is no significant difference in the perceptions of family therapists toward family-based music therapy before training and after training and implementing family-based music therapy.

Importance to the Field

The gap in the literature concerning the use of musical interventions by family therapists in family therapy context represents the hesitance of family therapists to use music in family therapy (Hibben, 1992) as well as the lack of training in this specialized area. This research proposes to inform family therapists and music therapists of the potential benefits and value of family-based music therapy. As noted in the preceding pilot study (Nemesh, 2014), using structured musical interventions and techniques in family therapy offered a meaningful therapeutic experience that may be introduced into the family therapy field as a potent, applicable, and creative

family therapy technique. Although family therapists may recognize the potential of employing music in family care, and music therapists may recognize the rationale of working with families, currently there is little or no training in the field of family-music therapy other than by acquiring a dual professional training. This study seeks to evaluate the outcomes and impact of a single training workshop on family therapists' abilities and confidence to employ a musical intervention with non-clinical families in family therapy settings. More so, the study explores the therapeutic value and professional benefits of the model.

Assumptions

Provided suitable training, family-based musical interventions can become an addition to the therapeutic techniques of a family therapist's toolbox. Family therapists who receive training in family-based music therapy may overcome their hesitance to use music in therapy and provide musical interventions that will enable families to cope with family and individual challenges experientially. Combining musical, verbal, and nonverbal processes, the interventions may offer meaningful experiences while bypassing habitual defenses and gaining new insights with a playful and attractive media.

Limitations

This research does not attend to the complementary side of family-based music therapy, exploring the music therapists' perspectives on including families in music therapy interventions. Although this is highly valuable and important topic is also absent in music therapy literature, it remains to be investigated in future studies.

CHAPTER 2

Literature Review

This chapter aims to set the background for the development of a family-based music therapy model with an emphasis on treating non-clinical families as defined in the previous chapter. The review examines two theoretical models that form the foundations of the study—Juliette Alvin's free improvisation music therapy and Virginia Satir's experiential family therapy models—and their compatibility. Because literature on music therapy with non-clinical families is scarce, the review addresses relevant literature from neighboring fields, such as the integration of other expressive arts into family therapy and knowledge gathered from family-music therapy for treating families with children with special needs. Other contributions were obtained from group-music therapy and group improvisation. Their designs, interventions, and outcomes were studied to form a basis for designing the interventions in this research. Finally, the review touches upon developmental models and theories featuring inherent musicality as well as neuromusicology studies that offered an additional and innovative dimension to understanding the ways in which family-based music therapy affects the body, the mind, interactions, and relations. This review aims to demonstrate the gap existing in music therapy and family therapy literature concerning the interdisciplinary field of family-based music therapy and to substantiate the potential of family-based music therapy as a family therapy technique.

Experiential Family Therapy and the Satir Model

Kempler (1981), known for his Gestalt family therapy model, highlighted the importance of experiences in the human existence. Interactions with other people "are the most powerful of all experiences for development of skills which we can use to

cope with future experience" (p. 7). Interactions we have within the family "are the most significant in generating and influencing our capabilities" (p. 7). Experiential family therapy implies that the sessions are used to practice and explore new experiences—practicing through actions and not just talking. Kempler stressed that in experiential family therapy, "the office is the laboratory in which the work is done. The learning is in the experience the family and the therapist have together" (p. 9). The essence of experiential family therapy is in the "interpersonal experience rather than the reliance on technique" (Goldenberg & Goldenberg, 2008, p. 207). The "here and now" experience enables exploration and experimentation with any information that surfaces.

Virginia Satir, among the founders of family therapy, developed the Satir Transformational Systemic Therapy or STST (Satir et al. 1991). Her experiential and humanistic family therapy model emphasized collaboration of the therapist with family members to achieve personal and family congruence by connecting the participants to their own inherent strengths (Goldenerg & Goldenberg, 2008). This study uses Virginia Satir's definition of *congruence*: "Choosing congruence means choosing to be ourselves, to relate to and contact others, and to connect with people directly. We wish to respond from a position of caring for ourselves, for other people, and with awareness of the present context" (Satir et al., 1991, p. 66).

According to Banmen and Maki-Banmen (2014), Satir added body experiences and a spiritual dimension to the definition of congruence: being in touch and connected to the person's body knowledge and the person's life energy that contains the innate resources and strengths for coping with life's encounters. A congruent therapist provides conditions where the family can experience new possibilities, feel hope, and work toward change (Banmen & Maki-Banmen, 2014).

Satir focused on positive experiential interventions and believed her clients' most important goal was developing self-worth and congruence. She emphasized building on individual and family strengths, accessing one's own resources, considering different possibilities and choices, and reconnecting her clients to their positive life-energy. Satir believed that transformation cannot be achieved merely through cognition. Satir "engaged right-brain capabilities through her use of humor, trance, meditation, music, physical touch, and vocal tone. She made the change process more comprehensive by adding experiential learning to the cognitive process" (Satir et al. 1991, p. 162).

Individual therapy aspires to promote individual congruence, a state of openness, awareness, acknowledgement, and connectedness in the intrapsychic, interpersonal, and universal-spiritual dimensions. Correspondingly, family congruence is a state of openness, awareness, acknowledgement, and connectedness—internally at the self level—among all family members and with relation to the outside world that gives rise to balanced, healthy family communication, relationships, and behavior.

Satir's experiential family therapy was innovative in her use of nonverbal experiential techniques to promote family awareness and change, including the use of creative arts such as psychodrama, family sculpting, and role-play in family therapy (Goldenberg & Goldenberg, 2008). This integration of the arts paved the way for integrating musical interventions into family therapy, forming the foundation for family-based music therapy.

Juliette Alvin's Free Improvisation Model of Music Therapy

Of the major music therapy improvisation models mentioned in the music therapy literature, none had been developed for family intervention. Instead, they

were predominantly individual therapies adjusted to fit within group therapy.

Although no models were family oriented, some studies mentioned their use with families (Bruscia, 1987).

Juliette Alvin developed the music therapy free improvisation model based on the philosophy that music is a potential space for free expression without confinement to musical and expressional rules or previous training (Wigram et al., 2002). Alvin believed that musical instruments could be used as *intermediary objects*, "conceived as prolongation of man's body through contact with his mouth, hands, fingers, knees and so on, with which he provokes a vibration and projects himself" (Alvin, 1977, p. 8). Similar therapeutic projections are used in drama therapy as well (Jennings, 1992). Alvin believed clients should be allowed to choose whatever instrument they wished from a large and varied selection, driven by visual characteristics, symbolic significance, the substance from which it is made, tactile experience, the way the instrument is held or played, or auditory perceptions of the instrument. The client develops a subjective relationship with that musical instrument, as well as with the therapist's musical instrument, and then create a therapeutic relationship with the therapist and their mutual music (Alvin, 1977). The client can hear himself through his music, which is reflected back, and even make "a change in himself through the return of the sound to him in the feed-back which completed the experience" (p. 9). Alvin's use of multiple therapeutic approaches was referred to as an "eclectic model" (Wigram et al. 2002, p. 132). She used psychodynamic, analytical, behavioral, humanistic, and developmental clinical approaches while adding her holistic belief that music affects the body, mind, and soul. She was considered an innovative leader in the 1960s with her psychotherapeutic stance of an equal relationship between therapist and client, with the therapist at the same level and having equal control in

the session. Alvin believed that the therapist's use of self was the most important instrument in therapy. Although Alvin is best known for working with children with autism and disabilities, she also worked with parent-child dyads, adults, and groups using free improvisations, titled improvisations, receptive listening to music, vocal improvisations, discussions, and movement (Bruscia, 1987; Wigram et al., 2002).

Building upon Alvin's experience, the free improvisation model seemed suited for music therapy improvisation in a family-based context. The current study joins Alvin's free improvisation model with Satir's experiential family therapy, offering families an opportunity to create improvised music in a clinical setting without prior musical training or experience. Grounded in Alvin's ideas of creating a therapeutic relationship, individual family members would develop a subjective relationship to a musical instrument and then relate to instruments of other family members, followed by establishing a relationship with the other members and their mutual musical creation in a therapeutic experience.

Integration of Expressive Arts in Family Therapy

Music, drama, art, and dance were common in rituals; in body, mind, and soul healing practices for individual, families, and communities; and in promoting individual, impersonal health and balance (Rogers, 1993). The use of the arts as a vehicle to achieve health is manifested in archeological and historical findings in addition to ancient mythology and biblical stories (Bunt, 1994; Kerr et al., 2008).

Modern family- and arts-therapy models emerged mainly since the mid-1950s and inspired a variety of models. Although the parallel development of the fields was significant, only a few theorists combined family therapy and the expressive arts. Despite the scarcity of family-arts theories, Kerr, Hoshini, Sutherland, Parashak, and McCarley (2008) noted major potential benefits to incorporating arts in family

therapy. Specifically, the artistic experiences are able to bypass imbedded defenses and overcome rigid structures of individuals and families, and art enables participants to gain insight through experiential understanding. More so, the artistic experience offers possibilities to express feelings, thoughts, and yearnings through an art product. Additionally, combining arts and verbal processing creates an opportunity to analyze family interactions and communicate using an artistic creation. Finally, making an artistic creation offers families an opportunity to connect to their positive life-energy, which facilitates positive family relationships by changing dysfunctional communication styles and family interactions, "liberating bound and redundant interpersonal styles that often make relationships stale, rigid and dysfunctional" (p. xv). Forthcoming studies of family-art therapy offer insight to the niche professions of family-arts therapies and contribute to understanding the challenges, implications, and possibilities in the field, including family-based music therapy.

Hanna Kwiatkowska, the mother-pioneer of family-art therapy, studied family-art therapy with mental patients and their families. She created innovative assessment protocols and art-based interventions based on the mainstream psychodynamic theory (Kwiatkowska, 1978; Robb, 2012). Kwiatkowska acknowledged the unique power of family-art therapy, which "demands a solid background in family therapy and extensive psychotherapeutic experience in addition to art therapy training" (p. 137).

With the development of family art, additional assessment tools were developed to support the effective application of the modality, including kinetic family drawings, family-based circle drawings, family portraits and murals, joint-pictures and self-portraits, integrative family art, family landscapes, MARI assessment cards, draw-a-person, house-tree-person, and person picking an apple off a

tree (Kerr et al., 2008; Malchiodi, 2003). Although family-art assessments and interventions are now widely used, they are subject to cultural variations and affected by cognitive development, subcultural influences, artistic skills, and schooling that could influence their validity (Malchiodi, 2003). Family objectives are explored using family-art therapy interventions employing numerous techniques in conjunction with the majority of psychological theories (Kerr et al., 2008; Lowenstein, 2010; Malchiodi, 2003).

Arrington (2001) noted that mutual art making was a communication experience that allows expression of inner thoughts, feelings, and attitudes and enables "all individuals in the creative process to be both 'seen and heard'" (p. 6). She highlighted the augmenting impact of art making "through projective art processes, the expression, comprehension, and transmission of information within the family system is maximized" (p. 7).

Visual-art therapy leads the field of family-arts therapies, with many publications establishing a theoretical basis, intervention procedures, and assessment tools (Landgarten, 1981; Lowenstein, 2010; Malchiodi, 2012; Sobol & Williams, 2001). Still, only a few studies assessed the validity, credibility, and therapeutic value of family-art therapy with non-clinical families. Instead, family-art therapy research focused mainly on children with special needs and their families (Armstrong & Simpson, 2002; Gabriels, 2003), and child psychiatry (Landgarten, 1981; Sobol, 1982). Rare examples presented studies in family-art therapy with non-clinical families. Banker (2008) presented a case study exploring family relations and communication using family clay sculpting. Additionally, Sutherland (2011) illustrated the use of family-based art therapy in a single case study that focused on assessing and promoting family communication, family roles, and relationships.

Family-art therapy created a solid foundation of literature that supported the theoretical and practical value of integrating arts in family therapy, adding credibility to the profession of family-art therapy (Brooke, 2004).

Other expressive arts such as dance-movement therapy, drama therapy, and psychodrama are currently following the lead of family visual arts similar to the developing field of family-music therapy.

Family-Music Therapy: from a Music therapy Perspective

Family-music therapy is a developing discipline that requires unique expertise. It has gained popularity and attracted more research in the past 15 years.

Traditionally, the literature referred to family-music therapy as working with families who have children with special needs (Kirkland, 2013). However, the literature is inconsistent when defining family-music therapy, attributing a variety of interchanging and confusing definitions for family-music therapy. Family-music therapy is not a brand name or attributed to a single model. For example, musical interventions with families have been referred to as family-music therapy, family-centered music therapy, therapy with children and their families, clinical music therapy with families, music therapy with families, and interactive family-music therapy. In the literature, *family-based therapy* refers to counseling and family therapy sought by families who seek to resolve family needs and conflicts. According to the European Family Therapy Association (Skorunka, 2009), "Family therapy addresses the problems people present within the context of their relationships with significant persons in their lives and their social networks" (Introduction). The term *family-based music therapy* was used by Pasiali (2012) to describe clinical work with families that emphasizes all family members being actively engaged, addressing

family functioning and dynamics, and focusing on communication, relationships, needs, and resources while regarding the family as a unit.

The literature mentions the hesitation and apprehension of music therapists to include parents and family members in child-focused therapy, which "initially felt like something new and quite alien" (Horvat & O'Neill, 2008, p. 100). However, there is growing awareness that including the family in a child's therapy can promote and facilitate the child's wellbeing and development. "The most effective way to work with individuals is in the context of their families" (Lowenstein, 2010, p. xxiii). It provides therapists with accurate assessment of the family dynamics and shifts the focus from the identified patient to the family interactions.

Currently, two larger bodies of knowledge concerning family-music therapy have developed, led by Oldfield in the United Kingdom and the Australian project Sing & Grow. Existing family-music therapy literature is mainly derived from a music therapy standpoint where music therapists address families within their clinical settings. Literature that draws from a family therapy viewpoint where family therapists coalesce music into their clinical work is currently absent.

Oldfield, a pioneer and educator in the field of family-music therapy, has contributed significantly to the family-music therapy literature since her 1993 publication *Music Therapy with Families* (Oldfield, 1993). Two case studies of individual family-music therapy sessions showed how music helped create positive and fun interactions between parents and children to promote positive communication and relationships. Oldfield has since published numerous articles as well as the only books focused on family-music therapy (Oldfield, 2006a, 2006b; Oldfield & Flower, 2008). The interventions described "the interactive processes between the therapist and the child, between the child and the parent, and between the therapist and parent"

(Oldfield, 2006b, p. 196). The main conclusions highlighted music therapy's contribution to the assessment and treatment of families with children who had special needs either in a family group setting or in individual short-term interventions. Family-music therapy addressed issues of control, motivation, expressing feelings, and gaining insight into their relationships while having a joyful, positive experience in a nonverbal interaction. In conclusion, Oldfield (2006(b) noted music therapy's advantages included "being cost-effective because the music therapist can effect change through only a small amount of intervention" (p. 109).

In *Music Therapy with Children and Their Families* edited by Oldfield and Flower (2008), they presented a variety of family-music therapy studies in various setting and populations. The experiences of the professional music therapists demonstrated how family-music therapy benefitted the families and children by addressing relationship, communication, and interaction issues. The book provided case examples and research with children with special needs with the children as the focus of therapy and interventions. The majority of family-music therapy studies mentioned was group-oriented; others described individual case studies.

Another significant body of knowledge came from an Australian national music therapy project exploring early intervention and promoting parental skills (Sing & Grow, 2013). The project, established in 2001, has been evaluating short-term (10-session) family group-music therapy. The client groups were at-risk families "experiencing disadvantage, marginalization and additional need or risk factor" (p. 3) with children up to three years of age. The outcomes noted a reduction of negative feelings and interactions between parents and children; increasing positive interactions, activities, and communication skills; and promoting health and wellbeing of parents and their children. Sing & Grow has expanded to studying families of

children with disabilities (Williams et al., 2012) and since 2010 has expanded the program to England, Ireland, Scotland, and Wales (Sing & Grow, 2013).

Autistic Spectrum Disorder

Much of the family-music therapy research focused on families with children on the autistic spectrum. Their limitation was their small-scale or limited case studies. Oldfield (2006(a)) described the use of an *interactive music therapy model* for working with children and families. This model has been used predominantly with children with autism spectrum disorder and children with physical and learning disabilities. Allgood (2005) studied family-based group-music therapy for four children with autism with their parents and siblings. Pre- and post-interviews with parents revealed the benefits of a seven-week family-based intervention. Bull (2008) studied a group of three dyads of mothers with an autistic child. A verbal reflection by the mothers followed a 45-minute improvisation. The dyad relation was considered in the family context. Bull noted significant positive outcomes on relations, which offered a starting point for future family-music therapy involving entire families. Likewise, Thompson (2012) provided seven case examples of family-based music therapy in a home environment with collaboration and participation of family members. The case studies revealed the benefits for autistic children and their families in promoting positive relations; improving attunement at the child's level; modeling acceptance, affection, and play; lowering anxiety; and stimulating social communication. The main limitations were the small scale and the focus on an individual within the family.

Terminal Illness

Studies of children with terminal illness and palliative care by Aasgaard (2001), Abad (2003), Flower (2008), Lindenfelser (2005) Lindenfelser, Grocke, and McFerran (2008), and Shoemark and Dearn (2008), each outlined several case studies

that demonstrated the benefits of family-music therapy on families' physical and emotional wellbeing and improvements in family relations and overall quality of life. Abad (2003) uniquely addressed case studies focused on family-music therapy with teenagers and their families confronted with hospitalization and cancer treatment. Lindenfelser, Hense, and McFerran (2012) conducted a mixed-method research of 14 families confronting terminal illness using interviews with parents and a parent quality-of-life measurement. The results indicated quality of life diminished for half the families as their child's health declined but were inconclusive for improved communication. Other positive outcomes included physical relaxation and comfort of the child and shared positive experiences. Although the study could not control the course of the illness and other issues that could have affected the outcome, the families benefited from the intervention. Finally, O'Kelly (2002) interviewed 20 music therapy colleagues working with the terminally ill and noted that only six mentioned music therapy as an opportunity "for providing a positive contribution to [family] relationships with terminally ill loved ones" (p. 237). This hints that family-music interventions may not be well timed during the course of a terminal illness but may be valuable later.

Child Psychiatry

Few studies discussed children in psychiatric treatment and their families. Here too, the limitations were their small-scale studies and a focus on an individual member. Davies (2008) illustrated two case studies with children (10 and 13 years old) and their families at an outpatient psychiatric unit. Using structured music interventions and free improvisations, the long-term (up to two year) music therapy sessions addressed family communication, expressing emotions, family roles, parent-child bonds, controlling behavior, and self-esteem. Data collected through clinical

observations and parent- and child-feedback questionnaires displayed valuable and effective improvements in all addressed areas. McIntyre (2009) studied two family-based short-term musical interventions. The outcomes mostly supported an assessment procedure in a multidisciplinary center. Oldfield (2006a) presented three family-based case studies and a six-session family-music therapy group intervention. She noted improvement in family roles, satisfaction from nonverbal interactions, enthusiasm, positive experiences, expressing emotions, and gaining new insights. Oldfield recognized that the short-term interventions were many times too short. Similarly, Oldfield, Bell, and Pool (2012) provided in-depth observation of three families receiving family-music therapy in child psychiatry that helped recover family relations and control behavior through joyful nonverbal improvisation experiences. Although the aforementioned showed marked improvement of family relations, communications, behavior, and family roles, further research on the subject is required.

Child Trauma

One study by McDonnell (1984) described two cases of hospitalized children suffering from physical trauma. Music therapy intervention with the children's family members enabled reduction of stress, expression of feelings, comfort, and a pleasurable activity in a painful reality. The musical sessions offered an opportunity for parents to contribute to the children's emotional balance. Other than these small samples, no other papers concerning family-music therapy and child trauma were found.

At-Risk Families

Australian researchers performed several large-scale studies in family-music therapy in the Sing and Grow project (mentioned above) focused on early intervention

with families at risk for marginalization due to low socioeconomic status, parental depression, single parenthood, indigenous minority status, young parenthood, addiction, and other risk factors. The project goals were to strengthen parent-child family relationships and enhance child development. The project was established in 2001 by the Australian Government's Department of Child's Abuse Prevention in Queensland and has grown steadily since then. The project offers a 10-week group program for families with infants up to three years of age aimed at improving outcomes for young children by facilitating parental competencies in families identified as at risk of marginalization (Sing & Grow, 2013). Structured sessions designed by music therapists provide the framework for one-hour sessions. Experienced music therapists carry out the sessions in a family-group setting in the community. The main limitations were that the intervention included a parent-child dyad rather than the complete family, the intervention was carried out in a group context and that there was no comparison to a control group.

Researchers collected data using pre- and post-evaluation forms as well as clinical observations and feedback from collaborating organizations. Over 10 large studies performed by a large group of researchers explored the outcomes since 2002. Three recent studies using the Sing & Grow format (Abad & Williams, 2007; Nicholson et al., 2008; Nicholson et al., 2010) totaling nearly 2,000 participants found a marked improvement in overall parenting skills in the family self-evaluation form and the clinical observations. More specifically, the parent self-report measured (a) four aspects of parent-child interactions (i.e., warmth, irritability, self-efficacy, and activities with child), (b) parent mental health, (c) child behavior including social skills, and (d) communication. Clinical observations included parent sensitivity, engagement, and acceptance; child responsiveness; and interest and participation

(Nicholson et al., 2008, p. 233). The overall outcome showed that 81% of participants were very satisfied with the program, 96% would like to do it again, and 99% would recommend it to other parents. Parent self-report measures presented a reduction in angry-coercive parenting and mental health symptoms; an increase in parent-child activities, child communication, and social play skills; and less parent irritability. The Sing & Grow studies did not include a control group, making it difficult to establish whether the changes were due solely to this intervention. However, the large sample gave more validity to the outcomes, and highlighted the achievements of family music therapy to promote family congruence and well-being.

Families with Children with Disabilities

Based on the Sing & Grow project, Williams, Berthelsen, Nicholson, Walker, and Abad (2012) investigated 201 families with children up to five years old who had disabilities. A quantitative analysis provided evidence of overall improvement in parenting skills that highly correlated with the observations and thus added to the results' validity. Although the results were impressive, here too the intervention was group oriented with a parent-child dyad, and there was no control group to substantiate that the improvement was due to the intervention rather than a normal maturation process. Researchers noted that attending a minimum of six sessions contributed to the positive outcomes and that "families who attended more sessions had higher odds of achieving higher outcomes" (p. 40), thus linking the research outcomes to the interventions. An additional limitation was the attendance of only the mothers in the research. Outcomes with fathers' or both parents' attendance need further investigation.

