Music Therapy as an Intermodal Practice: Clients and Therapists Perspectives

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MUSIC THERAPY AS AN INTERMODAL PRACTICE: CLIENTS AND THERAPISTS PERSPECTIVES

A DISSERTATION

(submitted by)

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In partial fulfilment of the requirements for the degree of
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ABSTRACT

This qualitative study used a phenomenological approach to investigate the lived experiences of clients and music therapists working with an integrated arts approach in music therapy. Seventeen client participants (aged 11-19 years old) underwent five consecutive therapy sessions with one of three qualified music therapists. The guiding questions pertained to the participants’ experience of having various arts materials in addition to the standard musical instruments available during the music therapy sessions.

The results showed a positive response from the clients’ perspectives, and a negative response from the therapists. The clients unanimously preferred having choice in the sessions. The therapists, however, noted that once the clients chose their preferred arts modality, they remained loyal to this mode and did not deviate from using it. When the client utilized music in the session, the music therapists felt confident. When the client chose a non-music modality, the music therapists felt insecure about their professional abilities and competencies.

The study results underscored a need for further dialogue within the expressive therapies around the integrative approach, and specific integrated arts training. The study also raised ethical and professional questions regarding a singular arts therapist using other arts modalities without formal training and or qualification. The study also reflected the experiences of the clients and whether offering an array of arts modes was seen as beneficial to their therapy. The study provided the grounding for further investigations into the integrated arts approach, specifically, the relationship between music and the other arts. In addition, the study reiterated the need for training in the practical use of working with specific arts forms and the therapists’ understanding why a particular arts mode would be an appropriate intervention, particularly if they felt that music, in this case, was not engaging the client.
CHAPTER 1

Introduction

Working as a music therapist in school settings in London, clinical practice normally took place in an allocated room for music therapy that was often shared with other arts classes. Because of this, music therapy clients were exposed to not only musical instruments, but also arts materials and play equipment. Through professional practice, I began to notice that many of the children referred to music therapy were gravitating towards using non-music therapy materials. At times the children would ask permission to play with these apparatus, and at other times, the children would begin to use these materials without inquiry. As a music therapist, I began to notice a phenomenon that has yet to be recognized in music therapy literature. I also noticed that clinically, the integration of other arts and play materials would enhance the therapeutic relationship, with many children requesting that certain materials be present in the music therapy room. This phenomenon took place in a number of different school settings with all ages of children, from 5 years old to 19 years old. This, however, created concern for myself as a music therapist; therefore I began to undertake training and workshops in other creative arts therapies and play therapy, and without formal training, introduced and integrated other arts materials into my music therapy practice. As a music therapist, I inquired with fellow music therapists working in similar environments and found that this was common amongst those colleagues I had engaged in conversation.

The purpose of this study is to replicate the music therapy environment in which I have worked clinically and explore whether the exposure to non-music therapy materials in the music therapy room encourages music therapy clients to utilize these other arts modes, and whether this has any effect on the music therapy relationship. It is anticipated this will highlight some of the realities of working in multi-disciplinary settings and having music therapy allocated to specific rooms that have shared usage. This study is not intended to train music therapists to use
intermodal therapy techniques, but to illustrate potential outcomes of working in school settings in rooms that have not been designed exclusively for music therapy practice. In addition, it is hoped that this will begin to add a relatively underrepresented topic in the music therapy literature. It is anticipated that this study may also contribute to or further invite development of theory around the use of multiple modalities in music therapy.

**Music Therapy and its Relationship to other Arts Modalities**

The subject of music therapy’s relationship with other arts modalities has been discussed in the literature. Bruscia (1989), a music therapist, briefly linked other arts modalities to music therapy. He suggested, “Music is not always just music. It is often intermingled with other art forms” (p. 13). Bruscia recognized that music was interrelated with drama, dance and other visual arts (p. 14). Bruscia suggested that music therapy could lead into other arts forms, and recognized the close relationship between the individual arts disciplines. From this, Bruscia raised questions about the boundaries of music therapy when utilizing other arts modalities.

Knill (1978), a musician, therapist and educator, theorized the concept of intermodal expressive therapy as utilizing all of the arts modalities, and as a way of allowing clients to express themselves through all of the arts. Knill (1978) considered all of the arts as equal and that artist-therapists were able to use them all regardless of expertise or skill because of their high sensitivity to the arts and the creative process. He stated “intermodal expressive therapy neither requires nor promotes the mastery of several distinct schools of therapy… rather, it finds its primary focus in the artistic tradition of all that the arts have in common” (Knill, 1994, p. 319).

Knill, Barba and Fuchs (2004) linked the relationship between music and the other modes, defining a reason for integrating the arts modes into one practice. They wrote, “Music engages not only the auditory sense, but also the sensorimotor, tactile and visual faculties. It communicates through means of rhythm and sound, and through words/lyrics that may evoke
strong visual images” (p. 32). Therefore, music can elicit visual images that can be communicated through creating a visual art piece, hence transferring from a music-based exercise to an art-based exercise within the therapy session.