Several small-scale studies of positive parenting and child development included small samples or individual case studies within varied settings (Abad, 2002;

Oldfield, 2008; Oldfield & Bunce, 2001; Pasiali, 2012; Walworth, 2009) highlighted the positive effect of the intervention. Several anecdotal studies focused on selected topics such as adoption (Salkeld, 2008) and teenagers in foster care and their caretakers (Hasler, 2008), and case studies focused on treating families with a neonate or child in intensive care to promote family coping and empowerment (Shoemark, 2004; Shoemark & Dearn, 2008). Additional studies that included a control group could further enhance and validate the results.

"Well" Families

Mackenzie and Hamlett (2005) published the only paper exploring family-music therapy interventions with "well" families in an early intervention project. They studied families in an Australian community program, *Music Together*, for families with children up to four years of age. Contrary to other early intervention studies, this program addressed families who had no additional risk factors or diagnoses. The aims of the study were to improve early attachment and family resilience, reduce the impact of stress on the family unit, and build social support. Music Together offered a weekly one-hour music therapy session with 10 to 15 families who paid a nominal fee. The 140 participating parents completed questionnaires evaluating the effectiveness of the program to enhance parent-child interactions, develop new parenting strategies, and promote social support networks. In all three topics, the parents perceived the music therapy interventions as beneficial, providing "a strong foundation for the use of music therapy to address the needs of 'well' families" (p. 53). The limitations of the study were that it was carried out in a group context, with parent-child dyads and without a control group.

Adult-Focused

Studies of family-music therapy focused on adults were rare. Hinman (2010) explored the potential of music therapy among four couples within a hospital setting and illuminated the ways music therapy offered positive communication, relations, and closeness. Bailey (1984) explored the positive impact of music therapy using two adult cancer patients and their families, while focusing on coping and making positive changes. Hanser, Butterfield-Whitcomb, Kawata, and Collins (2011) studied a small sample of families struggling with dementia of a family member. They noted the caregivers' feelings of higher satisfaction and less burden, as well as more relaxation and comfort for the member with dementia.

Overall, the majority of family-music research has been based on a small number of case studies. Not many have studied large populations or used quantitative research methods, and most had no control groups. There remains a great need to conduct large-scale studies with these populations, as well as use improved assessment and validation tools. In reviewing the current trends in family-music therapy, most studies appear focused on either family group sessions or child-mother dyads. As a result, there is a great void in family-music therapy research involving family-based interventions that are not child centered or do not involve family group interventions or children or adults with special needs.

Family-Music Therapy: from a Family Therapy Perspective

As previously mentioned, literature exploring family-music therapy from a family therapy perspective is scarce. Three articles related to the use of music from a conventional family therapy perspective. Decuir (1991) discussed music therapy where "the family is an integral part of the treatment process" (p. 195), thus changing traditional music therapy targeting individuals to targeting family goals. The musical

media offered additional nonverbal information about communication and emotions, bypassing fixed defensive behaviors, in a relaxed atmosphere. Decuir concluded the active involvement of parents mainly contributed to improved family communication. Decuir's work described individual case studies. He discussed families of children with a variety of special needs (terminal illness, pediatric trauma, autism, mental retardation, and speech and special needs) that were mainly addressed in a hospital setting. Hibben (1992) explored treatment of families with young children using musical interventions. She noted the reluctance of engaging young children in family therapy and suggested playing music is similar to play therapy. That is, music was a suitable media to engage parents and young children playfully to promote communication and individuation and offer children a nonverbal, nonthreatening way to externalize their thoughts, needs, and feelings. The musical intervention was also a persuasive family assessment tool.

Music playing can be seen as a metaphor for family functioning: Who chooses what instrument and how each person holds and plays the instruments provides diagnostic information about the interactional patterns in the family-communication, power struggles, alliances, and roles. The instruments can objectify the inner psychic experience of the family for all to see. (Hibben, 1992, p. 35)

Hibben (1992) described a single case study of a five-year-old boy with behavior problems and his parents. She showed the value of the musical interventions, which promoted family roles and parental functioning, by moving beyond their habitual stances and obtaining functional parent roles that affected the child's behavior and the family as a unit. Hibben stressed that music therapists are "well equipped to include families in their work with children and children in their

work with families" (p. 43) but did not relate the possibility of family therapists borrowing the interventions into their territory. Finally, Miller (1994) examined the potential of music therapy in family therapy "to build a foundation for integrating music therapy with primary, yet divergent, philosophical schools of family therapy" (p. 40). He examined the compatibility of musical interventions with systemic, structural, and strategic family therapy theories using various musical interventions developed to fit those philosophies. Miller stressed the qualities of music as a valuable family assessment tool as well as an intervention for a variety of family therapy objectives including self-differentiation and individuation, developing communication skills, establishing boundaries and structure, expressing emotions, and strengthening parental roles. Miller described two dysfunctional family systems that received several musical interventions in a family therapy context addressing the family as a unit. He noted in the first family, the musical sessions had an impressive impact on promoting positive family communication and family cooperation and enabled the mother to take control and practice parenting skills, express emotions, and regulate anxiety and chaos, as well as experience productive family dynamics. The second family music had a powerful assessment value and means to express emotions, but raised the issue of family members' resistance and fears to participate in a musical session. The musical interventions clarified the potent assessment and intervention potential of music in family therapy and helped formulate a foundation for musical interventions within a family context.

Currently, Jacobsen and Killén (2015) developed a validated, accurate and fast music therapy assessment tool to assess parental competencies and parent-child interactions. It is based on Stern's (1985) developmental model and affect-attunement between parents and child and nonverbal communication skills. They stressed that the

musical experience served as an analogy to real life. The assessment used fixed improvisational exercises and was analyzed using video observations of parent-child interactions. Such assessment tools lead the way to developing family-based music therapy assessment tool.

Group-Music Therapy

The interdisciplinary field of family-music therapy has not yet been solidified, although some implications might be inferred from group-music therapy. The American sociologist Charles Cooley introduced the concept of a primary group. A family is considered a basic primary group "by membership in these groups that the gregarious instinct in us develops and we learn how to live as sociable beings" (Clow, 1919, p. 327). Bates and Babchuk (1961) noted how a primary group has become an accepted concept in sociology, defined by orientations toward other members in the group and the emotional quality of the relationship. More so, group psychotherapy recreates and re-enacts the primary family experiences (Collison & Miller, 1983; Yalom & Leszcz, 2005). As such, the family may be assessed and understood using group psychology and dynamics. On a different note, Sorrels and Meyers (1983) examined similarities and differences between family functioning and group functioning by comparing 11 well-researched group characteristics. Results indicated that merely six of the group characteristics had the same influence in families, implying that research in the field of group-music therapy can be a valuable vehicle of knowledge but should be applied to family-music therapy with reservations and caution. Bloch and Ackerman (1976) contended there is a basic difference between family and group therapy. Unlike groups, families share a past and will have a shared future that affects the dynamics and behavior of a family. The focus in family therapy

is "in the family system rather than in the individual patient," whereas the goal in group therapy is "for change in the individual members" (p. 292).

With this in mind—and with caution—exploring group-music therapy outcomes could reveal possibilities for change and growth within family interventions. Group-music therapy is a popular and widely used music therapy method. It is a highly cost-effective intervention; applicable with different age groups, populations, and settings; and addresses physical, emotional, social, cognitive, and spiritual needs (American Music Therapy Association, 2015).

Building upon group experiences, Pavlicevic (2012) devoted the chapter "Between Beats: Group Music Therapy Transforming People and Places" to the impact of group-music therapy on wellbeing. She ascribed the quality of transformation to group-music therapy and highlighted the attained changes in personal, social, and relational aspects and enhancing personal and interpersonal resources in addition to improving communication.

Cross (2003) compared group-music therapy with groups using spoken language and contended, "Music, rather than being semantically deficient relative to language, encourages a complementary mode of interpretation that is a major source of its appeal" (p. 177).

Group Improvisation in Music Therapy

Music improvisation was defined as the art of making up music "while playing or singing, extemporaneously creating a melody, rhythm, song or instrumental piece" (Bruscia, 1991, p. 5). Music improvisation is one of four basic music interventions (i.e., improvising, recreating, composing, and listening) and has been a well-established intervention in music therapy, which employs making live music. It can range from highly structured to free and unstructured, individual, dyadic, or group

experiences. It can be solely musical or use additional elements such as words, other arts, and voice. It can employ a theme or idea and use diverse musical elements and techniques for varying purposes and goals (Gardstrom, 2007).

Musical improvisations hold many prospects, including personal growth, improved interactions and social competences, and higher levels of wellbeing (McFerran & Wigram, 2005). Although music therapy group improvisation is a powerful and a widely used intervention, the literature focused mainly on individual improvisations and rarely addressed group improvisations. McFerran and Wigram suggested that the difficulty of "communicating these musical processes via the written word" (p. 46) contributed to this scarcity in literature, postponing empirical research in music therapy group improvisations to future researches.

Davies and Richards (2010) discussed the nature of analytical music therapy groups using free improvisation combined with verbal conversation. They suggested that musical and verbal analytical groups have many shared components. Group free improvisations elicited subsequent conversations that directly reflected the improvisations, relationships and communication within the group. The authors shared examples of how spontaneous music playing expressed what language could not express, overcoming verbal defenses. This study outlined how "the experience of the music can be a precursor to putting states of being, relatedness, and the emotional climate of the group into words, thus, making them available for thought" (p. 33).

Most group-improvisation studies used a qualitative approach, studying small samples and individual case studies. For example, Pavlicevic (1999) studied music therapy improvisation with groups of high-functioning adults in South Africa who felt stressed or burnt out. Three intervention methods were used: structured, semi-structured, and unstructured (which included musical improvisations) followed by

group verbal reflections and discussions. Pavlicevic noted the impact of the intervention on promoting participants' expressiveness, communication, and relations.

McFerran-Skewes (2000) studied six bereaved adolescents in a 10-session music improvisation group. The group improvisation created an opportunity for the participants to experience group empathy; the improvisation and verbal reflections facilitated emotional expression and enabled the participants to reveal their current emotional state in a safe environment. Similarly, McFerran, Roberts, and O'Grady (2010) studied two music improvisation groups of 16 bereaved adolescents. The outcomes were similar, noting an overall improvement of emotional expression as well as better coping behaviors. The promising outcomes from the above short-term group music therapy studies appeared to be adaptable to family therapy, which could similarly employ free improvisations along with verbal discussions.

Improvisation and Musical Congruence

Corresponding to Satir's concept of family congruence, musical congruence may be defined as a state of openness, awareness, acknowledgement, and connectedness between and among all improvising members that is musically demonstrated. Musical congruence may employ constructs of congruent musical communication, relationships and roles, individual and mutual awareness, acknowledgement of and respect for others, and musical individuality and mutual connectedness, as well as a spiritual, energetic experience. The current research aspired to promote family congruence by promoting family musical congruence—family and musical parallel processes seeking harmony. Current literature provided some insights concerning the interconnection between family music improvisation and congruent family functioning.

Music, Communication and Relationship

Stern's (1985) child development of self and Bowlby's (1982) attachment model emphasized the primary relations achieved through maternal attunement, responding, matching and mirroring, and providing a safe environment for development (Davies & Richards, 2010; Stern 1985). Stern (2010a) further theorized that inherent musical elements have a major effect in achieving intersubjective contact between participants. This phenomenon of mutual *affect attunement* between infant and parent plays an important role in developing the sense of self and connection to others. This nonverbal subliminal experience precedes verbal interpretation, because "music comes before lyrics" (Stern, 2002, p. 4).

In fact, Sawyer (1999) contended that conversations employ similar characteristics to musical improvisations. That is, both are unplanned collaborations of participants that cannot be predicted; they call for spontaneity and listening and involve mutual responses. More so, Bruscia (1987) contended that verbalization and improvisation mutually stimulate one another, promoting social connections, identification, and empathy; exchanging ideas; and sharing feelings with others.

Trevarthen and Malloch (2000) found *musicality* to be an innate capacity of the newborn child. This intrinsic musicality and rhythm enables the baby to perceive body movement, melody, and voice in a rhythmic organization making sense of the surrounding information and seeking mutual communication. More so, Blacking (1973) proposed that music is an ethnosociological experience, reflecting the inner experiences and personal meanings made within a particular society and culture. He noted that there is no absolute, measurable quality of music. It cannot be judged, criticized, or dismissed by others because it is a musical product of the inner and outer interrelations between self and others. Similarly, Cross and Woodruff (2009)

suggested musical communication has universal, biologically inherent factors that affects the individual's musical meaning based on the individual's past experiences and social contexts. Cross (2001) emphasized the biological evolutionary capacities for innate human musicality that influence and contribute to the development of flexible social interactions.

Miell, MacDonald, and Hargreaves (2005) expanded the comparison of music and communication. They illustrated how music acts as a fundamental channel of communication for sharing and communicating emotions, intentions, and meaning making. They noted music's impact on the body and body functions, as well as music's impact on the brain structures.

Molnar-Szakacs and Overy (2006) studies of the brain noted music's unique abilities affecting the development of emotional and social interactions and communication using processes involving mirror neurons and other brain formations. "We propose that human mirror neuron system may subserve some of these effects, linking music perception, cognition and emotion via an experiential rather than a representational mechanism" (p. 139).

Families making improvised music together in a family-music therapy session may similarly employ the interrelated connections among the musical components and social communication and their interaction with the family members, the family agenda, and the context in which it is situated. Attunement, matching, and imitating qualities are fundamental aspects of music improvisation. In family music therapy, families encounter what is reflected from the improviser's inner world and how it is matched and mirrored by other family members. Borrowing from group-music improvisation, family-music improvisation can similarly accentuate the relationships within the family. The therapy strives for balance and a nurturing, safe place that

enables individual and family development and growth. Coalitions, cast outs, separation, and enmeshment are all family concepts that can be instigated in family-music improvisation. They unbalance and disrupt the family and musical congruence, and can be addressed through musical interventions.

Theories in communicative musicality (Malloch & Trevarthen, 2009), musical dialogues (Trevarthen & Malloch, 2000), and affect attunement (Stern, 1985) may play a role in family-based music therapy, where mutual music improvisation that involves responding, matching, and communicating may similarly support the development of self in relation to others.

Music, Individuality and Self-Expression

Margaret Mahler described the process of the child moving away from the mother-infant dyad towards greater individuation and independence. This separation-individuation process can be achieved when a child can hold within himself or herself the maternal concept and feels safe to explore and investigate the world without the mother's presence (Kerr et al., 2008, p. 72). This process repeats in the adolescent search for independence and individual identity. Strategic family therapy founded by Bowen focused on differentiation of self a central task that "must be completed to achieve adulthood and establish intimate and satisfying relationships" (Kerr et al. 2008, p. 100). Highly differentiated individuals will be neither overly involved nor cut off from other family members, but rather be able to stand up for themselves and their needs with individual congruence, being able to speak, feel, think, and act regardless of external pressures.

Music improvisation is mainly a group experience of collaboration, group challenges, and collective creativity, although solo players are acknowledged as well (Sawyer, 1999). The soloist listens to the group and is inspired with new rhythms and

harmonies. The soloist is a part of the group's harmony, rhythm, and themes and simultaneously stands out with his or her own individual music. Individuals seen and acknowledged by others gain a sense of their own selves as reflected by others in the room, similar to infants' early experiences of maternal mirroring (Winnicott, 2005).

In a congruent family, there is a place for the group as well as for the individual. Clinical improvisation provides a place for self-expression and externalization of feelings, ideas, images, and fantasies (Bruscia, 1987). This developmental task of individuation can be practiced in the safe, accepting environment of family-music improvisation.

Music Enhancing Vitality and Life-Energy

Bruscia (1987) described improvisation as a cycle of energy flowing from the improviser, the instrument, and the music back to the improviser and listener. This energy varies between stimulating and relaxing and regulates energy and tension levels between the client and the therapist. This energy can rise to the level of a peak experience, a joyful experience of "release, union, and beauty" (p. 565).

Stern (2010b) explored conceptual forms of vitality. He contended that vitality is "a manifestation of life, of being alive" (p. 3) and that the arts, including music, move us "by the expressions of vitality that resonate in us" (p. 4). Vitality originates in both physical and mental processes and is the most fundamental of all experiences among people and relationships. Music seems to cause similar body reactions in different people at the same time; it therefore has the power to connect and unite a group. Music intensifies emotions by creating mutual resonance and instigates high arousal states and vitality by touching our bodies and minds, making connections, and making more sense of our inner experiences. Stern (2010a)

concluded that music is not a sensation, an emotion, or a cognition; nonetheless, it impacts, moves, and resonates with all of us.

New Dimensions in Neuromusicology

Studies in neuroscience highlighted music's effect on the brain and body functions, illustrating the impact of music on communication, intrapsychic, and social interrelations with others. Neuroimaging supports the outcomes of many studies in musical processing (Overy & Molnar-Szakacs, 2009). Music was shown to influence a person's energy levels, emotions, social interactions, social connections, communication, empathy, and understanding others. It promotes cohesion, cooperation, shared goals, and physical synchronization (Koelsch et al., 2010; Molnar-Szakacs & Overy, 2006; Overy & Molnar-Szakacs, 2009; Stegemoller, 2014). Family-music therapy improvisations may evoke similar reactions, suggesting that recent neuromusicology research may help explain the ways in which music stimulates biological neuron paths and brain formations. As it powerfully effects our emotions, communication, interactions, and dynamics (Overy & Molnar-Szakacs, 2009), it promotes family communication, relationships, and dynamics.

Engaging in music is clearly not a passive experience. Rather, it is "physical, social, synchronized interactions involve imitation, learning, shared understanding, and prediction, and can encourage eye contact, smiling, laughter, and relationship building, while also allowing for leadership, competition, and individual expression—all powerful social learning experiences" (Overy & Molnar-Szakacs, 2009, p. 489).

Conclusion

Family-based music therapy literature is uncommon and sporadic. Building upon the knowledge gathered from family-music therapy studies, experiential family therapy, family-art therapy, and music therapy groups, there seems to be a stable

theoretical foundation for continued research in the interdisciplinary field of family-based music therapy for treating non-clinical families. Developmental and communication theories as well as neuromusicology studies offer new dimensions to understanding the family musical experience, further supporting family-music therapy.

Based on the literature and its evident gap in research of musical interventions in family-based therapy, this study aims to shed more light and understanding on the applicability and therapeutic value of providing musical interventions in the family therapy context, carried out by family therapists treating non-clinical families.

CHAPTER 3

Methods

This study explored family therapists' perceptions concerning the use of musical interventions in the family therapy context. The study sought to provide a better understanding of the family therapists' existing perspectives on using music therapy interventions in family therapy. More so, how those perceptions changed after a single family-based music therapy training session, and after implementing the family-based music intervention in their clinical settings. Additional questions evaluated the therapeutic aspects of the intervention and the professional value of family-based music therapy interventions in family therapy. Finally, the study evaluated the training workshop and sought recommendations for the future development of the model.

This study employed a *sequential* and an *explanatory mixed methods design* (Creswell, 2008); using a quantitative instrument to develop a basic understanding of the therapists' perceptions, along with open-ended questions and interviews for qualitative explorations. Combining a quantitative instrument with qualitative questions and interviews enabled a deeper understanding of the research questions and consequently added more credibility to the study's conclusions (Hesse-Biber, 2010). The information was gathered sequentially in four phases, enabling the researcher to investigate the changes in family therapists' perspectives at different phases of the research. The study's main emphasis was on the qualitative strand, which offered extensive explanation for the quantitative data using rich descriptions of the therapists' experiences.

Recruiting

The research goal was to recruit as many family therapists as possible to participate in the study. Potential participants were recruited using various strategies. First, a letter of invitation to participate in the research (Appendix A) was sent to fellow clinicians, family therapists, personal contacts, and other professionals who could either participate or suggest suitable referrals. Second, the recruiting letter was posted on a social networking site. Third, the same letter was posted on *The Israel Association for Couple and Family Therapy* website. This association allows such posts only in the "wanted" section, which limited its circulation. Finally, the letter was e-mailed to family counseling centers and organizations listed with the official Israel Association for Couple and Family Therapy, inviting them to take part in the research; either individually or as a staff-training group, that would be introduced to family-based music therapy as an additional family therapy technique.

The recruiting letter invited family therapists from the entire country to take part in the study and offered training in several different locations. The letter explained the nature of the research, which aimed to examine the perspectives of family therapists concerning the use of a musical intervention in family therapy. The letter highlighted the added professional skills afforded by the research training and clinical application of an innovative family-based music intervention. The researcher aspired to reach and include as many participants as possible in the research, providing as large and diverse a sample as possible.

Sample Size

In the period between January and July 2015, the researcher recruited 35 certified family therapists, who provided information concerning their initial perceptions towards using music in family therapy, and participated in the training

and its evaluation. Subsequently, only 18 family therapists actively participated in the implementation of the musical session in their clinical work. These *active participants* provided data from their clinical experiences with 38 families who each received a single family-based music session.

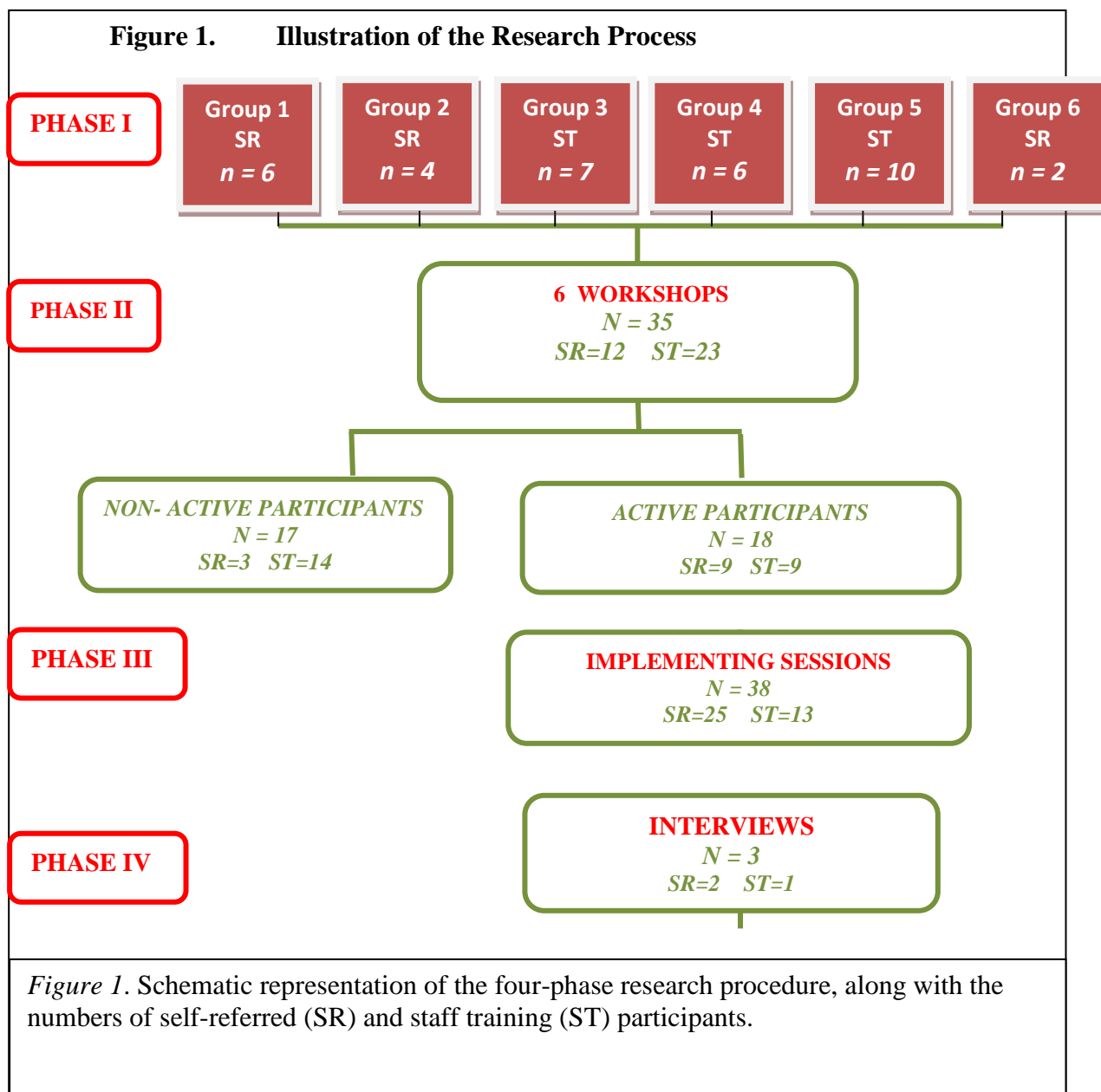
Following sample size guidelines (Teddie & Yu, 2007), the sample size of this study was tailored to fit the research aims and resources (time, money, etc.). The research placed more emphasis on the saturation of the qualitative data than on the representativeness and generalizability of the conclusions to a wider population.

Confidentiality and Ethical Considerations

The Institutional Review Board of Lesley University approved the study. Prior to commencing the research, each participant signed an informed consent form (Appendix B) to participate in the research. In the consent form, as well as in person, the participating family therapists were informed of the nature and purpose of the research and the procedures involved in participating in the study. The participants were invited to ask, and were given answers, to any questions or doubts. The participants were advised of the option to leave the study at any time without consequences. Participants were assured full anonymity and confidentiality; their names and other identifying information were excluded. On the forms, as in the dissertation or other publications, pseudonyms were used.

Procedure and Data Collection

The research was designed to follow four sequential phases, which are illustrated in Figure 1. (a) Pre-intervention data collection, (b) Training workshop, (c) Implementing family-based musical interventions in clinical practice, and (d) Individual interviews. Data were collected and analyzed separately for each phase and combined to outline the final outcomes of the study.



Phase I: Pre-Intervention

In the first phase, the study examined the initial perspectives of family therapists concerning the use of music in family therapy and their confidence in applying a musical intervention in their clinical setting. Participating family therapists were invited to complete a demographic questionnaire prior to any intervention (Appendix C). The researcher designed the questionnaire for the purpose of this study and included participant demographics, professional and contact information, musical background, and prior experience with expressive arts in therapy. An open-ended

question asked participants to describe their initial response to the initiative to use music in family therapy. This information formed the baseline for each therapist's perceptions concerning application of musical interventions in family therapy.

Participants. Thirty-five certified family therapists working in Israel responded to the invitation to participate in the study. There were no limitations or additional qualifying criteria for participation (e.g., professional background or training, gender, age, years of experience, etc.) other than being qualified family therapists. Table 1 displays their demographic characteristics.

Table 1

Participants' Demographic Information

	<i>n</i>	<i>M</i>	Range	%
Age		53.0	36 - 69	
Years of experience		11.1	0 - 25	
Gender				
Female	32			91.4
Male	3			8.6
Education level				
PhD	3			8.6
MA	31			88.6
BA	1			2.9
Education in expressive arts				
Music	0			0
Visual arts	2			5.7
Dance/movement	4			11.4
Drama	1			2.9
Psychodrama	1			2.9
Nature therapy	1			2.9
Family therapy orientation*				
Experiential	17			48.6
Bowen	17			48.6
Structural	12			34.4

Narrative	6	17.1
Psychoanalytic	6	17.1
Adlerian	5	14.3
CBT	5	14.3
Other	7	20.0
<hr/>		
Use of creative arts in clinical practice*		
Music	7	20.0
Visual arts	17	48.6
Dance/movement	7	20.0
Drama	10	28.6
Psychodrama	12	34.3
<hr/>		
Recruiting method		
Self-referred	12	34.3
Staff training	23	65.7

Note: $N = 35$

*Some participants fell into more than one category.

Of the 35 participants enrolled in the study and received the training, 18 (51%) implemented the family-music intervention in their clinical work. They are henceforth referred to as *active participants*, while the remaining participants are referred to as *non-active participants*.

In an attempt to adhere to a multicultural approach, the study invited therapists of all cultures, identities, and backgrounds to participate and maintained high ethical and moral standards of professional and personal practices. Although all participants were Jewish, the majority was secular Ashkenaz, and less than 10 were Sephardic Jews. Five were religious, and one was from an Ethiopian descent, one new immigrant from Argentina and two from Russia, with a majority of native Israelis.

Phase II: Training

The second phase provided therapists with a single family-music therapy workshop, training family therapists to implement a musical session focused on *family*

roles. Family roles are conscious or unconsciously assigned positions of the family members. Each family role plays a part in the family balance. A functional family strives toward clear and flexible roles that are adaptive and developmentally appropriate. In a dysfunctional family, roles are rigid, developmentally inappropriate, and restricting. Dysfunctional family roles reflect the family members' low self-esteem and will be manifested by incongruent family communication stances (Satir, 1983).

Subsequent to the workshop, the researcher explored the therapists' perceptions concerning the training, and how their confidence to implement a musical session changed following the workshop. Following the pre-intervention phase, the 35 family therapists received a single 3 to 4 hour training workshop given by the researcher. Six workshops were carried out between January and April 2015 in small groups of two to 10 participants. Three workshops were held in family-therapy centers that invited all their staff ($n = 23$) to participate in the workshop, and the other three workshops were held for self-referred therapists ($n = 12$). The training objectives were to prepare family therapists to implement the family-based music intervention *Family Roles* (Appendix D) in their clinical practices. This same intervention had been used in a preceding pilot study (Nemesh, 2014) and was found to elicit valuable assessment information and intervention opportunities.

This short training was intended to offer certified family therapists the theoretical knowledge and practical experience and skills needed to implement the family-based musical intervention.

Objectives. The training objectives were as follows. The participants will:

- Understand the theory behind the family-based musical intervention.

- Become familiar with and experience the various musical instruments provided in the session.
- Experience the subjective projection process onto the musical instruments.
- Take part in a "family role" musical demonstration, following step-by-step pre-structured guidelines.
- Practice implementing the musical session and verbal process questions.
- Be encouraged to ask questions and relate to the musical session, difficulties, obstacles, resources, and suggestions that might hinder or promote implementation of the session in their clinical settings.

Procedure. The training began with the family therapists becoming acquainted with the musical instruments. In an initial experiential activity, the therapists were familiarized with the projective qualities of the musical instruments. The researcher then presented the theoretical foundations of the research, providing participants a written summary of the information along with additional reading recommendations (Appendix F).

Following a short break, the participants took part in a simulation of a family-based music therapy intervention conducted by the researcher. Therapists who were not participants in the role-play were observers. The simulation adhered to the *family roles protocol* (Appendix D) given to the observers to follow along with the process. The simulation was brought to a closure after 45 minutes. The participants reflected on their experience as participants and observers. The researcher addressed queries about the process, explained the various issues enacted, and clarified the therapeutic goals and considerations employed by the researcher.

Finalizing the workshop, a volunteer member of the group discussed a family in therapy and conducted a family-based music therapy simulation using participants

from the group. Other therapists who desired to experience the role of leading were positioned as consultants. The session was concluded after 45 minutes with questions to the practicing therapist, researcher, and participants.

Evaluation. At the close of the workshop, each therapist evaluated the training using a questionnaire (Appendix G) designed by the researcher for this purpose. The questionnaire addressed accomplishment of the training objectives, and participant satisfaction, identified training weaknesses and strengths, and inquired about prospects of future training.

Phase III: Implementing Family-Based Musical Interventions

In phase three, the family therapists were asked to implement the family-based music intervention with families in their clinical work. Within this research, a *family* was defined as at least three persons who are related in any way—emotionally, biologically, or legally—with commitment and a relationship with each other connected by past and future histories. Following the application of the musical session in their clinical work, the researcher explored their perspectives on the applicability, therapeutic value, and contribution to their professional growth.

Each family therapist was asked to implement the musical intervention with at least three families in their clinical practice. The criteria for suitable families were (a) families participating with at least three family members and (b) families whom the family therapist had preliminarily assessed prior to the intervention. Each family was to receive a single musical intervention focused on family roles using the same intervention protocol and guidelines used in the training workshop.

Logistics. The researcher provided a set of musical instruments (Appendix E) to the family therapists who required them for the research intervention. The therapists coordinated delivery with the researcher. Each set of instruments included

an eclectic selection; percussion, wind, and stringed instruments; and a variety of ethnic and indigenous instruments made of various materials with diverse sounds that were easily portable and stored. Initially, two complete sets of musical instruments circulated among the participating therapists. Later, a third set of instruments was added to enable more therapists to deliver the intervention simultaneously.

Evaluating family sessions. Following each family-based musical intervention, the family therapist completed a questionnaire evaluating the session (Appendix H). The questionnaires were completed online and sent directly to the researcher. There was also an option for a paper version to be sent by mail. The researcher designed the questionnaire to assess the family therapists' perspectives on the use of the musical *family roles* intervention with each family.

Promoting Persistence. To retain the therapists during the research and ensure maximum participation, the researcher made participation as convenient as possible. Some conveniences included creating user-friendly online questionnaires; delivering musical instruments as needed; providing assistance, support, and supervision with questions and uncertainties; and offering easily accessible communication with the researcher by telephone and Skype.

Approximately every two weeks the researcher e-mailed participants who implemented the intervention, acknowledging their efforts and informing the participants of the ongoing progress of the data collection. They were reminded of the importance and value of the research to the field, and were encouraged to continue their active participation. The researcher also sent letters to those who did not implement the intervention to inquire about the difficulties in implementation. The open communication incentivized participants to persist with implementing the musical sessions.

Phase IV: Interviews

In this final phase, aiming to establish a profound understanding of the therapists' experiences applying family-based music therapy, the researcher interviewed several participants to gain additional and comprehensive insight on their experiences as well as their prospects for future family-based music therapy interventions. The researcher conducted individual interviews with family therapists who implemented the intervention. The aim of the interviews was to obtain a deeper and detailed understanding of experiences and perceptions of applying a family-based musical intervention in family therapy. The interviews intended to clarify information from the questionnaires, uncover new information, and inquire about future application of the model (Creswell, 2008).

Three interviewees were purposely selected, choosing participants with highest active participation rate; with three interventions or more. The researcher aimed to include participants whose experience could shed more light and understanding on the therapists' experience with the family-based musical intervention. The sampling considered including a diverse selection of participants reflecting different populations in the study. Initially, three interviews were planned. Considering additional interviews was guided by reaching saturation of the information after three interviews - a point where no new ideas and concepts emerged from the interviews (Creswell, 2008).

All interviews were carried out during the months of June and July 2015. The interviews were scheduled at the participant's convenience and conducted in person by the researcher. Each interview lasted between 45 minutes and one hour. Interviews were recorded using an audio recording device.

Structure of interviews. The interviews were unstructured and based on three very broad explorative questions that enabled the interviewees to discuss their experiences freely using their own ideas and choosing their own emphasis as much as possible. The three guiding questions were compiled to assure interviewees addressed the issues of interest to the research (Creswell, 2008).

- "Can you describe your experience in applying a family-musical intervention from the first encounter with this initiative until now?"
- "What have been the main difficulties and gains for you?"
- "In your opinion, how should the family-based music therapy model proceed from here?"

The researcher asked additional questions to clarify and expand the concepts brought up by the interviewees.

Data Analysis

Phase I to Phase III included two strands of data—quantitative and qualitative. Each data analysis followed a similar process for analyzing the quantitative and qualitative data. Phase IV, the individual interviews were analyzed qualitatively. Additionally, inferential statistics were used to track changes in family therapist's levels of confidence to apply a musical session, which were collected along three phases of the research.

Quantitative Data Analysis

Five survey items from the pre-intervention questionnaire inquired about the therapists' previous musical experience, previous use of expressive arts in family therapy, the potential of music as a family therapy interventions, and confidence to implement family-based music therapy interventions. The latter item was repeated in each questionnaire tracking the changes in confidence along the research.

The training evaluation included 13 items, which explored the participants' overall satisfaction with the training session and instructor's performance. The items explored points for improvement, future implications and the influence it had on their confidence to use the family-based music interventions.

The post-intervention quantitative analysis included 21 items. They addressed issues of feasibility (items 2 to 7), impact on the therapist's professional skills (items 8 to 9 and 12 to 16), the likelihood of continuing to use a family-musical session (items 10 to 11), and the therapeutic value of the session (items 17 to 21). Additionally, the questionnaire included the item measuring confidence to apply the intervention (item 1) which was used in the two previous phases. Items 7, 15, and 20 were scored in reverse (i.e., a response of "1" scored five points, a response of "2" scored four points, and so forth).

A descriptive analysis of the data offered insight into the family therapists' perspectives on each category as well as analysis of single items within the categories. The data offered a broad picture of the therapists' experience of the sessions.

Tracking Changes in Family Therapists' Confidence

Using inferential statistics, the study compared the results of one question repeated in three phases of the study: "To what extent do you feel confident to apply a family-based musical intervention?" The first scores were collected from the pre-intervention questionnaire; the second scores were collected after the training session from the training evaluation questionnaire; and the third after implementation of the intervention, from the final questionnaire the therapists completed.

Qualitative Data Analysis

The qualitative data included open-ended questions from the three questionnaires used in phases I to III, as well as the final interviews. The open-ended

questions and the final interviews were manually transcribed. Each open-ended question was thematically analyzed separately as a single item across participants, reflecting the significant common themes while avoiding cross-contamination from other items. Each interview was individually analyzed, and was then compared with the other interviews across participants.

The pre-intervention data included two open-ended questions, which described (a) the therapist participants' musical background, and (b) the initial responses to using family-based musical interventions in family therapy. The training evaluation data explored four open-ended questions. They inquired about (a) therapist's personal gains, (b) drawbacks, (c) additional requirements that might support implementation of the intervention, and (d) ideas to improve the workshop.

The post-intervention qualitative data included six open-ended questions focused on (a) perceived strengths and (b) weaknesses of the intervention, (c) how the training contributed to the families' wellbeing and (d) the therapist's professional growth, (e) comments about the musical instruments, and (f) any supplementary information they wished to add about the session.

The researcher used Atlas.ti qualitative analysis software to organize and analyze the data. The researcher followed a strict thematic analysis procedure according to Creswell's (2008) three-stage analysis recommendations. In the first stage, the researcher reviewed all answers to each question separately; assigning codes to quotes that represented a wide range of themes. The second stage included sorting and identifying overlapping themes and merging codes into distinct themes. Finally, the codes were sorted into sub-theme that highlighted similar aspects connected to an overarching category. Each category and sub-themes within the categories were accurately defined and named. Quotes were assigned to represent

each theme within each category. These quotes were presented in the Results chapter characteristic responses.

Interview Analysis

The recorded interviews were transcribed verbatim and analyzed in an iterative fashion, using phenomenological guidelines. The researcher sought to identify significant statements by the interviewees, ascribing them with appropriate codes and grouping them according to main categories and sub-themes.

Interviews were analyzed in an effort to maintain an individual focus, following Ayres, Kavanaugh, and Knafel's (2003) guidelines of "within-and-across-case analytic strategies" (p. 873). The independent analysis of each interview was meant to avoid contamination of the data across interviews. Consequently, the researcher compared the three interviews to identify the significant statements, themes, and categories common to all interviews and generate an overall description of the findings across the interviews.

Integration of Quantitative and Qualitative Data

Integration of both quantitative and qualitative data was performed following each phase in the process of the research, and is presented within the Results chapter. A *concurrent triangulation design* aspired to corroborate the outcomes of the two strands of data, strengthening the knowledge and findings of the study. The integration design gave priority to the qualitative information (Creswell, 2013).

Integration of the entire research outcomes, which included the four sequential phases, was performed at the final stage of results section. The final integration offered a broad view of the complete process of the research.

Role of the Researcher, Personal Bias, and Reflexivity

The personal experiences of the researcher were the main drive and influenced the dissertation topic. As music and a family therapist, the researcher experimented and developed a model for family-based music therapy interventions. Training other family therapists to use this model and exploring their experiences, naturally brings certain personal influences and biases. To further objectivity, it was important for the researcher to acknowledge and critically evaluate and examine personal biases and influence of the researcher on the participants and the research outcomes (Creswell, 2014).

As the research explored a phenomena based on the unique experience of the researcher, recruiting, training, data collection and interviewing relied on the experience and skills of the researcher. Ideally, teaching the researched intervention would not be done by the researcher. In reality, there was no one other than the researcher capable of delivering the training or interviewing. Because of the therapeutic nature of the activity, the researcher offered support and supervision; addressing questions encountered along the research but only after the session evaluation was completed by the participant, to avoid any influence of the supervision on the initial research results. In order to obtain accurate and unbiased information as possible, following the training, the participants implemented and evaluated the intervention without any involvement of the researcher.

As personal bias and subjectivity were unavoidable in the research, the researcher used several methods to minimize and critically evaluate personal bias and preconception about the interpretation of the data. Specifically, regular discussions and consultations were carried out between the researcher and a professional supervisor throughout the study. This enabled the researcher to reflect, clarify, and

differentiate between personal ideas, preconceptions and beliefs and the actual outcomes. Furthermore, in the analysis stage, an additional coder, a Master's level drama therapist and a family therapist was asked to review the transcriptions and individually code the data. The majority of themes and categories were initially in mutual agreement. Several themes, which elicited disagreement, and differences were discussed, lengthily debated, and then revised until fully resolved and agreed.

Finally, once the results were summarized, and in order to reduce the researcher's bias, an external audit was obtained. That is, a Master's level experienced art therapist and supervisor reviewed the methods and research findings, interpretations and conclusions. Several mutual meetings were scheduled offering feedback, questions concerning the methods and the results, raising questions about researcher's possible points of bias and offering additional points of view. For example, the researcher's interpretation for the rate of active participants in the research. What the researcher found as discouraging when 49% of the participants dropped out, the external audit found logical and encouraging, as music does not appeal to all family therapists, and an active participation of 51% was to be celebrated. Another example was the notable effect previous acquaintance with the researcher and the researcher's work had on the response to the recruitment letter, as well as on active participation. This issue might have been overlooked by the researcher who was not aware of this earlier.

For the most part, the assessments of the external reader added important knowledge in the process, offering additional perspectives and insights, and highlighted the 'blind spots' of the researcher.

CHAPTER 4

Results

The results present quantitative descriptive and inferential statistics along with qualitative thematic data analysis for the four sequential phases. The first offered information about the family therapists' demographics and prevalent perceptions towards using musical interventions in family therapy. The results from the second research phase report the influence of the single workshop on their perceptions and attitude. Results of the third phase examine changes after therapists implemented the musical sessions in their family therapy clinical settings. Finally, results of the interviews afford the research with individual experiences and insights from the entire study.

Phase I: Pre-Intervention Data Analysis

Quantitative Results

Five survey questions offered information about family therapists' initial perceptions regarding the use of music in family therapy. Results from participants ($N = 35$) are presented in Table 2. The analysis examined single-item scores that indicated general tendencies in the data and offered a broad picture of the initial perceptions of therapists before the intervention was carried out.

Table 2

Pre-intervention Scores: The Use of Music in Family Therapy

Question	<i>n</i>	%	<i>M</i>	<i>SD</i>
How knowledgeable and skilled are you in music?			2.31	1.08
Not at all	10	29%		
Slightly	9	26%		
Moderately	12	34%		
Very much	3	9%		
Extremely	1	3%		
How knowledgeable and skilled are you in other forms of art?			2.83	1.20
Not at all	4	11%		
Slightly	12	34%		
Moderately	9	26%		
Very much	6	17%		
Extremely	4	11%		
To what extent will your musical knowledge influence your ability to perform a family-based music session?			2.89	1.21
Not at all	6	17%		
Slightly	5	14%		
Moderately	15	43%		
Very much	5	14%		
Extremely	4	11%		
To what extent does family-based music intervention have a potential of becoming a common family therapy intervention?			3.31	1.05
Not at all	1	3%		
Slightly	7	20%		
Moderately	12	34%		
Very much	10	29%		
Extremely	5	14%		
*To what extent do you feel confident to apply a family-based music intervention?			2.94	1.26
Not at all	6	17%		
Slightly	6	17%		
Moderately	11	31%		
Very much	8	23%		
Extremely	4	11%		

Note. The questions were rated on a 5-point Likert type scale (1 – not at all, 2 – slightly, 3 – moderately, 4 – very much, 5 – extremely).

N = 35. *This question was repeatedly rated, tracking changes in family therapists' confidence levels.

Complementing this data is Table 3, which exhibits the participants' use of expressive arts in their clinical practice.

Table 3

Participants' Use of Expressive Arts in Family Therapy

Expressive art	Never	Rarely	Occasionally	Frequently	Very frequently	Total use of the art <i>n</i> (%)
Music	28	6	-	1	-	7 (21%)
Visual art	18	11	5	1	-	17 (49%)
Dance/Movement	28	3	2	1	1	7 (21%)
Drama	25	2	8	-	-	10 (29%)
Psychodrama	23	7	4	1	-	12 (34%)

Note. $N = 35$.

Results illustrated family therapists rarely used music in their clinical work, and at rates comparatively lower than visual arts or most other expressive arts. The use of music in family therapy was notably higher for nine family therapists with education in expressive arts ($n=4$; 44%).

Almost all participants were concerned to some degree that their existing musical experience and skills would influence their ability to perform a family-musical intervention, as reflected in their scores ($M = 2.89$, $SD = 1.21$). Most therapists anticipated that their current musical skills will have either a low or a moderate effect ($N = 20$, 57%) while few anticipated a high or substantial effect ($N = 9$, 26%). Only six (17%) considered their existing musical skills would not prevent them from applying a musical intervention.