Prior to this, Goldstein (1964) pioneered an integrative approach to music therapy with children, recognizing the relationship between each arts modality, such as movement and music, and applying each modality into the singular music therapy session. Grocke and Wigram (2007) explored visual art making with receptive music therapy. They found that a client listening to music evolved images and memories that were transcribed through the visual arts and writing.

Knill’s doctoral dissertation (1978) began to explore the relationship between each arts modality, and how all of the arts might benefit from being used in unison. Knill developed theoretical frameworks for intermodal therapy as part of his dissertation, such as Intermodal Transfer, meaning when the client transfers from one arts modality to another. Knill concluded from his own experiences as a musician and artist,

My sensitivity to the various modalities of art expression (Music, Visual Art, Dance, Theatre, Poetry…) is certainly one of the motivations in exploring their combinations within the therapeutic and educational context. Whilst I was concentrating on this exploration, I found that there is no basic literature about the rationale in such a practice. (1978, p. 1)

Knill’s own exploration into the lack of literature that explored the relationship of each arts modality into a combined practice became the foundations of his doctoral dissertation. Knill concluded, “It is not the music, the painting, the dance, the poem or the theatre which does the therapy. It is the communication process between the people which is essential in life as well as in therapy, and education. The arts are helpful tools to facilitate expression” (p. 84).
Purpose of the Study

The purpose of this study is to investigate the lived experiences of music therapists working in school settings in rooms allocated for a music therapist to work with clients that have other arts and play materials on offer. This study has been developed from years of personal professional practice in similar settings. The music therapy sessions will include arts and play materials that have been used by the researcher in clinical practice, as a way to explore the experiences and outcomes of other music therapists put in similar situations. The study will also focus on the lived experience of the clients of music therapy, and whether there is a preference for having other arts and play materials on offer. This study is not intended to train intermodal therapists, nor is it to promote intermodal therapy as a viable option for music therapists, but to illustrate the potential outcomes for both clients and therapists when using a multi-disciplinary room for music therapy.

This study will begin to explore an area of music therapy that is underrepresented in the overall literature. It will also focus on a technique that has not been highlighted in music therapy literature. As a foundation, the study will look to Paolo Knill and his development of intermodal expressive therapy or intermodal therapy as a basis for providing the therapeutic intervention, but this is not to suggest that music therapists are using intermodal therapy as part of the therapeutic technique. Throughout this dissertation, the term intermodal therapy will be used to refer to the approach defined by Knill.

Research Design and Question

This study used qualitative methodology in a phenomenological approach. The aim of the research was to study the lived experiences of clients and music therapists using an integrative arts approach to music therapy. The study addressed the following questions:

What were the experiences of the client participants having other arts modalities available during a music therapy session?
How can having other arts modalities available change the music therapy session for the client and the therapist?

What were the experiences of music therapists attempting to offer other arts modalities in music therapy sessions?
CHAPTER 2

Literature Review

The literature review will focus on how music therapy has been incorporated with other arts modes and focus on Paolo Knill’s development of intermodal therapy, as the foundations of the clinical study. Knill (1978), a musician, therapist and educator, theorized the concept of intermodal therapy as utilizing all of the arts modalities, and as a way of allowing clients to express themselves through all of the arts. Prinzing (2009) echoed Knill’s sentiment and suggested that all arts therapists should be able to incorporate modalities that are not their primary training into their practice.

Music Therapy as an Intermodal Practice

The topic of including other creative arts modalities into music therapy is minimal in the music therapy literature. A comprehensive search using electronic databases into the creative arts, education and healthcare revealed few articles, book chapters or book that discussed the topic of music with other arts modalities in the clinical setting.

Bruscia, a music therapist, briefly discussed the topic in the book *Defining Music Therapy* (1989). Exploring the historical roots and international definitions of music therapy, Bruscia wrote:

Music is not always just music. It is often intermingled with other art forms. Songs combine music and poetry. Operas integrate music, drama, dance, and the visual arts. Symphonies can be based on stories and artworks. Singers mime and act whilst they sing. Conductors use gestures and movements to shape and direct the music. Listeners can move, dance, mime, dramatize, tell stories, paint, draw, or sculpt as a means of reacting to music… Many of these “interrelated” art forms and experiences are used in music therapy. (p. 13-14)
Bruscia began to recognize that music is also part of the wider creative arts field, and that these other arts forms can become integrated into music therapy. Questions about how much other arts modes are incorporated into music therapy were briefly addressed:

The use of these activities [other arts forms] poses many questions regarding the boundaries of music therapy. Is song writing within the realm of music therapy, poetry therapy, or both? Is musical story-telling an activity for bibliotherapy, drama therapy, or music therapy? Is moving or dancing to music within the realm of movement/dance therapy or music therapy? Is painting to music an activity for art therapy or music therapy? (p. 14)

Goldstein (1964), a music therapist, highlighted an intermodal approach in music therapy. Goldstein described the use of movement and art making incorporated into a music therapy sessions. The session was divided into sections. Each arts modality had a specific focus that contributed to the overall therapeutic objective. For example, the music aided the coordination that movement was working towards and art was used to make everyday objects that extended the child’s vocabulary. Play was later introduced when a dollhouse was made. This developed a role-play that showed “hostility towards her family and siblings… directed through this house. The therapist used a nondirective approach, echoing or rephrasing the statement of the child” (p. 137). This paper demonstrated that other arts modalities, in addition to music, can enhance the therapeutic experience for the client, and can develop further insight into the client’s creative imagination and emotional responses. Whilst the author did not question whether the responses demonstrated by this client would or would have not emerged if the therapy was solely based in music, the variety of arts materials on offer provided an insight into the possibility of further creative play when the therapist works in a nondirective approach.

There have been other writings in music therapy literature that demonstrate the use of other arts modes within music therapy. Munro (1984) and Grocke and Wigram (2007) wrote
about the use of art media, particularly collage, with music. Grocke and Wigram described using art with receptive music (listening to recorded music) to enable the client to project internal feelings and express these non-verbally. Olofsson (1995) combined verbal and non-verbal communication into music therapy with the aim of engaging with the client’s unconscious. Working with cancer patients, this case study showed the intermodal approach as mainly directed by the client. Esther, the client, began by drawing and then followed with a movement depicting the visual image. Music was later integrated to develop the session in relation to the words and images used by Esther to describe her emotional processing. Booth (2002), a trained Bonny Method Guided Imagery and Music therapist (BMGIM) devised a method of using music, drawing and narrative combined “to extend the application of BMGIM and generate an even greater flexibility than was previously possible” (p. 44). These methods are generally used when recorded music is played as part of the therapy. The art making is used to enhance the feelings created by the recorded music. Skaggs (1997) used BMGIM with adolescent sexual offenders. Skaggs stated, “Often, two or more modalities were employed during a session, based on the theory that one art form can expand and enhance the other” (p. 75).

The writings noted here have the commonality that the music therapists intended to use other arts modes as part of the music therapy intervention. The question whether these other arts modes would have been well received by clients had they simply been part of the music therapy environment has yet to be discussed in the literature.

**Single-Modality or Multi-Modality in Creative Arts Therapy**

The debate about whether a single creative arts therapy modality should incorporate other arts modes has been discussed in the wider field of the creative arts therapies. Whilst some therapists have advocated that each individual creative arts therapy should only utilize the art mode it professes, other practitioners and authors in the profession have suggested that all of the arts should be incorporated into the therapeutic practice, placing emphasis on the creative
process of the client. By allowing all of the arts to be explored freely, the client will be allowed to develop further their creative expression. Art therapists Agell and McNiff (1982) articulated the opposing arguments for the single approach to art therapy versus the integrative arts approach. Agell claimed that art itself, as a singular modality, was extensive enough as a therapeutic practice and took years of training to develop the skills necessary, although recognized that art shared many links with other modalities in the creative sense, but “there is not enough time to learn how to be an art therapist, a dance therapist, and a music therapist, even though the underlying purpose of each is the same: to objectify feelings” (p. 122). McNiff, on the opposing side, suggested that the art therapist should use everything he or she had to support the holistic approach to healing and aid creativity. McNiff took the argument into a creativity-centered stance and theorized much about the healing aspects of the arts. McNiff wrote that restricting and separating the modalities “have more to do with the needs of the therapists than the needs of the clients” (p. 123).

Sikes and Kuhnley (1984), both psychotherapists, wrote about using a multimodal approach with a child with schizophrenia. However, the child received the individual modalities with each separate therapist. Using art therapy and play therapy individually, Sikes and Kuhnley recognized that “artwork is often used in play therapy, play may also be used during art therapy” (p. 273). They continued, “Multimodal therapy is the concurrent use of two or more therapeutic intervention techniques. Although single-modality treatment may be more common, or at least more commonly addressed in the literature” (p. 273). Sikes and Kuhnley stated that the combination of modalities is a benefit to the client. There were more disadvantages discussed, including transference between the two therapists and conflicting relationships of the client and each therapist. The concluding thoughts were that the child was able to use both mediums well, however there were some differences in responses to the individual modalities, and some aspects
of each modality worked better in one than the other. For example, Oedipal issues were prominent in play therapy, whereas sibling rivalry was a theme in art therapy (p. 283).

Thompson investigated the artistic choices a creative arts therapist makes in clinical practice (2010). Ten therapists were interviewed, which included dance/movement therapists using art in treatment, art therapists using dance/movement in treatment, and expressive arts therapists. One of the participants had credentials in art therapy, dance/movement therapy and expressive arts therapy. Thompson reviewed literature including works by pioneers in intermodal and expressive arts therapy. Exploring the foundations of intermodal therapy, Thompson wrote, “Although a generalist approach is the element that connects all applications of expressive arts therapy, different practitioners develop their own style of working based on their artistic and/or therapeutic history” (p. 22). Thompson added that an intermodal therapist tended to enter the modality with a specialization in one modality. Thompson referenced Lev-Wiesel and Doron (2004), and stated their study:

Discovered that patients who were allowed to choose between the modalities of art therapy, drama therapy, bibliotherapy, journal writing therapy, and dance/movement therapy were all content with the therapeutic process and outcome. The patients also clearly understood that being given the choice of modality contributed to their fulfillment (Thompson, 2010, p. 30.)