On the other hand, the scores show that the therapists perceived the potential of family-music therapy of becoming a common family therapy intervention as higher than moderate ($M = 3.31$, $SD = 1.05$). A considerable number ($N = 15$; 43%) of participants believed family-music therapy had a high and substantial potential, additionally many ($N=12$, 34%) saw a moderate potential. Only few saw only slight potential for family-based music therapy ($N = 7$, 20%) and merely one participant saw no potential for family-based music therapy.

Overall, analysis of the quantitative data revealed that most family therapists participating in the research had little knowledge and skills in music, comparatively less than their skills in other expressive arts. They perceived that lacking musical skills would affect their ability to use music as a therapeutic intervention. Yet in contrast, they considered musical interventions to have a good potential in becoming a common family therapy intervention. At this point, the therapists' confidence to apply the musical intervention was slightly lower than moderate ($M=2.94$; $SD=1.26$), and most stated they were moderately confident to try the musical intervention ($N = 11$; 31%).

Qualitative Results

Q1: Musical experience. The first question offered information about the participating therapists' past musical experience and background, such as playing instruments/studying music, singing in a choir, and other significant memories. Thirty-five responses were represented in four categories. Three categories overlapped and supported the quantitative data as exhibited in the following characteristic examples presented along with the number of matching responses: Having no musical experience ($n = 9$, 26%):

#17 "I have no experience other than the love for music."

Having basic musical experience ($n = 14$, 40%):

#28 "I played the recorder in elementary school."

Having significant experience ($n = 12$, 34%):

#26 "I played the mandolin, flute, as well as the oboe in the Symphonic Orchestra."

A fourth and new category that emerged reflected negative musical experience - especially in early childhood ($n = 5$, 14%):

#1 "I have negative feelings and perceptions about my musicality, a total lack of talent, especially the use of my voice. These led me to avoid any personal expression using music, and certainly not any musical professional expression."

#2 "At the age of 10 or 12 I tried to play the piano. My main memories are that I am very much an off-key musician."

Evidently, this theme of previous negative musical experience and personal perception of lack of musical abilities surfaces along the research, and was perceived as a major inhibitor for implementing a musical intervention.

Q2: Initial perceptions. The second question displayed the initial responses and perceptions of family therapists to the suggestion that they implement a musical intervention in family therapy.

Analysis revealed that the majority of responses elicited a positive reaction ($n = 25$, 71%) exhibiting curiosity, enthusiasm, openness to new ideas, and an opportunity to learn and use a new tool in therapy. They expressed their belief in the power of music to impact individuals and families and make changes through music's non-verbal, experiential and non-conventional characteristics. They noted music's ability to bridge people and promote communication, as well as create an activity of fun and vitality. In addition, they noted previous experience with music therapy in a variety of contexts as a positive incentive that drew them to engage in the study.

Three participants stated that exposure to the researcher's work with family-based music therapy was a meaningful incentive to join the research and acquire a musical technique for family intervention. Examples of positive responses:

#3 "I am so excited about using music in family therapy. I can only imagine all the experiential languages in such a session: the instruments..., the sounds, the rhythms."

Other responses conveyed either duality ($n = 8$, 23%) or an entirely negative attitude ($n = 2$, 6%) towards using music in family therapy. These participants' raised concerns which involved their lack of musical skills and knowledge that would be in their way, fear of using a new and unknown media, self-doubt and lack of confidence in their ability to execute the intervention, and fear that the session would not meet the client's needs or would disrupt the family therapy process.

6 "I fear that the lack of musical skills and understanding in music will come out and interrupt."

Two participants (6%) whose responses were entirely negative considered family-based music interventions either "nonsense" or "not applicable" in their work with families. They also conveyed feelings of anxiety from their clients concerning the use of music in therapy.

#30 "This seems to be not applicable to my patients; they have a hard time opening to unconventional interventions."

Both participants joined the workshop in order to examine the media closely and maybe change their attitude.

Integration of Quantitative and Qualitative Data.

The qualitative data seemed to well support the quantitative data. The data highlighted that the majority of participants who joined the research had no significant musical background, and had minor experience using music in family therapy. Family

therapists were hesitant to use music in family therapy. They used music notably less than other expressive arts, especially compared to visual arts. Therapists with dual expertise; expressive arts and family therapy trainings, used notably more expressive arts as well as music in their practice.

Two conflicting attitudes towards musical interventions in family therapy were presented. On one hand a positive reaction; with moderate confidence to apply the intervention, supported by their belief in music's non-verbal therapeutic qualities, and their acknowledgement that music has high prospects as a therapeutic tool in family therapy. This attitude was demonstrated through their considerable enthusiasm to participate in the study. What more, many therapists, who were previously exposed to the researcher and her work, noted how this influenced their decision and willingness to participate in the study.

On the other hand there were concerns which evoked a dual reaction towards using a musical intervention. Their lacks of musical skill, or negative musical experiences, were perceived as inhibitors to implementing a musical intervention. Extreme responses, which completely rejected the family-musical media, were rare, and included feelings of anxiety, embarrassment and perception that music is "nonsense".

Phase II: Post-Workshop Evaluations

The second phase of the research collected information concerning the family therapists' experience with the single 3 to 4 hour workshop on applying a family-based musical intervention. The aim of this stage was to appraise the requirements for family-based music therapy training. Participants ($N = 34$) completed a workshop evaluation questionnaire (Appendix G) which included both survey items and open-

ended questions. One participant did not complete the questionnaire due to leaving the workshop prior to its conclusion.

Quantitative Results

Table 4 presents the scores for the workshop evaluation. Of the 13 survey questions, items 1 through 5 evaluated the structure of the workshop and researcher's delivery of the training; items 6 through 8 inquired about professional outcomes and gains; and items 9 through 13 inquired about future training and implementing family-based musical interventions.

Table 4

Family-Based Music therapy Workshop Evaluation Scores

Item	<i>M</i>	Min	Max	<i>SD</i>
<u>Structure and Teaching</u>				
1. Were the training objectives met?	4.41	4	5	0.50
2. Was the trainer knowledgeable?	4.97	4	5	0.17
3. Was the quality of instruction good?	4.65	4	5	0.48
4. Was the length of the workshop sufficient for the training?	3.79	2	5	0.98
5. Were questions and problems dealt with appropriately?	4.50	3	5	0.66
<u>Personal professional outcomes</u>				
6. To what extent have your skills in family-based musical interventions improved as a result of the training?	3.23	1	5	0.92
7. To what extent do you expect this training will make a difference in the way you perform as a family therapist?	3.44	1	4	0.82
8. *To what extent do you feel confident to apply a family-based musical intervention?	3.38	2	5	0.78
<u>Future training and implementation</u>				
9. Will you be interested in participating in future family-based music therapy	4.03	2	5	0.94

training?				
10. To what extent will you recommend family-based musical training to other therapists?	4.36	3	5	0.65
11. To what extent could you use this intervention with your clients?	3.47	2	5	0.71
12. Would you recommend adding family-based musical therapy in basic family therapy education?	3.97	2	5	0.90
13. Would you recommend adding family-based musical therapy as an elective training?	4.50	3	5	0.62

Note. $N = 34$. The questions were rated on a 5-point Likert scale (1 – not at all, 2 – slightly, 3 – moderately, 4 – very much, 5 – extremely).

*This question was repeatedly rated, tracking changes in family therapists' perceptions along time

Qualitative Results

Data were collected for four open-ended questions and analyzed to identify their main categories and sub-themes. The data are presented in the order of their popularity along with the number of responses of each theme, in parenthesis, highlighting their relative significance.

Q1: Family-based music therapy workshop strengths. The analysis identified three categories that demonstrated the strengths of the workshop. They are presented in the order of their popularity along with the number of matching responses. Foremost, the experiential elements of the workshop; primarily active participation both as leaders of simulations or participating as family members ($n = 25$). Others noted observing family simulations ($n = 9$), personally experiencing the projective qualities onto the musical instruments ($n = 6$), and listening to the musical recordings ($n = 3$). For example a characteristic response:

#9 "The experience and practicing, moving between the different roles, listening to the different music created by different families."

The second strength of the workshop most often mentioned was learning to appreciate the therapeutic potential of the family-based musical intervention. This included observing the assessment quality of the intervention ($n = 13$), promotes fast changes ($n = 8$). They noted how the instruments offered abundance of expressions ($n = 5$), and nonverbal added value which bypassed habitual behavior and verbal censorship, adding authenticity and congruent communication ($n = 5$). For example:

#7 "The way information and family undercurrents exposed family dynamics, using projection onto instruments with many dimensions (texture, shape, sound, etc.). Connecting to an instrument from a primary, regressive state – was a rare occasion that holds within it abundant information."

Finally, the teaching quality and structure of the workshop were noted as strengths. This included professional knowledge and experience of the researcher, and conducting the flow of the workshop ($n = 9$), the integration of theoretical and experiential elements including handouts ($n = 4$), the use of process questions which avoided interpretations, but rather enabled the simulated families to acknowledge and gain insight of their needs and choices in a change process ($n = 3$). For example:

#18 "In a short time, we received a taste of the added value of musical instruments as projection objects, which promotes insights and understanding in family therapy. The theory and ideas were clearly presented, relevant examples were demonstrated."

Q2: Family-based music therapy workshop: Improvement suggestions:

The analysis identified four categories mentioned as points that needed improvement; they were mainly focused on receiving additional training.

The participants noted their desire to receive additional practice; in subsequent workshops ($n = 10$), as leading simulations ($n = 7$) or as family members in simulations ($n = 1$), and receiving additional supervision after the simulation ($n = 2$)

Participants noted they needed the workshop to be longer ($n = 10$); for additional practicing, asking questions and studying the variety of instruments.

Therapists noted their desire for additional theoretical background, for additional understanding of the musical elements and connecting the simulations to theoretical foundations ($n = 10$).

Using additional teaching techniques ($n = 4$) such as bringing live videos to be analyzed, or comparing traditional and musical sessions.

Q3: Identified obstacles in the way of implementing family-music therapy. Six therapists replied that they saw no obstacles that would prevent them from implementing the session. The remaining participants noted obstacles from three categories which the therapists felt they would encounter.

First were technical issues ($N = 31$). They included acquiring musical instruments ($n = 14$), working in a suitable room ($n = 3$), getting cooperation from families for this adventure ($n = 7$), and participants who currently are not working with suitable families ($n = 6$) and coping with technical challenges of a recording device ($n = 1$).

Second category involved issues concerning the therapist—mainly their lack confidence to implement the session ($n = 10$), feeling embarrassed ($n = 4$), fearing the chaos and noise in the room ($n = 2$), and not having adequate supervision after the session ($n = 1$).

Finally, the participants were concerned that the session would disrupt the family's ongoing therapeutic process ($n = 2$) and that the intervention was so structured, that it gave no room for the natural family process to develop ($n = 1$).

Q4: Resources needed for implementing family-based music therapy.

Foremost, the therapists mentioned their need for additional training and practicing the application of the intervention ($n = 16$), as well as supervision to understand the depth of the information ($n = 8$). Other resources were their need to establish more personal confidence using the musical media ($n = 6$) and overcome inhibitions such as feeling embarrassed, fear of chaos, and their ability to handle resistance of the family toward the media ($n = 4$).

The second category included technical and logistic requirements, mainly the need for musical tools ($n = 20$), working in a suitable room ($n = 2$) and working with entire families ($n = 2$). Finally, considering the needs of the family, one therapist mentioned the requisite that musical interventions should be implemented in the right timing for the family ($n = 1$).

Integration of Quantitative and Qualitative Data

The overall evaluation of the structure and teaching quality of the workshop showed considerable participant satisfaction, confirming that the workshop offered the skills required for implementing the intervention. The category that scored relatively the lowest addressed the length of the workshop, which should have been longer or repeated more than once. From a logistics perspective, their suggestions included additional time, another family simulation, practicing the role of the leader, repeating the workshop, adding more background on theory, and experiencing the musical media through other techniques such as live videos.

Evaluation of the therapists' professional gains corresponded with their need for additional practice, training, and ongoing supervision to acquire confidence and trust in the tool. This suggested that more training was required to master the skills.

The overall confidence to apply the intervention slightly increased from less than moderately confident ($M = 2.94$) before the workshop to higher than moderately confident ($M = 3.38$) after the workshop.

Future training and future application of family-based musical sessions elicited a high interest in participating in future training and highly recommending the training to other therapists. Adding family-music therapy as an elective training in family therapy education was highly advised (92%), or in basic training (82%).

The lowest score ($M = 3.47$) illustrated the therapists' deliberations concerning the implementation of the intervention in their clinical work. Merely half of the participants ($n = 16$; 47%) felt ready to implement the session (scoring above three = moderately). The qualitative data noted the conflicting feelings toward future application of family-based musical interventions stressing the requirement for additional training, practice, and supervision, theoretical knowledge in musical elements, and additional techniques needed to endorse the therapists' confidence in using this tool in the future.

Phase III: Family-Based Music therapy Sessions Outcomes

Phase III was the heart of the study—evaluating the outcomes of the family therapists' experience using a family-based musical intervention addressing *family roles*. This phase explored participants' perceptions on the applicability and professional and therapeutic value of a family musical session implemented in their family therapy clinical context.

Demographic Information of Active Participants

Of the 35 participants enrolled in the study, 18 (51%) implemented the family-music intervention in their clinical work. The analysis of the musical sessions' outcomes was conducted using responses acquired from the 18 active participants

who implemented 38 family-based music interventions in their clinical work. The active participants' demographic information is presented in Table 5.

Table 5

Active Participants' Demographic Information

	<i>n</i>	<i>M</i>	Range	%
Gender				
Female	18			100
Male	0			0
Age				
		52	39-67	
Years experience				
		10.6	2-25	
Education level				
PhD	0			
MA	18			
BA	0			
Trained in expressive arts				
	5			28
Music	0			
Visual arts	1			
Dance/movement	3			
Drama	0			
Psychodrama	1			
Nature therapy	0			
Family therapy orientation				
Experiential (Satir)	11			61
Systemic (Bowen)	11			61
Structural (Minuchin)	8			44
Narrative	3			17
Psychoanalytic	2			11
Adlerian	3			17
CBT	3			17
Other	3			17
Application of expressive arts in family therapy				
Music	4			22
Visual arts	10			56
Dance/movement	5			28
Drama	7			39
Psychodrama	7			39
Recruiting method				
Self referred	9			50
Staff training	9			50

Note. *N* = 18

The demographic data of the active participants was compared with that of the complete sample. There were no major differences between the two. The active participants seemed to represent the general demographics without any significant attributes that distinguished them. It was surprising to find a similar percentage of active participants trained as expressive arts as in the complete sample. Additionally, there were no significant differences in their clinical orientation, other than a slightly higher presentation of experiential and systemic (Bowen) family therapist orientations within the active participants. In spite of the resemblance, four items stood out as noteworthy when comparing active- and non-active participants:

- a) Their initial confidence levels;
- b) Their musical experience;
- c) Their recruiting method; and
- d) Previous exposure to music therapy, family-based music therapy, or the researcher's professional work.

Confidence levels. The mean scores reflecting the therapists' confidence to implement the musical intervention (on a scale from 1 to 5) were measured in Phase I using the initial demographic questionnaire. The researcher compared the mean scores of the active participants with those of nonactive participants. The scores of the active participants ($N = 18$, $M = 3.44$, $SD = 1.04$) were significantly higher compared with nonactive participants ($N = 17$, $M = 2.41$, $SD = 1.28$). This highlighted the crucial element of individual suitability for working with the musical media.

Previous musical experience. Active participation appeared to be slightly connected to their acquiring previous musical experiences than nonactive participants.

Nonactive participants reported more negative and no musical experience than did active participants, as Table 6 illustrates.

Table 6

Previous Musical Experience: Active and Nonactive Participants

Level of experience	Active participants ($n = 18$)	Nonactive participants ($n = 17$)
Negative experience	3	4
No experience	3	6
Basic experience	5	2
Significant experience	7	5

Note. $N = 35$

Recruiting methods. The complete sample included 12 self-referred therapists (of them nine became active participants) and 23 who participated as part of staff training (of them nine became active participants). The nine active participants who were self-referred represented 75% of all self-referred participants. On the other hand, the nine staff training participants represented only 39% of all staff-training participants. More so, the nine self-referred active participants implemented almost twice as many sessions (66%) as the nine staff-training active participants (34%).

Previous exposure to music therapy and family-based music therapy. A careful examination discovered that the majority of active therapists (61%) mentioned their positive previous experiences and encounters with music therapy in a variety of contexts, including being exposed to the researcher's professional work in previous workshops, conference presentations, as colleagues or hearing about it from others, prior to this study.

Reason for Non-participation

Understanding the reasons for non-participation contributed to understanding what might have hindered family therapists from actively using a musical intervention. Examining the sample of nonparticipants ($n = 17$, 49%) revealed that six had no suitable families who meet the research criteria and three were currently in positions of directors or supervisors and did not work directly with families. One participant withdrew with reasons unknown and seven replied that this musical media was not suitable for them as it caused them high anxiety, inconvenience, and doubt about the musical media's appropriateness for them. Reviewing the demographic data and initial reactions of the seven nonactive participants who felt intimidated by the musical media revealed that they were all recruited as part of staff-training group, and five were initially doubtful about their ability to implement a musical session or did not see the value of the intervention. For example "it is intriguing and interesting, but I am doubtful whether I can do it myself". These statements clarified the stance of participants who were initially reluctant toward the musical media and intervention.

Statistics of Family-Based Music therapy Implemented Sessions

Thirty-eight sessions were implemented by 18 active participants from January 2015 to June 2015. Although initially active participants were required to each complete a minimum of three sessions—one session for each family, in practice this was not achieved. Many active participants implemented the musical session with all families in their clinical work who met the requirements of the study (e.g., three family members and already had preliminary assessment by the family therapist prior to the intervention). Only seven active participants completed three or more family sessions; the other 11 completed only one or two family-musical sessions each. Figure 1 illustrates the distribution of the sessions according to the number of sessions

implemented by each therapist and divided according to self-referred and staff-training participants.

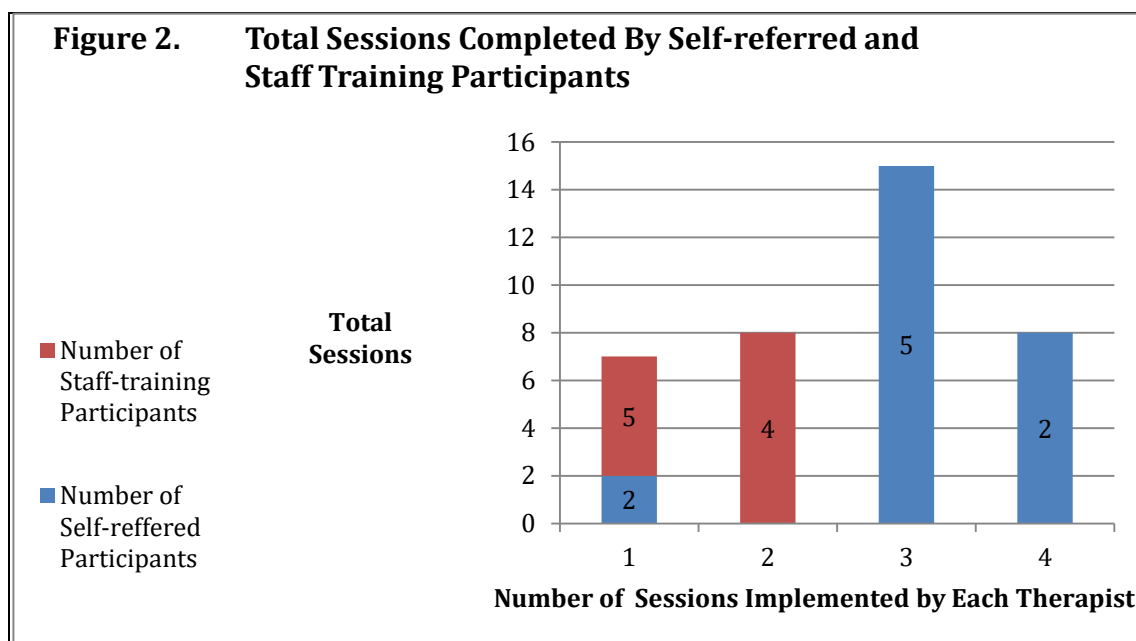


Figure 1. The distribution of the number of sessions completed by active therapists according to recruitment method.

Quantitative Results

Eighteen therapists carried out family-based musical sessions and completed the Session Evaluation Questionnaire (Appendix F) for each intervention. The questionnaires assessed the family therapists' perspectives on their experience using the *family roles* intervention, addressing issues of applicability of the intervention, the therapist's personal and professional experience, as well as an ongoing question concerning their confidence to use the intervention, the therapeutic and added value of the musical session, and future implementation of family-based music therapy sessions. For each item, the therapists were asked to check one of five descriptions that best applied to them on a five-point Likert-type rating scale. Table 7 summarizes single-item results within their categories.

Table 7

Quantitative Results from Session Evaluation Questionnaires

Category	Item (number and description)	<i>M</i>	<i>SD</i>
Implementation			
	2. Sufficient time	3.95	0.92
	3. Sufficient selection of instruments	4.61	0.55
	4. Room compatibility	3.92	1.09
	5. Ease of transporting instruments	3.87	0.88
	6. Ability to manage recording device	4.00	1.09
	7. Concerns about safety of instruments	2.89	0.92
Personal professional experience			
	1 *Confidence to apply a musical session	4.07	0.81
	8. Significance to the family	4.18	0.87
	9. Family cooperation	4.37	0.75
	12. Comfortable before session	3.74	0.76
	13. Comfortable during session	3.84	0.80
	14. Comfortable after session	4.03	0.95
	15. Importance of musical competence	2.00	1.14
	16. Contribute to professional growth	3.58	0.95
Future implementation			
	10. Family interest in future musical session	3.95	1.01
	11. Considering continuing FBMt session	3.68	1.09
Therapeutic Value			
	17. Therapeutic opportunities	3.87	0.77
	18. New information	3.82	0.78
	19. Validate prior information	4.29	0.80
	20. Contradict prior information	2.00	0.96
	21. Overall therapeutic value	4.21	0.84

Note. The questions were rated on a 5-point Likert scale (1 – not at all, 2 – slightly, 3 – moderately, 4 – very much, 5 – extremely).

N = 38.

*This question was repeatedly rated, tracking changes in therapists' confidence along the research.