In the study conducted by Lev-Wiesel and Doron (2004), undergraduate students referred to therapy were asked to participate in each of the five therapy approaches mentioned above and asked their preference. The participants did not receive these modalities as an integrated arts approach, nor did the topic of intermodal therapy arise in the study. The findings were that the clients preferred to choose their own non-verbal creative arts therapy.

Incorporating the arts into a singular modality has been developed into what is commonly called expressive arts therapy (Estrella, 2005). A review of the history and development of the
integrated approach will be discussed below, followed by a profile of its primary theorist, Paolo Knill.

**Intermodal Therapy – An Integrated Arts Approach**

The creative arts therapies encompass art therapy, music therapy, dance and movement therapy, drama therapy, poetry therapy and intermodal therapy. Intermodal therapy is the youngest of the modalities in terms of its representation amongst the creative arts therapies literature. Intermodal therapy integrates the individual art forms of art, music, drama, dance and movement and creative writing in one seamless modality.

Following the emergence of the Expressive Arts Therapy Program at Lesley College Graduate School (now Lesley University) in 1974 (McNiff, 2011, p. 79), Paolo Knill developed, what he termed, intermodal expressive therapy (1978). Knill considered that all of the arts are equal and that artist-therapists were able to use them all regardless of expertise or skill because of their high sensitivity to the arts and the creative process. This led to his theory of low skill-high sensitivity (Knill, Barba & Fuchs, 2004). He stated “intermodal expressive therapy neither requires nor promotes the mastery of several distinct schools of therapy… rather, it finds its primary focus in the artistic tradition of all that the arts have in common” (Knill, 1994, p. 319). Knill also considered that intermodal expressive therapy should be an arts based modality that solely considers the arts as the process towards healing over contemporary psychological thinking.

Historically, Knill termed the integrated approach intermodal expressive therapy (1978). This became the basis of his doctoral dissertation (1978) and writings to date. Since then, various terms to define intermodal expressive therapy have developed. Estrella (2005) referred to all of the various titles that are associated with the integrated approach, however no reason why the modality has adopted these various terms has been established in the literature. The abbreviated term intermodal therapy will be used in this dissertation to distinguish Knill’s
approach and how it relates to the research study. Estrella (2005) defined it as “founded on the interrelatedness of the arts and takes an integrated approach to the use of the arts as a tool for psychotherapy” (p. 183). Estrella described the intermodal therapy technique as applying the arts either simultaneously or in transition from one to another. Therefore, the aim of intermodal therapy is not to overwhelm the client with an array of arts interventions, but to offer all of the arts for choice and creative expression, which is led by the client. This gives greater choice to the client and expands the possibility for therapeutic transformation. As Atkins and Williams stated, “[the expressive arts] are used together to give shape and form to human experience, to hold and express emotional and reflective experience, and to expand and deepen personal understanding and meaning” (2007, p. 1).

**Primary Theorist - Paolo Knill**

Paolo Knill was a musician who recognized that music, as a stand-alone modality, could connect with a client. When Knill developed intermodal therapy in the mid-to-late 1970’s, he professed that no singular arts modality should take precedence and that “each discipline that uses the arts in psychotherapy can inform the others in the understanding and mastery of modalities. The poet learns from the musician or dancer about rhythm. The painter may learn from the actor… The dancer may learn from the sculptor” (2003, p. 34). When all of the arts were combined, they could contribute more holistically to the benefit of the client’s overall experience.

Written in 1978, Knill’s doctoral dissertation *Intermodal Expression* was the first text that dedicated itself to the theories and practice of integrating all of the arts modalities into a singular therapeutic practice. The opening paragraph demonstrated Knill’s professional and personal journey to his theories. He identified himself as an artist who became an educator and therapist. Throughout the prologue, he provided a clear foundation of how he arrived at his theories for intermodal therapy, first establishing that the expressive therapies are an expressive
form of communication that utilize all of the arts. Knill suggested that expression couldn’t be confined to any one arts modality, and presented reasoning for the possibility of choice within the intermodal therapy approach. As intermodal therapy provided choice of the arts modalities in the clinical setting, the possibility of expression was heightened because of this choice. Knill observed when people communicate through language; they use combined modalities, such as sound, movement and imagery (p. 154), thus developing intermodal expression from the various ways human beings communicated in our everyday lives. Knill considered that therapy should encourage a “wide repertoire of emphasis through expression as in discursive language” (pp. 155-156). Knill linked intermodal therapy to how each of these art forms impacts communicative language, and not as therapeutic interventions. Knill established communication as expression, thereby justifying what the intermodal approach was originally, and why he combined the words intermodal with expressive therapies.

The three concepts of Knill’s intermodal idea are what he phrased *intermodal transfer*, *intermodal amplification* and *intermodal processing*. Intermodal transfer is when the client segues from one arts modality to another. Knill presented several examples of this, however these examples stemmed from using the principles of art making as the initial practice. This continued into a movement-based exercise that then incorporated sound, all developing from the initial art exercise. Knill considered the benefits of working with people with learning disabilities because language is intermodal and this approach could help them to develop their sensory awareness. Intermodal transfer leads into the second stage of the intermodal process called intermodal amplification. This is when an intermodal transfer is taken further, meaning that the process of expression is intensified. Knill’s case vignettes (pp. 95-104) highlighted the use and theory behind intermodal transfer and amplification in different contexts. The third and final part of the transfer is intermodal processing. Allowing the client to verbally discuss his or her experience at the end of the creative process, Knill identified talking as part of the intermodal
sessions because verbal communicative language is intermodal. Knill defined these concepts as not being “rigid schemes, rather… flexible aids in becoming sensitive to the effect of changing modalities” (p. 191).