Qualitative Results

Qualitative data was collected from 38 questionnaires. Six open-ended questions inquired about (a) the musical instruments, (b) the strengths and (c) weaknesses of the musical session, (d) the professional and the (e) therapeutic value of the session, as well as (f) any additional remarks concerning the session. Thematic analysis identified the main categories as well as sub-themes for each question individually. They are presented along with characteristic responses and the number of matching responses in parenthesis, according to their prevalence.

Q1: Family therapists' comments concerning the musical instruments.

Most participants ($n = 28$, 74%) were satisfied with the musical instruments, their quantity and variety, and had no additional comments.

Ten remarks were made concerning the musical instruments recommending a smaller selection ($n = 6$) for smaller families and for younger children to avoid too much confusion, and for simplifying the logistics of storage and organizing the instruments for the session. Several comments ($n = 3$) noted concerns about the safety of the instruments and suggested removing vulnerable or fragile instruments (such as the guitar). Other comments ($n = 3$) related to the noise of the instruments which caused disturbance to other therapy rooms. For example:

#2 "The large selection requires a lot of organizing for those who don't have the instruments already in the therapy room."

#10 "Instruments that made loud noise interrupted the neighboring rooms."

Q2: What is the one most important thing you learned about the family? The answers highlighted various family functioning categories illuminated by the musical session. The most prevalent issue concerned family roles ($n = 26$), especially parental functioning ($n = 16$). Second was family dynamics ($n = 22$) which included issues of

coalitions and sub-systems, flexibility, mutuality and individuality. Another important category was family communication ($n = 22$) which included listening and attunement, conflicting messages, affect communication; all central constructs and common goals in family therapy. Additionally, the therapists noted the musical session demonstrated the family resources and strength ($n = 12$). The following examples illustrate therapist's characteristic comments concerning new information and awareness to the family issues through the musical intervention:

#2 "Understanding the family roles received a new perspective, but the complexity of the older daughter's role and the mother stuck in her perceptions of her role, came to light in such clarity, which I could not see so far."

#18 "The dynamics between the brothers and between both parents and between the parents and children was demonstrated remarkably. I saw the sibling dynamics in a way that could not be revealed in such a fast and accurate way in conventional therapy."

Q3: What is the one most important learning about yourself. This question explored the influences of family-based music therapy on the active participant professional and personal qualities and abilities. The majority of responses addressed the therapists' courage and openness to meet new challenges brought on by the new musical media; using a new therapeutic intervention tool in family therapy; and enjoying implementing the newly acquired technique ($n = 20$).

#13 "I learned about myself that I have the will and confidence to use unfamiliar tools, and that it is both fun and a challenge to experiment with musical instruments."

Therapists noted that the musical intervention improved their professional skills ($n = 11$), and enhanced their awareness to the added value and contribution of the musical media in family therapy ($n = 11$):

#25 "From one musical session to another, I learn to let go, intervene less, and let the instruments and the setting do the work."

Finally, the therapists noted that the experience highlighted professional challenges as well as expanded and added to their professional skills.

#2 "I learned how important and how difficult it is for me to listen to the family without hurrying to connect into previous information or my own ideas."

The musical session reinforced their choice to use experiential elements in family therapy and use of nonverbal media bypassing words. The session enhanced their trust in intuition and enjoyment of being in the moment and exhibited more trust in their professional abilities, new ways to ask questions, and listen more actively with less interpretation. The session offered a playful, fun experience with the families.

Q4: What were the greatest strengths and benefits of the session. The chief strength of the musical session-without doubt-was the clarity and precision in which the family dynamics, roles, conflicts, and communication stances were exposed through the musical representations ($n = 26$). The session's assessment contribution was by far the leading benefit mentioned by the therapists.

#2 "The session clarified the family roles each member adopted, with an understanding that they can also be changed."

The second contribution was revealing and expressing the individual voices in the family. The session offered an opportunity to share personal views in a playful

and less critical activity; and expressing personal needs, perceptions, feelings, and longings and wishes for personal and family change ($n = 19$).

#33 "For the first time the family listened to the unique expression of each member, their sound and rhythm as it is expressed in the family. They were able to communicate with one another in harmony, share their feelings and emotions through the musical instruments, without feeling intimidated. Through the musical instruments the family members could express their needs, and yearnings from the family."

The next valuable contribution was the opportunity to engage the family in an hour of mutual enjoyment and pleasurable family activity ($n = 14$).

#31 "The main advantage was the enjoyment and fun of the children with the instruments and the opportunity to record and listen to themselves."

Additional benefits of the sessions were increased family cooperation and solving conflicts ($n = 9$), encouraging open communication; listening to each other, and attunement to each other ($n = 7$). The use of a new musical media in the session enabled the families to experiment with nonverbal elements and bypass habitual stances ($n = 2$) and offered opportunities for new behaviors and change ($n = 7$).

Q5: Main weaknesses of the session. Most responses mentioned the logistic preparations for the sessions ($n = 21$); transferring the instruments, organizing the room before and after the session, and thin walls in many family therapy centers that caused the noise of the musical session to interrupt other rooms in the building. Other logistic considerations noted the session needed to be a little longer than usual. Another weakness was that the intervention protocol was sometimes too structured for young children ($n = 8$). Younger children had a difficult time verbalizing their reflections. These responses noted the need to adapt the protocol to a more musical and less verbal orientation with younger children. For example:

#19 "The younger children had less patience to stop and listen to the conversation with so many temptations."

Q6: Additional comments about the session. This question offered family therapists a final opportunity to comment or add information concerning their experiences implementing family-based music interventions. Only a few statements added any new information about the process. Most responses described moving and exciting stories and examples from the content of the sessions, which furthered the many ways in which new information was elicited and conveyed using the musical instruments, how musical projections and mutual improvisations reflected the family processes.

The family therapists used this question to add concerns on how to proceed with the new discoveries, such as whether to use additional musical sessions or to proceed verbally. Many noted the session as a positive and playful experience for the family, which put a smile on their faces and which the children preferred over the verbal sessions.

Several comments illustrated how the therapists adjusted the protocol to the families during the session. In one session, the family repeated the recording a third time to practice the growing changes in the family. Another family recorded the music on their cell phone so that they could listen to it again at home. Sessions with younger children had shorter verbal reflection.

Comments on the future application of family-based musical interventions involved participants' interest in additional family-musical intervention protocols for other family goals. Others raised questions about future training, as well as their need for continued supervision if they continue using family-based musical interventions.

Finally, responses highlighted the therapists' fascination for the musical media as a therapeutic tool and intervention and their appreciation as participants in the research and for the opportunity to acquire a new therapeutic tool. Several participants noted they had already gathered musical instruments and found storage solutions.

Integration of Quantitative and Qualitative Data

Results from research Phase III concluded the therapist's experience of implementing the musical session in four areas: (a) logistic issues concerning the application of the musical session, (b) therapists' professional challenges and experiences in the sessions, (c) continuing family-musical interventions, and (d) the therapeutic value of the family-music intervention.

Logistical issues. The scores from the quantitative data depicted an overall satisfaction in all areas, which indicated a practical and applicable intervention.

Musical instruments. The highest satisfaction noted the adequate selection of musical instruments, with some concerns about the safety of delicate instruments. Transporting the instruments was easy and practical in most cases.

Therapy rooms. Most therapy rooms were suitable. The concerns about noise to other rooms in family therapy centers or small rooms did not prevent the sessions from proceeding as planned, noting the difficulties were not very significant.

Length of intervention. The family roles musical protocol was designed for 60 minutes, which was mostly satisfactory. Several qualitative responses noted that they would have enjoyed a slightly longer session, lasting as long as 75 minutes.

Professional challenges and experiences. These questions addressed the experience from the therapists' perspectives.

The family's experience. The therapists noted families were highly cooperative with the session, which was rated as highly significant for the family.

The extent to which the therapists felt comfortable implementing the session. Examining comfort levels before, during, and after the session, therapists felt moderate-to-high comfort employing the session, with a growing sense of comfort along the session. More so, the therapists were able to relax and enjoy the musical session with growing ease.

Importance of previous musical competence. The therapists perceived their musical skills and competence as only slightly influencing their abilities in the session, in contrast with a similar question from the demographic questionnaire, where the therapist's initial perceptions were that their musical competence would mildly influence their ability to use this media.

Contribution to professional growth. The main professional gain from the sessions was acquiring a new tool for family assessment and intervention. Additional gains included a new way of actively listening and asking questions, avoiding giving an immediate interpretation, learning to trust the power of music and experiential nonverbal learning, and trusting intuition. The therapists were also confronted with professional difficulties such as confronting family chaos, disruptive behavior, and resistance. Becoming aware of personal professional difficulties was viewed as professional growth.

Continuation of family-musical interventions. This question was explored from two points of view: the therapist's belief about what the family would like and the therapist's incentive to continue the musical session or employ other musical

sessions. The families seemed to be very interested in future additional musical interventions and the therapists were in favor of continuing musical interventions.

Therapeutic value of the family-music intervention.

Promoting family functioning and congruence. Therapists saw many opportunities for therapeutic interventions in the sessions. The sessions created opportunities for interventions in major family functions such as family communication, family cooperation, individualization, shared emotions, and expectations. There were opportunities to show mutual appreciation and praise; take up appropriate family roles; and promote parental leadership. The family-musical intervention enabled families to move beyond their usual behaviors and find new opportunities to change and improve family functioning in a variety of domains; mainly improving parental roles and functioning, promoting family cooperation and mutuality, family communication, affect attunement, individuality within the family, flexibility; and identifying family strengths and overcome conflicts.

Family assessment. The therapeutic value of the session underlined the significant and a highly potent family assessment quality with the music representing the family dynamics accurately, bypassing verbal and habitual defenses.

New information. The musical interventions revealed substantial new information, which surfaced during the sessions. The musical sessions profoundly validated previous information and moderately contradicted earlier information. New information that contradicted earlier information was "surprising" and many times positively oriented; the family *identified patient* was seen as the more attuned and less disruptive child; a parent was experienced with much better functioning and leadership; a depressed mother had for the first time smiled and actively participated; parents could cooperate and share leadership. The therapists gave examples noting an

abundance of new information about family strengths and new competences. Family members expressed new information about their feelings, expectations, needs, and yearnings in a way that was not enabled in conventional verbal sessions.

Quantitative Analysis of Confidence Levels

The null hypothesis of the study was that there would be no significant difference in the family therapists' perceptions toward implementing family-based music therapy before and after training and following their experience in the application of musical interventions. For this matter, the question: "To what extent do you feel confident to apply a family-based musical intervention?" was repeated at three points of time: pre-intervention, after the training session and from the final intervention completed by each active participant. The question tracked changes in scores (on a scale of 1 to 5). The researcher assumed that a change in confidence levels to apply the sessions might reflect the change in the therapists' perceptions toward applying family-music sessions

The confidence levels of the therapists were divided and presented in Table 8 according to three groups: the entire sample recruited for the study ($N = 35$), the active participants who actualized the musical intervention session in their clinical work ($N = 18$), and nonactive participants ($N = 17$).

Table 8

Scores of Family Therapists' Confidence to Apply a Family-Music Intervention

Participants	<i>M</i>	<i>SD</i>	Distribution of scores				
			Not at all	Slightly	Moderately	Very much	Extremely
Pre-intervention							
Whole sample (<i>N</i> = 35)	2.94	0.21	6	6	11	8	4
Active (<i>N</i> = 18)	3.44	0.25	1	2	5	8	2
Nonactive (<i>N</i> = 17)	2.42	1.27	5	4	6	0	2
Post workshop							
Whole sample (<i>N</i> = 34)	3.38	0.13	0	3	18	10	3
Active (<i>N</i> = 18)	3.72	0.16	0	0	7	9	2
Nonactive (<i>N</i> = 16)	3.00	0.73	0	3	11	1	1
Post clinical interventions							
Active (<i>N</i> = 18)	4.22	0.88	0	0	5	4	9

Note. $p < .05$.

The questions were rated on a 5-point Likert-type scale (1- not at all, 2- slightly, 3 - moderately, 4 - very much, 5 - extremely).

Active therapists levels of confidence.

The confidence levels of the active participants increased from one phase to the next as exhibited in Figure 2. By the end of the workshop, the lower scores (not at all confident and slightly confident) were replaced with levels registering above moderate. Specifically, by the end of the intervention phase, nine therapists scored 5.0 (extremely confident), as opposed to only two therapists in the previous stages.

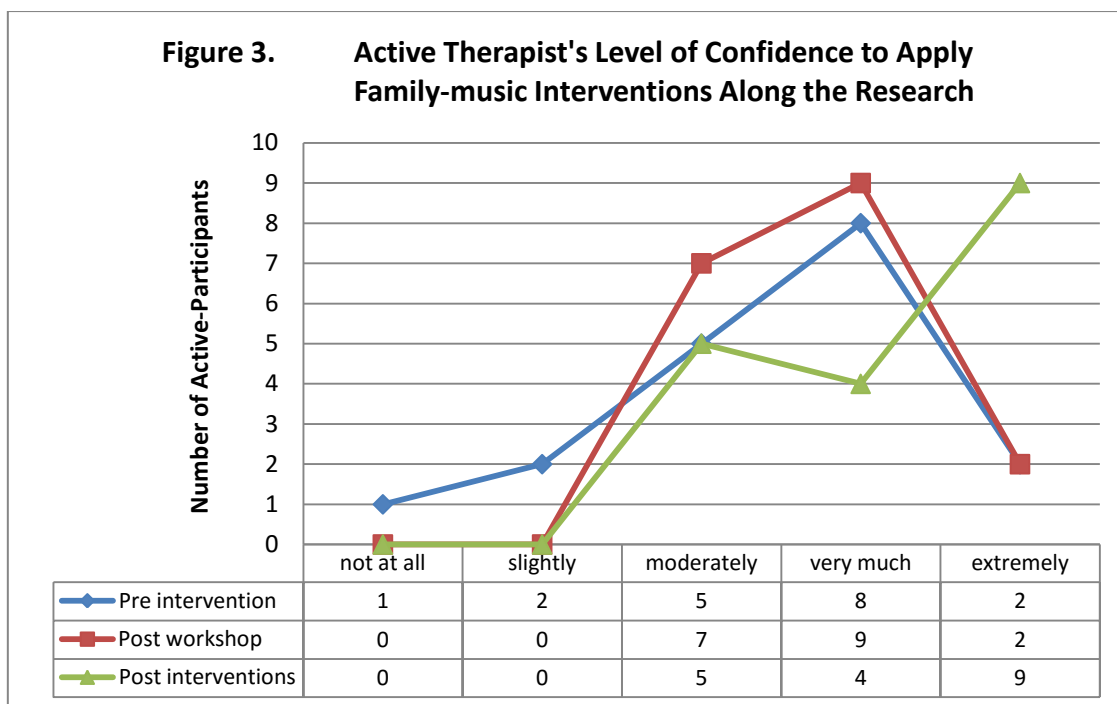


Figure 2. Comparing active participant's confidence levels (on a scale from 1 = not at all confident to 5 = extremely confident) as noted at three points of time along the research: Pre-intervention, post workshop and post family-musical interventions. *N=18

Non-active therapists levels of confidence.

Active participants' scores were initially higher in the pre-intervention as well as the post-workshop scores in comparison with the nonactive participants. This might offer an explanation for therapist's withdrawal from the research. Exploring two nonactive participants who scored "extremely confident" to apply the musical intervention revealed that one did not actively participate as she left the study before completing the workshop and the other was a director and supervisor who currently did not meet with families.

Inferential data analysis of active-participants 'confidence levels

The data were analyzed using Wilcoxon signed-rank test using SPSS statistics. The analysis compared the three sets of scores for the same group of active

participants, investigating whether the change of scores among three points of time was statistically significant at significance level $p < .05$.

Between the pre-intervention and post-workshop scores, the analysis indicated no statistically significant difference ($p = 0.425$). Similarly, there was no statistical significance between the post-workshop scores and the final scores ($p = 0.057$). On the other hand, a statistically significant difference existed between the pre-intervention and the final session scores ($p = 0.012$).

IV: Personal In-Depth Interview Analysis

The thematic analysis of three interviews revealed eight categories common to all interviews, with several sub-themes each. The categories included (a) rationale for using music in family therapy, (b) unique elements of the musical session, (c) fears and hesitations, (d) opportunities for professional growth, (e) logistical challenges, (f) the therapeutic value for the benefit of the families, (g) continuing music-based family sessions, and (h) training.

Although many significant statements by the interviewees overlap the previous data, they reinforce and validate the preceding quantitative and qualitative data. The interviews added a deeper understanding of the family therapist's perspectives and experience using family-based music therapy interventions. They are presented with a selection of characteristic responses.

Rationale for Using Music in Family Therapy

The interviewees pointed to several reasons why music was a suitable media for working with families.

First, they believed musicality was naturally inherent within everyone, and music is a natural, common activity. More so, they were surprised that the musical media was not an existing technique used in family therapy:

"I was surprised to realize that music was not used in family therapy. Why wasn't it natural to use music like we use games and a sandbox?" (Mary).

They also mentioned music was a surprising, new and unconventional technique, which elicited family curiosity and cooperation.

"What I loved about music was the element of surprise and the excitement in their eyes" (Mary).

All interviewees noted that due to music's nonverbal quality, the musical sessions were especially suited for working with children and less verbal families. They mentioned music's ability to bypass verbal censors and habitual stances, enabling faster learning and prompting a process of change within the family.

"Through music, you learn faster, it is a more profound learning, and it is followed by fast changes. I was surprised by the magnitude of the experience. In my experience, it was powerful, impressive, and effective" (Lisa).

The Unique Role of Music in the Sessions

The interviewees mentioned several characteristics of the musical media made the musical sessions special. First, it enabled an embodied and experiential learning that complemented the intellectual knowledge—experiencing nonverbally was many times stronger and impactful for the participants.

"With music, they are able to apply the change to the family. Even if it is not discussed, it is already embodied" (Mary).

The music offered a celebration of playfulness and fun, which was in itself a significant family goal and achievement. The family mutual improvisations offered simultaneous family cooperation, which was unique to music making.

"Music enabled everyone's participation and that nobody needed to wait. Their opportunity to play music together (in this format) was a togetherness that was implemented even easier than in visual arts" (Mary).

Finally, music—bypassing habitual censors—offered an authentic and precise representation of the family dynamics and needs, more than was possible using their previously used interventions.

"It was fascinating. It revealed information that could not be elicited in other ways"
(Lisa).

Fears and Hesitations

All interviewees noted that using music in family therapy elicited their reservations, fears, and hesitations about the media. For the most part, participants considered music to be only for those with a musical background or musicians. Thus, they doubted their abilities to apply the musical session without being a musician or having a musical education.

"There is something intimidating about this media, thinking that you need to be a musician. You need to be a musician in order to use music in therapy, and that the client needs to be a musician" (Mary).

Music, along with other expressive arts, was considered less intellectual and more experiential—with a lower status in therapy than words. Thus, it provoked resistance toward using music by individual family therapists who refused to join the research and resistance from the administration of the family therapy center who opposed the use of music.

"Where I work, we don't use any arts. It [work place] is so uncreative, there is no legitimacy for this. At the most, they would use symbols" (Lisa).

Finally, the musical session was considered a noisy or chaotic experience that was a difficult experience for family therapists to endure. The fear of noise and chaotic experience, losing their grip on the session provoked hesitation to use musical interventions:

"There is a certain chaos in the room. It is noisy...I think a therapist needs to be able to withstand a lot of freedom, not stick to "do"s and "don't"s; rather, enable the chaos. This chaos in the room created uncertainty that you do not know how it will develop and you need to be able to endure this" (Donna).

Opportunities for Professional Growth

All interviewees saw the musical sessions as an opportunity for professional growth in various directions. It was foremost acquiring a new tool for their clinical practice. They admitted to prior misconceptions about the musical media and noted the clarity and easy-to-follow structured protocol was practical and gave them confidence within the sessions.

"Contrary to my earlier thoughts, it was very practical, easy, and was not such a big challenge" (Lisa).

Through the musical interventions, they learned to trust the music and musical process with fewer interpretations; rather, they let the experiential process develop with the family's interpretations. The interviewees noted that the musical sessions elicited profound and more authentic family processes, enabling the therapist to understand and evaluate the families on a deeper level.

"I could see things that I could not see using words. I could see the family processes in a deeper and more accurate way" (Lisa). "

Logistical Challenges

All interviewees noted the logistical challenges of the intervention, such as obtaining a room big enough and preferably, where noise will not disturb others. A locked closet to keep the musical instruments, and a variety of musical instruments. They all mentioned that the families were especially interested in and chose unfamiliar and unconventional musical instruments such as those from the indigenous

collection. The interviewees mentioned they needed to obtain such musical instruments.

Therapeutic Value for the Families

The assessment and intervention quality of the musical session was profound. The interventions addressed the family goals in a playful experience, and enabled the families to reach insights concerning their dynamics and family functioning and inspired them to make musical changes in real time.

"One child said, 'Wow!' in wonder and excitement. 'I never had such an experience; I never had such an experience with my family.' For him, it was like an 'Ahhhh'—a good and empowering experience. Suddenly he fits in, and the family was attuned to him" (Lisa).

The interviewees noted that it was much easier for the families to grasp the family reality and make changes using the musical media than in their real lives.

Integrating Music into Family Therapist's Clinical Work

All interviewees noted that since the musical experience, they were more open to implement musical activities in their clinical work and used the ideas from the musical activity with other families and other forms of art:

"I must say that I am already adding music and new ideas into my sessions and I have your protocol in my head" (Mary).

Several families asked for additional musical interventions, which were implemented in various forms. Other families were impressed with the musical experience and outcomes and continued the session using musical instruments at home.

Future Outlook and Training in Family-Based Music Therapy

All interviewees noted they were optimistic about the potential of the model, but all stated there is a need for some form of training:

"It was a very good experience and I would like to continue with it. However, I feel it is not enough for me to integrate it into my work. I need more supervision, and a training framework, and acquire tools" (Lisa).

In their opinions, there is a growing openness toward incorporating expressive arts in therapy in therapy in general—not only in family therapy. The interviewees referred to the lack of formal training using the arts in family therapy, for which they had no explanation or justification:

"In family therapy training, we had three sessions about play therapy, which is when visual arts came in. There were no other arts such as drama or music; it was more games and cards" (Lisa).

They also pointed out that the trend of family therapists to exclude children from family sessions was mainly a result of lack of training and techniques suited for working with entire families

The interviewees disagreed about when and where such training should take place. One preferred an academic course as part of a basic training:

"I think that family-music therapy could be just like other models, narrative family therapy, and structural family therapy. As such - family-music therapy could be another model studied. I don't think one should be first a qualified family therapist and then learn to incorporate music; on the contrary" (Donna).