Knill concluded his doctoral dissertation by providing a format and structure to an intermodal session, distinguishing five areas to match the communication and interaction: centering; interaction; sharing; processing and celebration (p. 192).

Knill defined his theory low skill-high sensitivity in Levine & Levine’s edited book Foundations of Expressive Arts Therapy (1997). This was extended further in Knill’s book co-written with Barba and Fuchs Minstrels of Soul: Intermodal Expressive Therapy (2004), which is the only book within creative arts therapies field that uses the term intermodal in its title. Low skill-high sensitivity was based on the idea that the therapist needed not to have a mastery of the arts or an arts specialization. It was based on the idea that the artist-therapist could utilize any arts modality because of the person’s artistic inquiry and responsiveness, thus shunning experience and expertise for artistic expression engagement (p. 150). The low skill-high sensitivity theory is the basis for all intermodal expressive therapy (p. 150). Knill, Barba and Fuchs wrote:

Many of us have been taught that the quality of art lies in the perfection of manual skills that enable us to expertly mold, modulate, change, build and handle art materials. As we investigate the arts of various cultures, however, we find that often what touches us most in art is not virtuosity, but rather something that we might call competency of expression… We can certainly learn from other’s cultures sensitivity to material. (Knill, Barba & Fuchs, 2004, p. 50)

Knill suggested that an appreciation and open mindedness to other cultures would assist in the therapist’s acquisition of skill through their sensitivity to the arts process. Thus, it was not formal training that gave the therapist the skill or mastery; it was their own individual experience
and exposure to the arts. In this description of low skill-high sensitivity, Knill used art as the basis for his theory. It would be interesting if this theory might differ if its basis were in dance or music modes, rather than art. Any consideration for other arts modalities was not included, nor was the consideration for technical ability of some arts modalities.

Knill’s attempt at answering some of the criticisms of intermodal therapy can be found in his earlier journal article *Multiplicity as a Tradition: Theories for Interdisciplinary Arts Therapies-An Overview* (1994). Knill did not mention any particular criticism or individual critique, rather defended his theories and highlighted the concerns of the intermodal therapist being a jack-of-all-trades, in response to doubts whether the therapist can master all of the arts modalities. Knill discussed the competency issues other creative arts therapists were raising and defended the artistic right to choice. He compared intermodal therapy to a more classical approach to the arts from a time when, he suggested, there were no specializations, and the arts were perceived as one combined unit. Many of the arguments in this paper were later produced in *Minstrels of Soul* (2004), particularly the issue of competency, where Knill coined the phrase “low skill-high sensitivity” (p. 150), meaning the arts are accessible to anyone, regardless of both training and experience using the arts. Knill suggested that all artists and arts therapists were able to utilize the various forms of arts modalities, and that it was the individuals’ sensitivity to the arts that was key to their professional and personal practice.

In a later publication Knill (1999) began to consider psychoanalytic theories, such as free association (p. 44) in relation to the imagination, providing links between the role of imagination from both an artistic perspective, as well as a psychological. However, intermodal therapy, according to Knill, lies in the classical origins of the arts and the integrated use of communication and language. It is accessible to everyone and is rooted in the creative process. Although Knill maintained that intermodal therapy should not be linked to analytic interpretation such as Freud’s, Knill looked to the ancient uses of story telling, play and creative imagination to
develop the ideas for which he became known. Knill has contributed to the journal *Poiesis: A Journal for the Arts and Communication* (2000, 2001, 205, 2006). In these articles, he furthered his views and application of the intermodal in therapy and education. Knill sees expressive arts as “unlimiting limits” (Knill, 2001, p. 73-74) and freeing of the artistic boundaries to become more expressive (p. 73-74). This, he wrote, was the basis of is low skill-high sensitivity theory (Knill, 1997, p. 45).

**Knill’s Contribution to this Study**

Knill actively introduced other arts modalities into his therapy practice, which informed his teaching and writings. Knill’s dissertation (1978) will provide the theoretical framework for the study being introduced. There are questions that have arisen from Knill’s dissertation and later writings that will be addressed in this study.

Knill considered intermodal therapy to be centered in the creative experience, rather than a psychological perspective. Although Knill later referenced psychoanalytic frameworks as part of the creative process (1999), Knill maintained that the arts are what both the client and therapist use as part of their therapeutic work. This divide between the arts in therapy versus the arts as therapy will be addressed, and later used to categorize the therapists’ training backgrounds and approaches that contributed to the study.

**Music ‘As’ Therapy or Music ‘In’ Therapy?**

There is a continued argument in music therapy as to whether the music should be rooted in creativity or should base itself in a psychotherapeutic approach, thus using the creative expression for recognizing internal conflicts (Bruscia, 1998).

In music therapy, the two primary theoretical approaches are creative music therapy, often considered to be a Nordoff Robbins approach and psychodynamic or psychoanalytic music therapy, as first proposed by Tyson (Hadley, 2003) and Priestly (1975). However, Forinash (2005) categorized five methods of music therapy, including the aforementioned, as well as

Wigram, Pedersen & Bonde (2002) referenced Ruud (1990), who presented levels of music and understanding. Music that was considered aesthetic and was interpreted as musical elements was considered music ‘as’ therapy. Music ‘in’ therapy was distinguished as referring to the internal and external world of the client. The music was perceived as a metaphor for this analysis (Wigram, Pedersen & Bonde, 2002, p. 40). Wigram, Pedersen & Bonde (2002) stated that the Nordoff Robbins approach was “Music as therapy, where the music provides the therapeutic catalyst through which change will take place” (p. 127). The writers also stated that the Priestly model of music therapy, considered analytic, was “music in therapy, as the music is used to symbolically express inner moods, emotions and associations” (p. 124). Bruscia (1998) also referenced the difference of music ‘as’ or ‘in’ therapy, linking this to the different types of music therapy trainings that were being offered (pp. 214-215).

Kim (2004) reviewed the history of Paul Nordoff and Clive Robbins as music therapists, and the development of the Nordoff Robbins approach to music therapy. Kim stated Nordoff Robbins music therapy “focuses on awakening an unborn musicality in every client in order to develop his/her full potential as a human being” (p. 321). To establish a music-centered approach to Nordoff Robbins, Kim stated, “This self-actualizing potential is most effectively awakened through the use of improvisational music in which the individual’s innate creativity is used to overcome emotional, physical, and cognitive difficulties” (p. 322). Paul Nordoff and Clive Robbins collaborated as music therapists working with children. Three books were published demonstrating their theories and techniques, *Therapy in Music for Handicapped...*

Hadley (2003) dedicated a book to psychodynamic music therapy. Using case studies, Hadley wrote a historical introduction to the development of psychodynamic music therapy. Hadley noted that Florence Tyson first introduced this approach in the United States in the 1960’s (p. 2). Analytic music therapy was introduced by Priestly (1975) in the United Kingdom. Odell-Miller (2001) explored the relationship between music therapy and psychoanalysis. Odell-Miller recognized the importance music therapists placed on transference and counter-transference (pp. 127-128) and stated,

Aspects concerning music and the unconscious are important, as clearly the spontaneous abilities of the musical processes to stir the emotions and help bring issues to the consciousness… Psychoanalytic theory has enabled music therapists to understand the context in which they are working (p. 128.)

Odell-Miller discussed the debate in the United Kingdom about psychoanalytically informed music therapy, addressing that music therapy students must undertake personal therapy throughout training (p. 140). Odell-Miller shared her views of the debate, and stated,

I would stress that in a psychoanalytically informed approach, the relationship with the therapist is of equal value to that of the art form. In my view, a good arts therapist will focus on the person as a whole primarily through the art form but will also pay attention to the aspects of the person shown through talking and thinking (p. 140).

Odell-Miller recognized that some music therapists believe that music therapy theory should develop from music practice and not from existing psychologically informed theories.

Hadley (2003) categorized the various established psychodynamic approaches and how they related to music as a theoretical framework. Hadley used case studies to define each of the
theoretical frameworks in the use of music with various client populations and music therapy approaches, such as improvisation, song writing, and guided imagery and music.

Creative music therapy and psychodynamic music therapy present themselves as two opposing approaches to music therapy. However, both are utilized with many different client populations in many different settings. The main difference is theoretical frameworks, rather than the use of music and musical instruments. Whilst the creative music therapists would place the greater of importance on the music created by the client, the psychodynamic would consider the music as metaphor. It is useful to recognize this difference in approach in relation to the therapists who contributed to this study. Each music therapist might adopt one approach over another, then incorporate this into his or her definition and identity as a practitioner. Bruscia (1993) wrote that “When creating a definition, it is important to consider which facet of music therapy or which clinical approach will be of greatest interest and relevance to the person inquiring” (p. 1). Therefore it is the therapist that defines their approach to music therapy, and how the music will be represented in the therapeutic practice with the client.

**Music Therapy with Adolescents**

As this study will focus on working with 11-19 years old client participants, music therapy literature focusing specifically on interventions with adolescents will be reviewed.

Music therapy has been effective with adolescents (Abad, 2003; Albornoza, 2011; Austin, 2007; Brooks, 1989; Choi, 2010; Dalton & Krout, 2005, 2006; Flower, 1993; Frank, 2005; Frisch, 1990; Gold, Wigram & Berger, 2001; Kennelly, 2001; Magee, Baker, Daveson, Hitchen, Kennelly, Leung & Tamplin, 2011; McFerran, 2012; Ragland & Apprey, 1974; Rickson, 2006; Robb, 2003; Robarts, 1994, 2000; Roberts, 2006; Skaggs, 1997; Tyson, 2012; Veltre & Hadley, 2012). Music therapy research and practice has also been recognized in English language psychiatry, psychological, social work and education publications, thus demonstrating the music therapy’s representation outside of the creative arts therapy literature (Ciardiello, 2003; Daveson,
Dissertations that focused on music therapy with adolescents have utilized qualitative and quantitative methods (Albornoz, 2009; Ashrafzadeh, 2011; Gitman, 2010; King, 2008).