Another preferred this to be an elective course in basic training:

"I think that, like there is a course about play therapy, there needs to be a course about using expressive arts. And within this course, one should choose various

workshops such as drama in family therapy, family-art therapy, sandbox, music in family therapy—choose several of them. But it should be at least a semester" (Mary).

A third preferred to receive a taste of the arts in the basic training and have an advanced training or workshop when they are already experienced therapists:

"In my opinion, first you need to gain experience with families to understand what interventions are better, and it is individual and different from one therapist to another. I think that the stage I am in right now is a very good time for the training, as I have experience in family processes and various intervention tools from different theories...And after you have experience with families, it is suitable" (Lisa).

Despite this diversity, they agreed there should be some practicum and supervision using arts in basic family therapy training. They were also enthusiastic about receiving additional family-music protocols and techniques addressing additional family goals.

Integration of Family-Based Music Therapy Results

Family therapists' initial perspectives towards using musical techniques in family therapy were ambivalent. On one hand, they noted the unique therapeutic qualities of music, as well as their positive past experiences with music therapy as substantial contributors toward adding a musical intervention. Their general unequivocal perceptions highlighted the significant potential family-based musical interventions might have in family therapy. Music and musicality were perceived as "natural, inherent elements within all people". Music was perceived as a creative arts technique like other arts, with additional nonverbal, unique qualities that added to the therapeutic potential of music therapy.

On the other hand, their concerns, hesitance and lack of confidence to employ the musical interventions were mainly linked to their beliefs that "you need to be a musician in order to use music in therapy". Expressive arts were generally perceived

"less academic, less intellectual by society", and "public clinics do not legitimize the use of creative arts". More so, they felt intimidated and anxious about the chaotic and noisy nature of the musical media. These beliefs were major impediment for using music in family therapy.

The study highlighted the rare existence of music in the field of family therapy. Music was the least utilized art in family therapy among the expressive arts, and notably practiced less by family therapists especially when compared with visual arts. The underlying perception that "music is for musicians" discouraged family therapists from using music and musical instruments in therapy. Therapists were much more likely to own and use art materials with families than they were to possess or use musical instruments in their sessions.

Following a workshop, which offered a short training focused on applying a *family roles* musical intervention, several therapists stated they were "ready to go" and experiment with the musical media. Many therapists expressed their lack of confidence and need for additional training sessions, more practice, acquiring additional theoretical background, receiving ongoing supervision, and additional musical interventions for other family objectives, before they would apply the musical session in their clinical work. Other concerns involved logistic challenges (e.g., owning instruments, suitable rooms, and suitable families). Despite the mentioned reservations, the majority of therapists stated that other than logistics, (especially acquiring the instruments), they were confident enough to try out the session. In conclusion, most therapists believed that the single workshop prepared them well enough to implement a structured musical session. With the researcher providing them with a set of musical instruments, they were adequately prepared.

Implementing the musical session in family therapy clinical work elicited the key outcomes of the study, which reflected family therapists' experience concerning the applicability, therapeutic and professional value of family-based music therapy.

Merely half of the participants applied the musical session in practice. It was realistic to assume that not every therapist would connect to using music in therapy. As a technique which offered an expansion of the therapeutic toolbox, it must meet the personal abilities and individual choices suited for each therapist. Active participants were mainly self-referred, their initial confidence to use music was higher, they had slightly higher musical experience and they had previous exposure to the family-based music therapy model and the researcher's work. This exposure seemed to influence their curiosity as well as their confidence in the media and in the researcher.

Surprisingly, the number of active participants who had an experiential family therapy orientation was not much higher than participants from other orientations. Furthermore, the intervention did not necessarily attract more therapists with an expressive arts orientation or dual expertise in family and expressive arts. This may suggest that having an education in expressive art does not necessarily mean being more attracted to or able to implement musical interventions.

Despite the therapist's initial fears, the logistical challenges of applying the musical session were not confronted with obstacles, which prevented any of the planned sessions from being implemented. The findings suggested that other than acquiring musical tools and storage solutions, the intervention was applicable in a high variety of private and public settings.

For the most part, the families were very cooperative. There were no significant challenges concerning the family's cooperation, convenience, or resistance.

On the contrary, the families appreciated the discoveries revealed through the nonverbal musical media. The music augmented and presented the family issues and difficulties in an enjoyable and playful experience, which was better tolerated than verbal sessions. The families' appreciation of the musical intervention was conveyed in their wish for additional musical sessions. The majority of therapists felt very comfortable applying the sessions, noting the chaotic nature of the musical intervention was a new experience for them but not an obstacle in the way of implementing the session or enjoying the sessions' outcomes and benefits.

The majority of active therapists believed the musical session was a significant contribution to their professional toolbox. The musical sessions improved their professional skills, practicing experiential interventions, improved their active listening; they used less interpretation, trusted the musical and therapeutic process, and became aware of their own professional challenges.

Contrary to their initial belief that their musical skills would affect their ability to employ the musical intervention, their lack of musical education and skills had only a minor impact on their professional abilities. This strengthened their desire for additional significant training for family therapists to acquire further confidence in the tool and additional musical interventions and techniques. The therapists noted the families were very interested in additional family-musical sessions, and from their own standpoint, they were willing and interested to consider additional musical interventions with them and other families.

The therapeutic outcomes of this single musical session were impressive. The therapeutic value touched on various aspects of family functioning. Most of all, the sessions were noted for their accurate assessment quality. This quality was previously discussed in the preceding pilot study (Nemesh, 2014) and by Miller (1994), Hibben

(1992), and Decuir (1991). Family therapists compared the musical session with their conventional sessions and highlighted the phenomenon of music bypassing habitual responses and stances. The session accurately reflected the family's reality in a surprising way.

Additionally, the families made use of the session to make new choices and implement changes. Their verbal reflections and processing of the emerging information connected the nonverbal and verbal processes to form a coherent congruent experience. The session promoted family congruence including family cooperation and mutuality, family communication, affective sharing, attunement, individuality and differentiation, self-worth, flexibility, and problem solving. A significant number of responses highlighted the sessions' contribution to parental roles such as leadership, placing boundaries, affect attunement, taking responsibility and giving support. Notably, the musical improvisations highlighted individual voices within the family and the uniqueness of the family members while supporting differentiation along with mutuality, in a flexible and open inquiry of the family relationships and balance. The sessions offered the family an opportunity to see new personal qualities, identify individual and family strengths, and promote mutual respect, cooperation, and problem solving. These findings suggested that the musical session was a potent intervention augmented by the unique features of music and non-verbal components.

The final interviews supported the highly therapeutic experience of the intervention in a variety of settings, which only required openness towards a new and unfamiliar media. It was surprising, playful, and especially suited to working with children. From their own professional perspectives, they found musical interventions an opportunity for professional growth and development, enriching their techniques as

well as their personal attributes as therapists. Based on their experiences, they offered suggestions concerning the future of family-based musical interventions in family therapy.

CHAPTER 5

Discussion

Family-based music therapy is currently a developing niche in the field of music therapy. As previously reviewed, few studies examined the use of music therapy interventions with non-clinical families and hardly any mentioned family therapists' use of musical interventions.

This study explored family therapists' perceptions concerning the use of musical interventions in a family therapy context. As previously mentioned, the research questions were:

- What are family therapists' initial perspectives on using musical techniques in family therapy? How do they change after a single family-based music therapy training session, and after implementing family-based music interventions in a family therapy setting?
- Based on the family therapists' experiences of implementing family musical interventions, what are the family therapists' perspectives on the applicability, therapeutic, and professional value of family-based music therapy interventions in family therapy?
- Null Hypothesis: There is no significant difference in the perceptions of family therapists toward family-based music therapy before and after training and implementing family-based music therapy.

Description of the Study

This mixed methods study explored family therapist's perceptions towards using musical interventions in family therapy following four sequential phases; beginning with the therapists initial perceptions, then after a training workshop and subsequent to their own use of the intervention in their work. The research concluded

with three personal interviews, which summarized the therapists' experience of implementing family-based musical intervention in family therapy.

This broad picture of the therapist's experience addressed the questions of the study, and provided an overview of the applicability and therapeutic potential of the model. For this purpose, the researcher borrowed a music therapy structured intervention concerning *family roles* used in the preceding pilot study (Nemesh, 2014). The intervention was based on Juliette Alvin's Free Improvisation Music Therapy model where playing musical instruments music was perceived as a potential space for free-expression (Wigram et al., 2002). The musical interventions followed a structured protocol and did not require the therapists or the family members to have any prior musical background. The protocol offered family therapists a framework that helped minimize the possible chaotic effect of the musical experience. Following a short specialized training, the therapists implemented the musical technique in their clinical settings. The projective attributes of musical instruments and musical improvisations elicited information which the families acknowledged, and the therapists used for further family verbal reflections and promote growth, just as Alvin (1977) described and intended in her work.

Contribution to the Field

The study outcomes helped identify family therapists' perspectives concerning the use of music in family therapy. They illustrated an initial enthusiasm, curiosity, and openness to acquire a new musical tool, along with some hesitation and fear to use music in family therapy. The enthusiasm was also about the therapeutic qualities of music, an experience that they appreciated due to previous experience with music therapy. Their main fears and hesitations were based on their prevailing beliefs that "music is for musicians." They perceived their lack of musical skills as a hindrance in

the way of implementing a musical session. They felt unconfident to apply the session, as music was perceived as an expressive art that only experts could use, whereas in contrast, everyone could use visual art. This was exhibited in the rare use of music in family therapy, which was notably lower than their use of visual art.

As noted by the participants, this perception may perhaps be linked to educational and cultural experiences and expectations encountered in life in Western cultures. In line with Roger's (1993) observations, "this society has squeezed the tasty juice out of the creative process right out of most of its citizens. We need to find ways to recapture our spontaneous freedom of expression, without looking to others for approval" (p. 18).

Several participants linked their reluctance to use music to external criticism about their musical abilities and musicality, which was experienced at a young age. Fear of internal and external judgments which criticized their aesthetically 'unaccepted' musical outcomes resulted in their abstaining from free and natural experimentations using musical instruments and the voice. Others related the difference between using visual arts and music in family therapy in that visual arts were more familiar to them, and were in use throughout their education, easily accessible and used throughout school years.

With this in mind, the study may inform of the importance of exploring early childhood musical education methods; and highlight the importance of providing children with opportunities to use musical instruments in free play and free improvisation without following predetermined rules or directing and aiming for aesthetic outcomes. Being able to improvise freely with musical instruments without criticism is the core concept of the family-based music therapy intervention; but

"although the urge to express ourselves is powerful, it seems to be easily squashed in childhood" (Rogers, 1993, p. 19).

Additionally, when comparing music to visual arts, the visual arts were perceived as less revealing and less chaotic than music. As the participants—especially those who withdrew from the project—acknowledged, music holds within it a factor of noise and chaos; "there is a fear of the chaotic nature of the musical media" (Participant #8). This notion is furthered by recent neurological studies, which noted how noise could increase stress, while impairing many brain functions (Stegemoller, 2014). More so; participants referred to a prevailing cultural negative attitude towards 'making noise', and how noise disturbs others. These perceptions could have contributed to the hesitance to use music and free improvisation in family therapy.

Family therapists mentioned an additional reason for refraining from using music and expressive arts. They underlined the belief that "expressive arts are perceived less academic; less intellectual by society", as well as "public clinics do not legitimize the use of creative arts" (Interviewee M.). For reasons that need further exploration, our society seems to be less appreciative of the expressive arts compared to 'talk' therapy. Thus, it is more likely to be practiced 'behind closed doors'. Music, as it spills out of the room into the public spaces, might be less tolerated or accepted; and as such - less practiced.

On a different note, following the designated family-based music intervention training, approximately half the participants continued with implementing the session. The active participants represented an array of professional orientations, which included all the main family therapy disciplines, without necessarily having an education in expressive arts or experiential family therapy. This matched findings by

Kerr et al. (2008), who found family-art therapy to be compatible with most family therapy orientations. Similarly, Miller (1994) found musical intervention compatible with the major schools of family therapy, suggesting that the musical intervention could be equally suited to working with most family therapy models.

The study found that self-referred therapists implemented twice the number of sessions than did staff-training participants. Checking for demographic and professional differences between the groups, there were no meaningful differences. For the most part, self-referred and staff-training participants implemented the sessions in public settings, in similar circumstances. One noteworthy difference was that self-referred participants had previously been exposed to music therapy, the family-based music therapy model or to the researcher's work. This positive experience helped inspire them to join the research. As such, it seems to be consistent with self-referred participant's initial higher confidence to use the musical media. Additionally, the active participants in the study seem to have slightly more musical experience. This information needs further exploration to understanding the meaning musical experience had on active participation. With this in mind, it might be inferred that the exposure to the family-based music therapy model or other music therapy models could inspire therapists to acquire the skills and use the musical interventions in clinical practice. As mentioned previously, none of the participants had any training regarding the use of musical interventions in family therapy education.

The results collected from the 18 active participants who implemented 38 musical sessions highlighted the viability and ease in which the sessions were implemented when provided by family therapists. The therapists offered their insight into the diverse therapeutic values of the session. This was supported by similar outcomes of the pilot study (Nemesh, 2014) and studies in family-music therapy with

clinical populations mentioned in the literature review such as Hibben (1992), Miller (1994), Oldfield and Flower (2008), Pasiali (2012) and Silverman (2014). The musical session provided a fast and accurate intervention technique; promoting family dynamics and communication; establishing proper family roles; sharing experiences and emotions; finding solutions; promoting individuality; and resulting in individual and family positive changes. Such outcomes were displayed in the family therapist's reflections: "through the musical instruments the family members could express their needs and yearnings from the family". The therapeutic benefits of the musical intervention was due to the augmenting effect, precision, and clarity of the musical representations, which accurately reflected the family reality. This was similarly recognized in earlier studies (Deucuir, 1991; Jacobsen & Killén, 2015).

Additional added value of the musical interventions was in the playful and nonverbal qualities of free musical improvisation as illustrated: "I saw how powerful the musical instruments are, bypassing the conscious, and which incorporate within them elements of surprise". It is furthered by literature, wherein the musical intervention enabled families to deal with troubling issues by recruiting their positive life energy and resources and bypassing habitual stances (Oldfield, 2006b; Oldfield, Bell, & Pool, 2012; Pasiali, 2012).

Family-based music therapy afforded the family therapists an accurate and valuable tool for family clinical assessment. Music therapy as a family assessment tool is a relatively new and developing division in music therapy. Innovative studies developed valid assessment tools based on structured observations of parent-child musical interactions (Davies, 2008; Jacobsen & Killén, 2015; Oldfield, 2006). Following the development of validated parent-child music therapy assessment tools (Jacobsen & Killén, 2015), this study may inform of the potential of family-based

musical interventions as a family assessment tool. This needs to be further explored, researched, developed and validated. Observing family-musical interactions may provide easy, accurate, and rapid family assessments in an array of clinical circumstances, in family therapy settings, in a music therapy setting, or as part of an interdisciplinary team as carried out in psychiatry (Oldfield, 2006; McIntyre, 2009).

On a different note, participants emphasized that the sessions were highly effective with families with young children, offering them a non-verbal intervention media. Goldenberg and Goldenberg (2008) discussed an existing paradigm shift toward systems theories, shifting to a family perspective in therapy, acknowledging the importance of understanding the context of what is occurring with the whole family; which "provides the context for understanding individual functioning" (p. 16). Although there are many valuable reasons to include children in family therapy sessions, at the same time the literature describes the growing tendency to exclude children from the therapy room (Armstrong & Simpson, 2002; Goldenberg & Goldenberg, 2008; Hibben, 1992; Lowenstein, 2010). Some reasons concerned the children's inability to express themselves verbally, or they might misbehave, become bored, or interrupt the sessions. Other reasons related to the therapists, such as their wish to protect the children, while other reasons were their unfamiliarity with working with children and lack of training and techniques suitable to work with and treat families with children, many times overlooking the needs of the family. Nevertheless, there is a growing awareness to the added value of using expressive arts, especially when families with children are involved (Kerr et al., 2008; Lowenstein, 2010). Oldfield, Bell, and Pool (2012) contended, "In many cases involving music therapy work with families, nonverbal, improvised music-making and playful musical exchanges seem to be key components in facilitating family interactions" (p. 250).

With this in mind, the system approach of family-based music therapy interventions offered an opportunity for inclusion of children in family therapy in a playful and positive family experience, provided by family therapists who acquired a designated short training.

From a professional perspective, active participants described the sessions as a professional opportunity for growth—an addition of an experiential musical technique to their toolbox. It also offered an opportunity for personal explorations of various professional attributes and challenges which were explored in the musical sessions. Therapists were challenged with self-doubt, feared confronting family resistance, chaos, noise, and the unpredictability of where the session might lead. More so, the therapists were confronted with the need to trust the musical process, become playful with the families, improve their attention, hold back on their interpretations, and become more intuitive. In spite of the professional challenges, active participants agreed that the family-based musical sessions they applied in the research were positive experiences for the families as well as for the therapists. The outcomes noted the therapists' growing comfort to employ the sessions, high satisfaction with the sessions' outcomes, and a statistically significant growth in their confidence to implement musical sessions from pre-intervention scores to their final application of the musical session. The majority of therapists asserted their intention to keep applying musical interventions in the future, but the same time, stressed their desire and need for additional training in the field of family-based music therapy to gain confidence to use music in their clinical work.

Coinciding with the growing openness toward expressive arts mentioned by the participants, innovations in neuroscience presented studies in which music contributed to an array of individual and family developmental, interactional and

social objectives (Koelsch et al., 2010; Molnar-Szakacs & Overy, 2006; Overy & Molnar-Szakacs, 2009; Stegemoller, 2014). Studies in neuroscience concluded that music therapy could promote the brain's neuroplasticity, affecting many functions by creating new and alternative neural connections and pathways (Stegemoller, 2014). These theories could help explain what makes music therapy interventions work in such an impressive manner. Stegemoller illustrated how music stimulated the development of new neurochannels, inducing change in ways that could not be accessed by words. This may well have an impact on a range of family functioning domains including social interactions, emotional expression, cognitive functioning, speech and communication, and body movement. The neurobiological discoveries reinforce theories in communicative musicality (Malloch & Trevarthen, 2009), musical dialogues (Trevarthen & Malloch, 2000), and affect attunement (Stern, 1985) which may play a role in family-based music therapy, wherein mutual music improvisation that involves attuning, responding, matching, and communicating may similarly support the development of self in relation to others.

Providing music therapy interventions by family therapists could raise ethical and professional questions as to the extent in which musical interventions can be provided by clinicians, who are not trained as music therapists. Ruud (2010) noted that "music therapists tend to defend their profession from outsiders" (p. 7). Ruud asserted that professionals and clinicians from other disciplines, as well as people themselves, may use musical interventions "as a toolkit of music therapy intervention techniques" (p. 7) to promote health and well-being. As noted earlier, borrowing from music therapy interventions does not replace the immense body of knowledge of music therapy, but rather uses the natural human musicality and the natural therapeutic qualities of music. Rudd stresses the importance to establish clear borders

between "traditional music therapy and other health musicking or music educational practices" (p. 6). With this in mind, there needs to be an understanding of the necessity to comply with health care guidelines and ensure ethical considerations when teaching and using musical interventions, and establishing guidelines to using music in other clinical fields. Family-based music therapy as used in this study is a technique rather than a profession. As such, it does not provide family therapists with a music therapist's professional competence.

It a world of fast growth and changes it might be time for more cooperation between the various therapies. This study informs, that like in a family, strength comes from learning from each other, sharing knowledge, acknowledging the unique value of each field, and growing together to form a solid integrated field of creative arts and family therapy. It is now commonsense that at this point, the fields of therapy are ready for mutual collaboration: a collaboration of family therapy and music and music therapy with families. They offer an interdisciplinary connection, which helps promote individual and family congruence and wellbeing.

Recommendations

The outcomes of the study inferred that the first step needed to develop the professional niche of family-based music therapy is to create opportunities to present the interdisciplinary field within professional communities. Although Bruscia (1986) mentioned family formats as an area which calls for advanced competencies and clinical skills in the field of music therapy, currently, the researcher found no training options in either music therapy with relation to family systems interventions, or family therapy with relation to music therapy interventions. Current family therapy and music therapy literature rarely address training or courses that teach the multidisciplinary field of family-music therapy. The literature only noted that

therapists who use family-art interventions must have dual expertise, with a creative arts education as well as a family systems perspective (Lowenstein, 2010).

Current studies show that family-centered practices are increasingly associated with highly effective intervention for children and families (Dunst, Trivette, & Hamby, 2007). Complementing this, expressive arts are associated with being a highly effective intervention for families and children (Kerr et al., 2008). With this awareness, and based on the study outcomes, specialized training in family-based music therapy may be developed and added to family therapy education. In the complementary field of music therapy family-based music therapy training may be added in music therapy education. The outcomes suggest that it is imperative that the family education systems acknowledge the therapeutic value of creative arts in family therapy, encourage and promote the integration of knowledge and wisdom. This connection, cooperation and collaboration could benefit personal and family health and well-being.

Based on the success of the short training in the study, it seems that training family therapists to use musical techniques is a viable accomplishment. Courses and training in the family-based music therapy model and other family-music therapy models need to be created and designed, and presented to educators in the field. Based on the participants' suggestions, it could be designed as a compulsory basic course, or be given in small samples which enable students a taste of family-music interventions, or as an advanced-level elective training for experienced therapists, and anything in between. It is important to advocate the importance of family-music therapy, so that it may become an integral part of family therapy education. This study may be viewed as a step towards accomplishing this goal.

On a different note, family therapists mentioned their lack of training, practice, and shortage of interventions and techniques for working with children in the family context. This study offers a potent experiential intervention for families and children. As Donna in her interview noted, family-based music therapy could become a great asset and opportunity, especially when therapists aspire to include the children. She stressed the need for additional and comprehensive training to accomplish this successfully. She also called for additional family-based music therapy structured interventions for addressing other family objectives.

As previously mentioned, hesitations to use musical interventions were linked to early childhood criticism and negative experiences. As children, they were criticized for their lack of musical talent, singing off-key, or making too much noise. These negative feelings and perceptions about personal musicality, led many therapists to avoid any personal expression using music and voice. Future research may address topics such as early musical education and free-expression; cultural and professional attitude towards expressive arts; cultural issues concerning free musical and vocal expression, and perceptions towards 'making noise'.

The research outcomes warrant further substantiation. This denotes replicating the study questions concerning applicability and therapeutic value of family-based music therapy interventions with larger samples, addressing diverse populations, and expanding the research to other family-based musical interventions. Future studies could also compare musical interventions with verbal or other interventions seeking a quantitative comparison.