Songwriting and lyric writing as a music therapy intervention have been discussed in the research: (Dalton & Krout, 2006; McFerran, 2012; McFerran, Roberts & O’Grady, 2010; Roberts, 2006). Using songwriting has proven effective within grieving and bereaved adolescents to recognize the stages associated with the grieving process (Dalton & Krout, 2005, 2006). The use of lyrics was included in a book dedicated to the use of rap and hip-hop music in music therapy (Hadley & Yancy, 2012). *Therapeutic Uses of Rap and Hip-Hop* (2012) included a number of chapters from music therapists who wrote about adolescent music therapy in a variety of psychiatric settings and mental health treatment. This section will demonstrate that a variety of music therapy techniques can be incorporated into music therapy; therefore there is versatility in the modality to cater to the clients’ best interest.

McFerran, Baker, Patton and Sawyer (2006) used song writing as part of a research study with adolescents with anorexia nervosa. Fifteen participants composed 17 songs, and the researchers used lyric analysis to identify common themes. Six themes were categorized, with identity being the most common theme produced amongst the participants. McFerran, Baker, Patton and Sawyer suggested that within expressive therapies, a psychodynamic theoretical framework was commonly used (p. 398). This study is important to this dissertation research methodology, because it used thematic analysis to determine the role and importance of song writing with this client population. The motivation for song writing as part of the music therapy intervention was that adolescents spend most of their musical engagement listening to music or watching music videos, therefore this “high level of involvement with songs suggests that song-
writing interventions may assist in the engagement of adolescents to explore emotionally charged themes” (p. 398).

Albornoz (2009, 2011) researched group improvisational music therapy with adolescents with depression and substance abuse. The group included 24 participants who received 12 sessions over a three-month period to relieve stress. Two groups were facilitated, an experiential and a control group. The results showed less depression in the experiential group. Gold, Voracek and Wigram (2004) researched the efficacy of music therapy with adolescents with psychopathology. One hundred and eighty-eight participants contributed to the study. Using quantitative methodology, the music therapy group statistically had a positive effect on the participants. However, results showed a higher efficacy for clients with developmental and or behavioural disorders versus emotional disorders. The results also showed that in terms of theoretical framework of the therapy, psychodynamic and or humanistic proved more effective than behavioural models of music therapy.

Daveson and Kennelly (2000) worked as music therapists in inpatient palliative care with terminally ill adolescents. Music therapy in this setting was used to support the patient and to “promote adaptive coping, to reduce pain or distress, and to promote cognitive and/or physical development (p. 35.). Two case studies with individuals were included, using song writing and listening to music. Working with the family was also part of the therapists remit, and the authors included a rationale for working with the family and the individual during the process of therapy, as well as after the client has passed away.

Skaggs (1997) used guided imagery and music as the music therapy technique with other creative arts modalities, such as art making and creative writing, with adolescent male sex offenders. Skaggs employed an intermodal approach because of the multilayered aspects of sexual abuse. Skaggs suggested that many abusers are often abused earlier in life; therefore
“because these therapies are multimodal and multidimensional, they allow increasing access to inner feelings and provide diverse modes for expression” (p. 74).

Various music therapy interventions have been recognized as effective with adolescents. Whilst the research shows that being a flexible music therapist may contribute to the efficacy with this client population, this study examines further the flexibility of the therapist when working in an environment that introduces other arts modalities to the client.

**Clients Experiences of Music Therapy and Other Therapies**

There is scarcity of research that includes client experiences of music therapy. This section will review the music therapy literature that has focused on client’s experiences, as well as other creative arts therapies and psychotherapies that have based research studies on having client experiences as the data.

**Client Perspectives of Music Therapy**

Hibben (1999) edited a book dedicated to client perspectives of music therapy. Thirty-three narratives were contributed to the book, ranging from children to older adults. Hibben wrote that in both music therapy and general psychology literature, there was a lack of clients writing about their own experiences of therapy, and that “Therapists typically write from the perspective of their own theories and techniques” (p. x). This book examined the meaning for the client, rather than the interpretation or response of the therapist. Hibben stated, “evidence of or searches for clients’ points of view are far outnumbered by writing about clients by therapists or researchers” (p. x).

The book was divided into five parts: (a) Clients who wrote about their experiences; (b) Clients who told their therapist about their experiences through interviews, and therapists who transcribed their thoughts; and (c) Clients whose experience was written by their parents. This was done for children and adolescents who were unable to talk about their experiences; and (d) Therapists who used a variety of techniques to infer clients experiences. This was provided for
clients who were unable to fully converse. The therapists used body language and testimony of other observers to complete the narratives; and (e) Researchers who gathered clients words using qualitative methodology. Smeijster (1999), who contributed to Hibben’s edited book, used thematic analysis of the clients’ verbal responses to determine seven themes that arose from the interview transcripts. These seven themes highlighted the important aspects of music therapy for the client, in particular, the progression of the therapy sessions and how music therapy impacted the clients’ self-perception. The chapter demonstrated that the client felt insecure at the introduction to music therapy, but through the process of the therapy, the client began to find her voice and felt confident to be vocally expressive by singing, which the client related to expressing feelings and sharing her voice and thoughts with others. The music therapy sessions allowed the client to become comfortable and confident vocally, thus being a positive experience. Smeijster’s use of thematic analysis and the inclusion of the raw data from the client’s self report, which was written after each therapy session, demonstrated the progression of the therapy for the client and how the client viewed her own development over the entire course of therapy.