Lastly, based on the noteworthy assessment quality elicited by using the musical intervention, the study may pave the way to developing a family-based music therapy model as a family assessment tool. The multifaceted experiences of a family

improvisation are manifested in complex verbal, non-verbal and musical representations. The amount of data in family-based musical sessions is enormous. Therefore, it calls for wisely choosing the musical elements to be analyzed, and meticulous and careful analysis of the data.

Limitations

The study was initially designed for self-referred therapists who found the research topic attractive and were interested in participating in the study. With this intention, the researcher set the goal for each participant to deliver at least three interventions in their clinical settings. As it turned out, there were fewer self-referred candidates for the research than expected and a surge of interest from family therapy centers inviting the researcher to deliver the research to their staff. This provided an opportunity to deliver the research to staff-training participants who were not always interested or open-minded about the use of music in therapy. These participants offered the researcher a broader view of family therapists' perceptions of the subject along with an unrealistic goal for them to apply three sessions. As it turned out, many family therapy centers focused on working with parents, excluding the children, which meant few families suited the research criteria. The active participants applied the intervention with all suitable families in their practices; which totaled 38 sessions. Due to practical considerations and the researcher's limited time resources and accessibility to additional participants, the researcher was satisfied with this amount, compromising the quantitative representation with highly saturated qualitative data.

Another limitation is that the model considered only family members who were not musicians. None of the research sessions included a musician family member. The use of music in family therapy with a musician as a family member remains to be explored.

Finally, the study was based on the unique expertise of the researcher using a family-based family therapy model. The researcher collected the data, and carried out the training other family therapists to use this model. Although the researcher took steps to increase objectivity and reduce personal biases (as mentioned in the Methods chapter), the researcher's roles might have influenced the participants and the results.

Conclusions

The goals of family-based music therapy are not to perform musically, but rather to improve family functioning. When music is introduced into family therapy, it stimulates family dynamics, interactions, communication, and behavior by providing an enhanced learning environment. The research aspired to communicate the potential of music therapy interventions for promoting family congruence and wellbeing. The study findings substantiated the therapeutic value, and potential role of family-based musical interventions in family therapy provided by family therapists with non-clinical families. This study complemented the preliminary pilot study (Nemesh, 2014) that established the potential for including families in music therapy sessions. This study urges the professions of expressive-arts therapies, music therapy and family therapy to formally acknowledge and address the interdisciplinary niche professions of family-arts therapies, address the training, skills and the advanced competencies necessary for professional competency. More research is required to gain additional knowledge and expand the use of family-music therapy from both music therapy and family therapy perspectives.

APPENDIX A

Invitation to Participate in Family-Based Music Therapy Research

Invitation

To participate in the research project: **Family Therapists' Perspectives on Using Music in Family Therapy**

Dear family therapist:

As part of my PhD research study in Lesley University, Cambridge, Mass. USA, I am conducting a research focused on the use of music in family therapy.

The aim of this study is to increase the knowledge of how the use of music in a family therapy session is perceived and experienced by family therapists.

Former knowledge or experience in music or playing music is not necessary.

As a family therapist, you can give me first-hand information from your own perspective.

The study provides family therapists with a 3-4 hour experiential workshop on the use of music in family therapy, concentrating on the musical technique "*family roles*" as a family-music intervention. Therapists who will be interested in participating in the research will be asked to implement the intervention with at least three families in their clinic. After each family-music session, the therapist will complete a questionnaire on their perception of the session.

Your participation, any identifying information, and responses will be kept confidential.

The musical instruments for the research will be provided by the researcher.

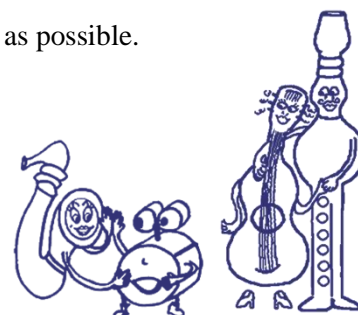
Your participation in the research is valuable, and the findings may offer greater understanding of the possibilities within structured musical intervention in family therapy.

If you are interested in receiving more information, have any questions, or wish to participate in the research, please contact me and I will get back to you as soon as possible.

Thank you,

Beth Nemesh, email: bnemesh@lesley.edu

Phone: xxxxxxxxxxx



APPENDIX B

Informed Consent

INFORMED CONSENT FORM

Study of: Family Therapists' Perspectives on Using Music in Family Therapy

Principal Investigator: *Beth Nemesh*. Co-researcher: *Dr. Robyn Flaum-Cruz*
PhD program in Expressive Therapies, Lesley University

You are being asked to volunteer in this study to assist in my doctoral research on
Family Therapists' Perspectives on Using Music in Family Therapy

The purpose of the study is to increase the knowledge about family therapists' perceptions on the use of a structured family-music intervention in family therapy.

- You will be asked to complete a demographic and professional questionnaire, which includes your personal information and professional training as a family therapist, as well as a consent form to participate in the research.
- The researcher will provide you with a 3-4 hour experiential training-workshop on the use of music in family therapy, concentrating on the musical technique "*family roles*" as a family-music intervention.
- After the training, you will be asked to fill an evaluation form regarding the training and future training prospects.
- You are expected to implement the intervention with at least three families in your clinic.
- The researcher will be responsible to equip you with set of musical instruments and a recording device. After each *family roles* music session, you will complete a questionnaire on your perception and experience of the session and email or mail the questionnaire to the researcher at the address:
bnemesh@lesley.edu or: Beth Nemesh, POB 47 Givat-Elah, Israel, 36500
- Upon completing your musical interventions for the research, a sample of the therapists will be invited to take part in a 30-minute interview about the family-music therapy experience. The interview will be scheduled at the convenience of the therapist and could be performed in person or by phone by the researcher.
- The aim of the interview is to facilitate a deeper understanding of the results, offering further insight and knowledge.
- Participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.

You will be personally interacting with only me as the principal researcher. This research project is anticipated to be finished by approximately *January, 2016*.

I, _____, consent to participate in the research:
Family Therapists' Perspectives on Using Music in Family Therapy, conducted by Beth Nemesh.

I understand that:

- I am volunteering for a workshop involving experiential training of a structured musical intervention on *family roles*, approximately 3-4 hours in length.
- I am required to complete a demographic form, and an evaluation of the training.
- I am asked to implement family roles musical intervention with at least three families at my clinic/work.
- My identity will be protected and session materials, including questionnaires, recordings, or interviews will be kept confidential and used anonymously only for purposes of supervision, presentation, and/or publication.
- The transcripts and questionnaires will be kept in a locked file cabinet in the investigator's possession for possible future use. However, this information will not be used in any future study without my written consent.
- I may choose to withdraw from the study at any time with no negative consequences.
- If I find that I have severe concerns, I will be provided with resources and referrals to assist me and will not lose any benefits that I might otherwise gain by staying in the study.
- The study will not necessarily provide any benefits to me. However, I am provided with a family-music therapy workshop and techniques, which may increase my professional knowledge and may be used in my therapeutic work. The results of the study may also help to increase public and professional awareness of the value of family-music therapy.
- The researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision, etc.).

Confidentiality, Privacy, and Anonymity:

*You have the right to remain anonymous. If you elect to remain anonymous, we will keep your records private and confidential **to the extent allowed by law**. We will use pseudonym identifiers rather than your name on study records. Your name and other facts that might identify you will not appear when we present this study or publish its results.*

If for some reason you do not wish to remain anonymous, you may specifically authorize the use of material that would identify you as a subject in the experiment. You can contact my advisor Dr. Robyn Flaum-Cruz by email: rcruz@lesley.edu with any additional questions. You may also contact the Lesley University Human Subjects Committee Co-Chairs (see below)

You will be given a copy of this consent form to keep.

(a) Investigator's Signature:

Date	Investigator's Signature	Print Name
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(b) Subject's Signature:

I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as described above. I understand that I am free to discontinue participation at any time if I so choose, and that the investigator will gladly answer any questions that arise during the course of the research.

Date	Subject's Signature	Print Name
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There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Co-Chairs Drs. Terry Keeney or Robyn Cruz (include email addresses) at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138.

APPENDIX C

Pre-Intervention Demographic Questionnaire

Therapist Demographic / Professional Questionnaire

Therapist Code

#

First name: _____ Family Name: _____

Tel. _____ Email: _____

Gender: F / M Age: _____

What is your highest level of education?

Bachelor / Master / Doctoral / Professional degree / Other: _____

Years of experience as a family therapist: _____

What are your main professional training orientations?

Structural / Narrative / Adlerian / Experiential / Psychoanalytic / Cognitive-behavioral

Other: _____

Are you also trained as an expressive arts therapist? Yes / No

If you are an expressive therapist, circle your modality:

Music / visual arts / Dance-movement / Drama / Psychodrama

You are currently employed in: Public sector / Private sector / Volunteer / Other: _____

How frequently do you use arts in family therapy?

	Never	Rarely	Occasionally	Frequently	Very Frequently
Music					
Visual arts					
Dance & Movement					
Drama					
Psychodrama					

Describe your musical background (playing/studying music, choir, significant memories):

	1 Not at all	2 Slightly	3 Moderately	4 Very much	5 Extremely
How knowledgeable and skilled are you in music?					
How knowledgeable and skilled are you in other expressive arts?					
To what extent do you believe your musical knowledge will influence your ability to perform a FBMT session?					
In your opinion, does FBMT have a potential of becoming a common family therapy intervention?					
To what extent do you feel confident to apply a FBMT intervention?					

- After completing your research intervention, will you be willing to take part in an interview concerning your personal experience? Yes / No
- Please describe your **initial response** to family-music therapy; what was your reaction at the suggestion to include music interventions in family therapy?

APPENDIX D

Family Roles—Intervention Protocol

***Family Roles*—PROTOCOL**

Music instruments: A large variety of instruments (percussion, wind, strummed, wooden, metal, plastic, large and small, modern and old). **A recording device.**

Aim: Identify family roles and their implications on self-identity, self-fulfillment and self-worth. Detect coalitions, exclusions, family rules, and boundaries. Encourage expression of emotions and facilitate family communication. Explore new possibilities for change and belonging.

Instructions: (approximate timing for a 60-minute session)

10 minute: Verbal check-in

15 minutes: Direct the family members to check out the instruments in the room and choose an instrument that reflects their perception of their family role. Invite them perform together an initial *family concert* improvisation. Remind them the music is being recorded.

Ask the family to listen to the recording.

15 minutes: Ask each of the participants:

- What instrument did you choose?
- How does this instrument reflect your role in the family?
- What did you learn through the family concert?
- What would you like to change?

10 minutes: Continue music intervention: Invite the family to play a second version of the *family concert*. The family can implement any changes or new ideas into the second improvisation.

Record, and let the family listen.

10 minutes: Verbal processing:

- What has changed?
- What have you learned from this about yourself and your role in the family?
- What would you like to change for yourself?
- What do you wish for your family?

Bring the session to a verbal or musical closure.

APPENDIX E

List of Musical Instruments

Family-Based Musical Intervention: List of Musical Instrument

Drums:

Large darbukah
 Small Darbukah
 Gathering drum
 Timbrel

Metal

Glockenspiel
 Cowbell
 Bell
 Wind chimes
 Cymbals
 Tibetan bell
 Cabasa

Guitar

Microphone

Wind instruments

Melodica
 Pan flute
 Recorder—plastic
 Recorder—wood
 Irish flute
 Bamboo flute
 Kazoo
 Harmonica
 Whistle
 Train whistle
 Clown sliding whistle

Wood Percussion

Guiro scraper
 Croaking frog
 Woodblock
 Wood claves
 Xylophone
 2 Maracas
 Rain stick
 Wood clacker
 Egg shaker
 Kalimba
 Castanets
 Plastic hammer
 Goat nails rattle (Chapch(a))

APPENDIX F

Workshop Handout—Theoretical Foundations

Family-Based Music therapy (FBMT)—Theoretical Background

Beth Nemesh, MA, MT-BC, R-MFT

While family therapy and music therapy have independently been well documented to be effective health practices, a review of the literature demonstrated a gap concerning conjoined family-music therapy for family based interventions. Family-music therapy has been a developing field in the last 15 years, focused primarily on children with special needs and their families. Contemporary family-music therapy literature focuses on early-intervention with young children or improving parenting skills (Nicholson, Berthelsen, Williams, & Abad, 2010; Pasiali, 2012), families who have children with autism (Thompson, 2012), child psychiatry (Oldfield, 2006), terminal illness (Abad, 2003), and other child-centered interventions. This research expands the application of family-music therapy interventions beyond the traditional treatment, developing a new perspective of family-music therapy as a family-based music therapy intervention for non-clinical families.

A preceding pilot study (Nemesh, 2014) offered insight into the therapeutic value and applicability of the family-based musical intervention applied by a dual expertise; family and music therapist. It was found to elicit valuable assessment and intervention opportunities. Families were able to identify family difficulties and make a musical and family change in the "here and now" experience. This study aims to explore the applicability and added value of family-based music therapy interventions provided by a single-expertise family therapist following a single training workshop. Introducing musical interventions borrowed from music therapists as additional techniques in traditional family therapy broadens the family therapist's toolbox with a potent experiential vehicle for assessment and intervention.

Two theoretical models form the foundations of the study—Juliette Alvin's free improvisation music therapy and Virginia Satir's experiential family therapy models. Because literature on music therapy with non-clinical families is scarce, this model is based on neighboring fields such as family-art therapy, knowledge gathered from family-music therapy for treating families with children with special needs, group-music therapy, and group improvisation. Their designs, interventions, and

outcomes were studied to form a basis for designing the interventions in this research. Finally, the review touches on developmental models and theories featuring inherent musicality, as well as neuromusicology studies that offer an additional and innovative dimension to understanding the ways in which family-based music therapy affects the body, the mind, interactions, and relations.

Virginia Satir's experiential family therapy focuses on positive experiential interventions. The most important goal is developing self-worth and congruence. She emphasized building on individual and family strengths, accessing one's own resources, considering different possibilities and choices, and reconnecting her clients to their positive life-energy. In her experiential interventions, she used expressive arts such as family sculpting, drama, visual arts, and other experiential activities aimed at promoting the family's communication and identifying the roots of their habitual, noncongruent survival stances (Satir, Banmen, Gerber, & Gomori, 1991). Experiential family therapy enabled the integration of family therapy and the arts and paved the way for family art therapies.

Complementing Satir's humanistic experiential family therapy is Alvin's free improvisation model based on the philosophy that music is a potential space for free expression without guidelines and confinements to musical and expressional rules. Free improvisation allows freedom to use any musical activity, play instruments, and make any sounds without previous training. Through choosing and playing musical instruments, members project their inner worlds onto the instruments and music. The family improvisation and musical representations accurately reflect and expresses internal needs, emotions, beliefs, and expectations of oneself and others (Bruscia, 1987).

Family-based music therapy is following the success of family-art therapy, which gained recognition in the 1970s as a powerful creative process that ultimately enhanced recovery, health, and wellness (Kerr, Hoshini, Sutherland, Parashak, & McCarley, 2008). As a result, art therapy became an effective and important method of communication, assessment, and treatment for both children and adults in a variety of settings (American Art Therapy Association, 2015). Visual-art therapy leads the field of family arts therapies, with many publications establishing a theoretical basis, intervention procedures, and assessment tools (Lowenstein, 2010; Malchiodi, 2012).

Molnar-Szakacs and Overy's (2006) studies of the brain noted music's unique abilities affecting development of emotional and social interactions and

communication using processes involving mirror neurons and other brain formations. Theories in communicative musicality (Malloch & Trevarthen, 2009), musical dialogues (Trevarthen & Malloch, 2000), and affect attunement (Stern, 1985) may play a role in family-based music therapy, wherein mutual music improvisation that involves responding, matching, and communicating may similarly support the development of self in relation to others. Music was shown to influence a person's energy levels, emotions, interactions, social connections, communication, empathy, and understanding of others. It promotes cohesion, cooperation, shared goals, and physical synchronization (Koelsch, Offermanns, & Franzke, 2010; Molnar-Szakacs & Overy, 2006; Overy & Molnar-Szakacs, 2009; Stegemoller, 2014).

References

- Abad, V. (2003). Time of turmoil: Music therapy interventions for adolescents in a paediatric oncology ward. *Australian Journal of Music Therapy*, 14, 20-37.
- American Art Therapy Association (AAT(A)). (n.d.). Welcome to the American Art Therapy Association! Retrieved from <http://www.arttherapy.org>
- Bruscia, K. (1987). *Improvitational models of music therapy*. Springfield, IL: Charles C. Thomas Publisher.
- Kerr, C., Hoshini, J., Sutherland, J., Parashak, S., & McCarley, L. (2008). *Family art therapy: Foundations of theory and practice*. New York, NY: Routledge/Taylor & Francis Group
- Koelsch, S., Offermanns, K., & Franzke, P. (2010). Music in the treatment of affective disorders: An exploratory investigation of a new method for music-therapeutic research. *Music Perception*, 27(4), 307-316.
doi:10.1525/mp.2010.27.4.307
- Lowenstein, L. (Ed.). (2010). *Creative family therapy techniques: Play, art, and expressive activities to engage children in family sessions*. Toronto, Canada: Champion Press.
- Malchiodi, C. (2012). Art therapy with families and couples. In C. A. Malchiodi (Ed.), *Handbook of art therapy* (2nd ed., pp. 409-421). New York, NY: Guilford Press.
- Malloch, S., & Trevarthen, C. (2009). Musicality: Communicating the vitality and interests of life. In S. Malloch, C. Trevarthen (Eds.), *Communicative musicality: Exploring the basis of human companionship* (pp. 1-11). New York, NY: Oxford University Press.
- Molnar-Szakacs, I., & Overy, K. (2006). Music and mirror neurons: From motion to 'e'motion. *Social Cognitive and Affective Neuroscience*, 1(3), 235-241.
doi:0.1093/scan/ns1029
- Nemesh, B. (2014). *Family-music therapy for promoting family congruence: From dissonance to harmony*. Unpublished manuscript, Doctoral Program in

Expressive Therapies, Lesley University, Cambridge, MA.

- Nicholson, J., Berthelsen, D., Abad, V., Williams, K., & Bradley, J. (2008). Impact of music therapy to promote positive parenting and child development. *Journal of Health Psychology, 13*(2), 226-238.
- Oldfield, A. (2006). *Interactive music therapy in child and family psychiatry: Clinical practice, research and teaching*. London, UK: Jessica Kingsley Publishers.
- Overy, K., & Molnar-Szakacs, I. (2009). Being together in time: Musical experience and the mirror neuron system. *Music Perception, 26*(5), 489-504.
- Pasiali, V. (2012). Supporting parent-child interactions: Music therapy as an intervention for promoting mutually responsive orientation. *Journal of Music Therapy, 49*(3), 303-334.
- Satir, V., Banmen, J., Gerber, J., & Gomori, M. (1991). *The Satir model: Family therapy and beyond*. Palo Alto, CA: Science and Behavior Books.
- Stegemoller, E. (2014). Exploring a neuroplasticity model of music therapy. *Journal of Music Therapy, 51*(3), 211-227.
- Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York, NY: Basic Books.
- Thompson, G. (2012). Family-centered music therapy in the home environment: Promoting interpersonal engagement between children with autism spectrum disorder and their parents. *Music Therapy Perspectives, 30*(2), 109-116.
- Trevarthen, C., & Malloch, S. N. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordisk Tidsskrift for Musikterapi, 9*(2), 3-17. doi:10.1080/08098130009477996

APPENDIX G

Workshop Evaluation Form

Family-Based Music Therapy (FBMT)—Training Evaluation

In your opinion:	1 Not at all	2 Slightly	3 Moderately	4 Very much	5 Extremely
Were the training objectives met?					
Was the training knowledgeable?					
Was the quality of instruction good?					
Was the length of the workshop sufficient for the training?					
Were questions and problems dealt with appropriately?					
To what extent have your skills in FBMT intervention improved as a result of the training?					
To what extent do you expect this training will make a difference in the way you perform as a family therapist?					
To what extent do you feel confident to apply a FBMT intervention?					
Will you be interested in participating in future FBMT training?					
What extent will you recommend FMT training to other therapists?					
To what extent could you use this intervention with other clients?					
Would you recommend adding FBMT training in basic family therapy training?					
Would you recommend adding FBMT training as an elective training?					

What were the best aspects of the workshop?

If you were given the task of revising, adjusting, or redesigning this training, what would you change to improve this workshop?

What obstacles might hold back your implementation of family-based musical interventions?

What additional assistance/resources, if any, will you need to be able to implement music in family therapy?

APPENDIX H

Musical Intervention Evaluation Form

Family-Based Music Therapy (FBMT)—Session Evaluation

Therapist Code# _____ Family # _____ Date _____

	In your opinion:	1 Not at all	2 Slightly	3 Moderately	4 Very much	5 Extremely
1	To what extent do you feel confident to apply the FBMT session?					
2	Did you have enough time to complete the assigned task?					
3	Was the selection of musical instrument suitable for the family's needs?					
4	Was the room and space suitable for the intervention?					
5	To what extent was it easy and practical to transport the musical instruments?					
6	To what extent did you feel competent using the recording device?					
7	To what extent were you concerned about the safety of the instruments?					
8	In your opinion, how significant was this session for the family?					
9	How much cooperation did you have from the family?					
10	Do you think the family will be interested in additional musical interventions in the future?					
11	Would you consider continuing the FBMT session?					
12	How comfortable were you providing family-music therapy before the session?					

	In your opinion:	Not at all	Slightly	Moderately	Very much	Extremely
13	How comfortable were you providing family-music therapy during the session?					
14	How comfortable were you providing family-music therapy after the session?					
15	To what extent was your own musical competence an important factor in the session?					
16	To what extent did this session contribute to your growth as a therapist?					
17	To what extent did you witness opportunities for therapeutic interventions in the session?					
18	To what extent did the session reveal new information about the family dynamics?					
19	To what extent did the session validate prior information?					
20	To what extent did the session contradict previous information?					
21	How would you rate the effectiveness of this session?					

- Do you have any remarks/suggestions concerning the musical instruments?

- What is the one most important thing you learned about the family?

- What is the one most important thing you learned about yourself?

- What were the greatest strengths/benefits of the FBMT session?

- What were the main weaknesses of the FBMT session?

- Any additional comments on the FBMT session:

References

- Aasgaard, T. (2001). An ecology of love: Aspects of music therapy in the pediatric oncology. *Journal of Palliative Care, 17*(3), 177-181.
- Abad, V. (2002). Sing and grow: Helping young children and their families grow together through music therapy early intervention programs in community settings. *Annual Journal of the New Zealand Society for Music Therapy, 36-50*.
- Abad, V. (2003). Time of turmoil: Music therapy interventions for adolescents in a paediatric oncology ward. *Australian Journal of Music Therapy, 14*, 20-37.
- Abad, V., & Williams, K. (2007). Early intervention music therapy: Reporting on a 3-year project to address needs with at-risk families. *Music Therapy Perspectives, 25*(1), 52-58.
- Allgood, N. (2005). Parents' perceptions of family-based group music therapy for children with autism spectrum disorders. *Music Therapy Perspectives, 23*(2), 92-99.
- Alvin, J. (1977). The musical instrument as an intermediary object. *British Journal of Music Therapy, 8*(2), 7-12.
- American Art Therapy Association (AAT(A)). (n.d.). *Welcome to the American Art Therapy Association!* Retrieved from <http://www.arttherapy.org>
- American Music Therapy Association (AMT(A)). (2015). *What is music therapy?* Retrieved from <http://www.musictherapy.org/>
- Armstrong, S. A., & Simpson, C. S. (2002). Expressive arts in family therapy: Including young children in the process. *TCA Journal, 30*(2), 2-9.

- Armstrong, V. G., & Howatson, R. (2015). Parent-infant art psychotherapy: A creative dyadic approach to early intervention. *Infant Mental Health Journal*, 36(2), 213-222. doi:10.1002/imhj.21504
- Arrington, D. B. (2001). *Home is where the art is: An art therapy approach to family therapy*. Springfield, IL: Charles C. Thomas.
- Association for Play Therapy (n.d.). *Play therapy makes a difference*. Retrieved from <http://a4pt.site-ym.com/?page=PTMakesADifference>
- Ayres, L., Kavanaugh, K., & Knafl, K. A. (2003). Within-case and across-case approaches to qualitative data analysis. *Qualitative Health Research*, 13(6), 871-883. doi:10.1177/1049732303013006008
- Bailey, L. (1984). The use of songs in music therapy with cancer patients and their families. *Music Therapy*, 4(1), 5-17. doi:10.1093/mt/4.1.5
- Banker, J. E. (2008). Family clay sculpting. *Journal of Family Psychotherapy*, 19(3), 291-297. doi:10.1080/08975350802269533
- Banmen, J. (Ed.). (2006). *Applications of the Satir growth model*. Wendell, NC: Virginia Satir Network.
- Banmen J., & Maki-Banmen, K. (2014). What has become of Virginia Satir's therapy model since she left us in 1988? *Journal of Family Psychotherapy*, 25, 117-131. doi:10.1080/08975353.2014.909706
- Bates, A. P., & Babchuk, N. (1961). The primary group: A reappraisal. *The Sociological Quarterly*, 2, 181-191.
- Blacking, J. (1973). *How musical is a man?* Seattle, WA: University of Washington Press.
- Bloch, D., & Ackerman, N. (1976). Family therapy, group therapy. *International Journal of Group Psychotherapy*, 26(3), 289-299.

- Bowlby, J. (1982). *Attachment and loss: Volume 1. Attachment*. New York, NY: Basic Books.
- Bratton, S. C, Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376-390. doi:10.1037/0735-7028.36.4.376
- Bromfield, R. N. (2003). *Psychoanalytic play therapy*. Retrieved from <http://www.psychceu.com/schaefer/0471264725.pdf>
- Brooke, S. L. (2004). *Tools of the trade: A therapist's guide to art therapy assessments*. Springfield, IL: Charles C. Thomas.
- Bruscia, K. (1986). Advanced competencies in music therapy. *Music Therapy*, 6(1), 57-67. doi: 10.1093/mt/6.1.57
- Bruscia, K. (1987). *Improvisational models of music therapy*. Springfield, IL: Charles C. Thomas.
- Bruscia, K. (1991). *Case studies in music therapy*. Gilsum, NH: Barcelona Publishers.
- Bull, R. (2008). Autism and the family: Group music therapy with mothers and children. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 71-87). London: Jessica Kingsley.
- Bunt, L. (1994). *Music therapy: An art beyond words*. London, United Kingdom: Routledge.
- Chan, Z. C. Y., & Ma, J. L. C. (2008). Unwrapping the box: Dancing with the clients. *Health Care for Women International*, 29, 431-445. doi:10.1080/07399330701876661
- Clow, F. R. (1919). Cooley's doctrine of primary groups. *American Journal of Sociology*, 25(3), 326-347.

- Collison, C. R., & Miller, S. L. (1983). The role of family re-enactment in group psychotherapy. *Perspectives in Psychiatric Care*, 23(2), 74-89.
doi:10.1111/j.1744-6163.1985.tb00259.x
- Creswell, J. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Upper Saddle River, NJ: Pearson Education.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Cross, I. (2001). Music, mind and evolution. *Psychology of Music*, 29(1), 95-102.
doi:10.1177/0305735601291007
- Cross, I. (2003). Music, cognition, culture and evolution. In I. Peretz & R. J. Zatorre (Eds.), *The cognitive neuroscience of music* (pp. 42-56). Oxford, United Kingdom: Oxford University Press.
- Cross, I., & Woodruff, G. (2009). Music as a communication medium. In R. Botha & C. Knight (Eds.), *The prehistory of language* (pp. 77-98). Oxford, United Kingdom: Oxford University Press.
- Davies, E. (2008). It's a family affair: Music therapy for children and families at a psychiatric unit. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 121-140). London, United Kingdom: Jessica Kingsley.
- Davies, A., & Richards, E. (2010). Making links between group analysis and group music therapy. *Groups*, 34(1), 21-35.

- Decuir, A. (1991). Trends in music and family therapy. *The Arts in Psychotherapy*, 18(3), 195-199. doi:10.1016/0197-4556(91)90113-O
- Devereaux, C. (2008). Untying the knots: Dance/movement therapy with a family exposed to domestic violence. *American Journal of Dance Therapy*, 30(2), 58-70.
- Duff, S. (1996). A study of the effects of group family play on family relations. *International Journal of Play Therapy*, 5(2), 81-93. doi:10.1037/h0089348
- Dulicai, D. (2009). Family dance/movement therapy: A systems model. In S. Chaiklin & H. Wengrower (Eds.), *The art and science of dance/movement therapy: Life is dance* (pp. 145-158). New York, NY: Routledge/Taylor & Francis Group.
- Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2007). Meta-analysis of family-centered helping practices research. *Mental Retardation & Developmental Disabilities Research Reviews*, 13(4), 370-378.
- Flower, C. (2008). Living with dying: Reflections on family music therapy with children near the end of life. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 177-189). London, United Kingdom: Jessica Kingsley.
- Gabriels, R. L. (2003). Art therapy with children who have autism and their families. In C. A. Malchiodi (Ed.), *Handbook of art therapy* (pp. 193-206). New York, NY: Guilford Press.
- Gardstrom, S. (2007). *Music therapy improvisation for groups: Essential leadership competencies*. Gilsum, NH: Barcelona Publishers.
- Gil, E. (2011). Family play therapy: Igniting creative energy, valuing metaphors, and making changes from the inside out. In C. E. Schaefer (Ed.), *Foundations of play therapy* (2nd ed., pp. 207-226). Hoboken, NJ: John Wiley & Sons.

- Goldenberg H., & Goldenberg I. (2008). *Family therapy: An overview* (7th ed.). Belmont, CA: Thomson Brooks/Cole.
- Hanser, S. B., Butterfield-Whitcomb, J., Kawata, M., & Collins B. E. (2011). Home based music strategies with individuals who have dementia and their family caregivers. *Journal of Music Therapy*, 48(1), 2-27. doi:10.1093/jmt/48.1.2
- Harvey, S. (2008). An initial look at the outcomes for dynamic play therapy. *International Journal of Play Therapy*, 17(2), 86-101. doi:10.1037/a0013663
- Hasler, J. (2008). A piece of the puzzle: Music therapy with looked-after teenagers and their carers. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 159-175). London, United Kingdom: Jessica Kingsley.
- Hesse-Biber, S. N. (2010). *Mixed methods research: Merging theory with practice*. New York, NY: Guilford Press.
- Hibben, J. (1992). Music therapy in the treatment of families with young children *Music Therapy*, 11(1), 28-44. doi:10.1093/mt/11.1.28
- Hinman, M. L. (2010). Our song: Music therapy with couples when one partner is medically hospitalized. *Music Therapy Perspectives*, 28(1), 29-36. doi:10.1093/mtp/28.1.29
- Horvat, J., & O'Neill, N. (2008). "Who is the therapy for?" Involving a parent or carer in their child's music therapy. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 89-101). London, United Kingdom: Jessica Kingsley.
- Jacobsen, S. L., & Killén, K. (2015). Clinical application of music therapy assessment within the field of child protection. *Nordic Journal of Music Therapy*, 24(2), 148-166. doi:10.1080/08098131.2014.908943

- Jennings, S. (1992). *Dramatherapy with families, groups and individuals: Waiting in the wings*. London, United Kingdom: Jessica Kingsley.
- Kempler, W. (1981). *Experiential psychotherapy within families*. New York, NY: Brunner/Mazel.
- Kerr, C., Hoshini, J., Sutherland, J., Parashak, S., & McCarley, L. (2008). *Family art therapy: Foundations of theory and practice*. New York, NY: Routledge/Taylor & Francis Group.
- Kidron, M., & Landreth, G. (2010). Intensive child parent relationship therapy with Israeli parents in Israel. *International Journal of Play Therapy, 19*(2), 64-78. doi:10.1037/a0017516
- Kirkland, K. (Ed). (2013). *International dictionary of music therapy*. East Sussex, United Kingdom: Routledge.
- Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry, 25*(2), 223-237. doi:0.1111/j.1939-0025.1955.tb00131.x
- Koelsch, S., Offermanns, K., & Franzke, P. (2010). Music in the treatment of affective disorders: An exploratory investigation of a new method for music-therapeutic research. *Music Perception, 27*(4), 307-316. doi:10.1525/mp.2010.27.4.307
- Kozłowska, K., & Hanney, L. (1999). Family assessment and intervention using an interactive art exercise. *Australian and New Zealand Journal of Family Therapy, 20*(2), 61-69. doi:0.1002/j.1467-8438.1999.tb00358.x
- Kwiatkowska, H. (1978). *Family therapy and evaluation through art*. Springfield, IL: Charles C. Thomas.
- Landgarten, H. (1981). Family art psychotherapy. *International Journal of Family Psychiatry, 2*(3-4), 379-395.

- Lindenfelser, K. (2005). Parents' voices supporting music therapy within paediatric palliative care. *Voices: A World Forum for Music Therapy*, 5(3). Retrieved from <https://normt.uib.no/index.php/voices/article/view/233/177>
- Lindenfelser, K. J., Grocke, D., & McFerran, K. (2008). Bereaved parents' experiences of music therapy with their terminally ill child. *Journal of Music Therapy*, 45(3), 330-348. doi:10.1093/jmt/45.3.330
- Lindenfelser, K. J., Hense, C., & McFerran, K. (2012). Music therapy in pediatric palliative care: Family-based care to enhance quality of life. *American Journal of Hospice & Palliative Medicine*, 29(3), 219-226.
doi:10.1177/1049909111429327
- Linesch, D., Aceves, H. C., Quezada, P., Trochez, M., & Zuniga, E. (2012). An art therapy exploration of immigration with Latino families. *Art Therapy*, 29(3), 120-126.
- Lowenstein, L. (Ed.). (2010). *Creative family therapy techniques: Play, art, and expressive activities to engage children in family sessions*. Toronto, Canada: Champion Press.
- Mackenzie, J., & Hamlett, K. (2005). The Music Together program: Addressing the needs of "well" families with young children. *Australian Journal of Music Therapy*, 16, 43-59.
- Malchiodi, C. (Ed.). (2003). *Handbook of art therapy*. New York, NY: Guilford Press.
- Malchiodi, C. (2012). Art therapy with families and couples. In C. A. Malchiodi (Ed.), *Handbook of art therapy* (2nd ed., pp. 409-421). New York, NY: Guilford Press.

- Malloch, S., & Trevarthen, C. (2009). Musicality: Communicating the vitality and interests of life. In S. Malloch & C. Trevarthen (Eds.), *Communicative musicality: Exploring the basis of human companionship* (pp. 1-11). New York, NY: Oxford University Press.
- McDonnell, L. (1984). Music therapy with trauma patients and their families on a pediatric service. *Music Therapy*, 4(1), 55-63. doi:10.1093/mt/4.1.55
- McFarlane, P., & Harvey, J. (2012). *Dramatherapy and family therapy: Essential pieces of the multi-agency jigsaw in education*. London, United Kingdom: Jessica Kingsley.
- McFerran, K., Roberts, M., & O'Grady, L. (2010). Music therapy with bereaved teenagers: A mixed methods perspective. *Death Studies*, 34(6), 541-565. doi:10.1080/07481181003765428
- McFerran, K., & Wigram, T. (2005). Articulating the dynamics of music therapy group improvisations. *Nordic Journal of Music Therapy*, 14(1), 33-46. doi:10.1080/08098130509478123
- McFerran-Skewes, K. (2000). From the mouth of babes: The response of six younger, bereaved teenagers to the experience of psychodynamic group music therapy. *The Australian Journal of Music*, 11, 3-19.
- McIntyre, J. (2009). Interactive family-music therapy: Untangling the system. *The Australian and New Zealand Journal of Family Therapy*, 30(4), 260-268. doi:10.1375/anft.30.4.260
- Miell, D., McDonald, R., & Hargraves D. (2005). *Musical Communication*. Oxford, United Kingdom: Oxford University Press.
- Miller, E. B. (1994). Musical intervention in family therapy. *Music Therapy*, 12(2), 39-57. doi:10.1093/mt/12.2.39

- Molnar-Szakacs, I., & Overy, K. (2006). Music and mirror neurons: From motion to 'e'motion. *Social Cognitive and Affective Neuroscience*, *1*(3), 235-241.
doi:0.1093/scan/nsl029
- Molyneux, C. (2005). Music therapy as a short-term intervention with individuals and families in a child and adolescent mental health service. *British Journal of Music Therapy*, *19*(2), 59–65.
- Nemesh, B. (2014). *Family-music therapy for promoting family congruence: From dissonance to harmony*. Unpublished manuscript, Doctoral Program in Expressive Therapies, Lesley University, Cambridge, MA.
- Nichols, M., & Schwartz, R. (2004). *Family therapy: Concepts and methods* (6th ed.). Boston: Pearson Education.
- Nicholson, J. M., Berthelsen, D., Abad, V., Williams, K., & Bradley, J. (2008). Impact of music therapy to promote positive parenting and child development. *Journal of Health Psychology*, *13*(2), 226-238.
doi:10.1177/1359105307086705
- Nicholson, J. K., Berthelsen, D., Williams, K. E., & Abad, V. (2010). National study of an early parenting intervention: Implementation differences on parent and child outcomes: Parenting program implementation. *Prevention Science*, *11*(4), 360-370.
- O'Kelly, J. (2002). Music therapy in palliative care: current perspectives. *International Journal of Palliative Nursing*, *8*(3), 130-136.
doi:10.12968/ijpn.2002.8.3.10249
- Oldfield, A. (1993). Music therapy with families. In M. Heal & T. Wigram (Eds.), *Music therapy in health and education* (pp. 46-54). London, United Kingdom: Jessica Kingsley.

- Oldfield, A. (2006(a). *Interactive music therapy: A positive approach; Music therapy at a child development centre*. London, United Kingdom: Jessica Kingsley.
- Oldfield, A. (2006(b). *Interactive music therapy in child and family psychiatry: Clinical practice, research and teaching*. London, United Kingdom: Jessica Kingsley.
- Oldfield, A. (2008). Working in partnership and supporting parents: Music therapy for pre-school children and their parents at a child development center. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 19-36). London, United Kingdom: Jessica Kingsley.
- Oldfield, A., Bell, K., & Pool, J. (2012). Three families and three music therapists: Reflections on short term music therapy in child and family psychiatry. *Nordic Journal of Music Therapy*, 21(3), 250-267.
- Oldfield, A., & Bunce, L. (2001). Mummy can play too: Short-term music therapy with mothers and young children. *British Journal of Music Therapy*, 15(1), 27-36.
- Oldfield, A., & Flower, C. (Eds.). (2008). *Music therapy with children and their families*. London, United Kingdom: Jessica Kingsley.
- Overy, K., & Molnar-Szakacs, I. (2009). Being together in time: Musical experience and the mirror neuron system. *Music Perception*, 26(5), 489-504.
- Pasiali, V. (2012). Supporting parent-child interactions: Music therapy as an intervention for promoting mutually responsive orientation. *Journal of Music Therapy*, 49(3), 303-334. doi:10.1093/jmt/49.3.303
- Pavlicevic, M. (1999). Music therapy improvisation groups with adults: Towards de-stressing in South Africa. *South African Journal of Psychology*, 29(2), 94-99. doi:10.1177/008124639902900206

- Pavlicevic, M. (2012). Between beats: Group music therapy transforming people and places. In R. MacDonald, G. Kreutz, & L. Mitchell (Eds.), *Music, health, and wellbeing* (pp. 196-212). New York, NY: Oxford University Press.
- Radmall, B. (2001). The dance between post-modern systemic therapy and dramatherapy. *Dramatherapy*, 23(3), 16-19. doi:10.1080/02630672.2001-2002.9689594
- Riley, S. (1994). *Integrative approaches to family art therapy*. Chicago, IL: Magnolia Street Publishers.
- Robb, M. (2012). The history of art therapy at the National Institutes of Health. *Art Therapy*, 29(1), 33-37. doi:10.1080/07421656.2012.648097
- Rogers, N. (1993). *The creative connection*. Palo Alto, CA: Science and Behavior Books.
- Ruud, E. (2010). *Music Therapy: A Perspective from the Humanities*. Gilsum, NH, USA: Barcelona Publishers. Retrieved from <http://www.ebrary.com>
- Salkeld, C. (2008). Music therapy after adoption: The role of family music therapy in developing secure attachment in adopted children. In A. Oldfield & C. Flower (Eds.), *Music therapy with children and their families* (pp. 141–158). London, United Kingdom: Jessica Kingsley Publishers.
- Satir, V. (1983). *Conjoint family therapy* (3rd ed.). Palo Alto, CA: Science and Behavior Books.
- Satir, V., Banmen, J., Gerber, J., & Gomori, M. (1991). *The Satir model: Family therapy and beyond*. Palo Alto, CA: Science and Behavior Books.
- Sawyer, R. K. (1999). Improvised conversations: Music, collaboration, and development. *Psychology of Music*, 27(2), 192-205.
doi:10.1177/0305735699272009

- Schaefer, C. (Ed.). (2011). *Foundations of play therapy* (2nd ed.). Hoboken, NJ: John Wiley & Sons.
- Shoemark, H. (1996). Family-centered early intervention: Music therapy in the playgroup program. *The Australian Journal of Music Therapy*, 7, 3-15.
- Shoemark, H. (2004). Family-centred music therapy for infants with complex medical and surgical needs. In M. Nocker-Ribaupierre (Ed.), *Music therapy for premature and newborn infants* (pp. 141-157). Gilsum NH: Barcelona Publishers.
- Shoemark, H., & Dearn, T. (2008). Keeping parents at the center of family centered music therapy with hospitalized infants. *Australian Journal of Music Therapy*, 19, 3-24.
- Silverman, M. J. (2014). Effects of family-based educational music therapy on acute care psychiatric patients and their family members: An exploratory mixed-methods study. *Nordic Journal of Music Therapy*, 23 (2), 99-122.
doi:10.1080/08098131.2013.783097
- Sing & Grow. (2013). *Fact sheet*. Retrieved from
<http://63.128.12.227/document.doc?id=1>
- Skorunka, D. (2009). *What is family therapy?* Retrieved from European Family Therapy website <http://www.europeanfamilytherapy.eu/what-is-family-therapy/>
- Sobol, B. S. (1982). Art therapy and strategic family therapy. *American Journal of Art Therapy*, 21(2), 43-52.
- Sobol, B., & Williams, K. (2001). Family and group art therapy. In J. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (2nd ed., pp. 261-280). New York, NY: Brunner-Routledge.

- Sorrels, J. P., & Myers, B. (1983). Comparison of group and family dynamics. *Human Relations, 36*(5), 477-492. doi:10.1177/001872678303600505
- Stegemoller, E. (2014). Exploring a neuroplasticity model of music therapy. *Journal of Music Therapy, 51*(3), 211-227. doi:10.1093/jmt/thu023
- Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York, NY: Basic Books.
- Stern, D. (2002). *The first relationship: Infant and mother*. Cambridge, MA: Harvard University Press.
- Stern, D. (2010(a)). *Forms of vitality: Exploring dynamic experience in psychology, the arts, psychotherapy, and development*. New York, NY: Oxford University Press.
- Stern, D. (2010(b)). The issue of vitality. *Nordic Journal of Music Therapy, 19*(2), 88-102. doi:10.1080/08098131.2010.497634
- Sutherland, J. (2011). Art therapy with families. *The Journal of Individual Psychology, 67*(3), 292-304.
- .
- Teddie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*(1), 77-100.
- Thompson, G. (2012). Family-centered music therapy in the home environment: Promoting interpersonal engagement between children with Autism Spectrum Disorder and their parents. *Music Therapy Perspectives, 30*(2), 109-116. doi:10.1093/mtp/30.2.109
- Trevarthen, C., & Malloch, S. N. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordisk Tidsskrift for Musikterapi, 9*(2), 3-17. doi:10.1080/08098130009477996

- Volgsten, U. (2012). The roots of music: Emotional expression, dialogue and affect attunement in the psychogenesis of music. *Musicae Scientiae, 16*(2), 200-216.
doi:10.1177/1029864912440778
- Wadeson, H. (1976). The fluid family in multi-family art therapy. *American Journal of Art Therapy, 15*(4), 115-118.
- Walworth, D. D. (2009). Effects of developmental music groups for parents and premature or non-clinical infants under two years on parental responsiveness and infant social development. *Journal of Music Therapy, 46*(1), 32-52.
doi:10.1093/jmt/46.1.32
- Wiener, D. J., & Oxford, L. K. (Eds). (2003). *Action therapy with families and groups: Using creative arts improvisation in clinical practice*. Washington, DC: American Psychological Association
- Wigram, T. (2004). *Improvisation: Methods and techniques for music therapy clinicians, educators and students*. London, United Kingdom: Jessica Kingsley.
- Wigram, T., Pedersen, N., & Bonde, L. (2002). *A comprehensive guide to music therapy: Theory, clinical practice, research, and training*. London, United Kingdom: Jessica Kingsley.
- Williams, K. E., Berthelsen, D., Nicholson, J. M., Walker, S., & Abad, V. (2012). The effectiveness of a short-term group music therapy intervention for parents who have a child with a disability. *Journal of Music Therapy, 49*(1), 23-44.
doi:10.1093/jmt/49.1.23
- Winnicott, D. (2005). *Playing and reality*. New York, NY: Routledge.
- Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.