Logis (2011) wrote an account of her experiences as client in music therapy. Using improvisational music making and singing to express her feelings, Logis detailed her experiences of the therapy in relation to her battle against cancer. Included in the article are transcripts of lyrics that she sung, and she stated, “Through music therapy, I was able to express my feelings, to become aware of the source of pain, and to take action to make a new life for myself” (p. 30). This paper followed from a chapter Logis wrote with her therapist in Hibben’s edited book (1999). Logis wrote that she had experiences of singing as an adult (1999) and writing the narrative with her music therapist formed part of the therapeutic process. In the later article (2011), there is greater attention to her own experiences of the overall therapy, rather than the
just the musicality of the therapy. From this, the reader can have a sense of how music therapy benefitted Logis and how this account relates to this study.

**Clients’ perspectives of other arts therapies.**

Spaniol (1998) used an ethnographic approach to research clients experiences in art therapy. Researching adult clients with psychiatric disorders identified as disability culture, Spaniol observed a group art therapy session and interacted in the session, to gain first hand experience of what it was like to be a participant rather than an art therapist. The article included Spaniol’s case descriptions of each participant that were written as an observer and after thoughts following the interviews with each participant. The article articulated the researcher’s own experience of art therapy over the direct experiences of each participant, but emphasized the importance of experiencing art therapy from the clients perspective to increase a therapist’s own empathy. Spaniol wrote, “To respectfully enter a person’s culture we must temporarily give up our roles as mental health professionals and become students” (p. 36). The study permitted the researcher to work within the field and engage with the client participants during the session, as opposed to interviewing each client after the session took place and speaking in retrospect.

Quail and Peavy (1994) used a phenomenological approach to assess a single client’s experience in art therapy. Prior to five interviews conducted throughout 16 weeks of art therapy, the researcher did not know the client. The participant was asked to recall the lived experience of the sessions and the process of creating the art. The participant was also asked to recall thoughts and feelings towards the completed artwork. The interviews were audio recorded and transcribed. The article also included verbatim extracts from the interviews. The findings were that “the client was able to relax her intellectual controls because the value the art therapist placed in individual art expression and because of the emotional intensity of what she was involved in” (p. 54). The findings overall focused on the process of art making but lacked a consideration whether the participants involvement in the 16-week long therapy sessions had an
affect on life outside of therapy. It was clear that the art therapy did have meaning for the client and that the client had a positive experience. This study illustrated the case for preserving the creative process in art therapy and to not intellectualize the process of art making. The client did offer that the art making objects made her feel exposed and vulnerable, and did not want others to observe what she was doing.

Clients’ Experiences in Psychotherapy

There have been a number of studies within the wider fields of psychotherapy and psychology that have focused on clients’ experiences of therapy. Straker and Becker (1997) investigated the lived experiences of the client and therapist in psychotherapy. Using a phenomenological methodology, the participants were therapists themselves engaging in personal therapy during the study. Each therapist participant was interviewed twice and focused on what they considered as therapeutic from the perspective of themselves both as a therapist and a client. The findings demonstrated that in the position of the client, the participant often felt vulnerable, whereas in the position of the therapist, the participant felt able to contain emotions using cognitive insights, therefore using their training and theoretical framework for recognizing emotional responses. This study seemed to be more of an analysis of the findings from an interpretational perspective, rather than allowing the participants to express their lived experiences. No uses of raw data were included, nor were any direct quotes used in a thematic approach. It is unclear what the actual lived experiences of the client were and how this can contribute to the wider understanding of a client in therapy.

Grounded theory has been used in qualitative research to investigate client experiences of psychotherapy (Chamodraka, 2008; Cragun & Friedlander, 2012; Frankel & Levitt, 2009; Henretty, Levitt & Mathews, 2008; Hoener, Stiles, Luka & Gordon, 2012; Poulsen, Lunn & Sandros, 2010). Hoener, Stiles, Luka, and Gordon (2012) interviewed 11 18-23 years old participants who were either current or former clients of person-centered therapy. Using semi-
structured interviews, the researchers focused on the clients’ experiences and opinions of therapy. The major theme that developed from the data analysis was termed client agency. Client agency was defined as the “clients’ disposition to actively make and enact choices regarding their therapy. Agency is thus a powerful person-centered concept that has explanatory relevance for all therapists” (p. 66). The article included extracts from the raw data and provided background information of each participant, including their age, reasons for referral, length of therapy and therapeutic approach. The results were also formulized into tables that defined each category or theme that developed from the data analysis. This provided the results with levels of frequency that each theme occurred across the participant pool. Six participants suggested they did not “expect their own agency to play a primary role in the therapy… they expected or wanted the therapist to inform them of their problems and tell them what they ought to do” (p. 77). This consideration demonstrated the true experience of what client may expect from participating in therapy, and provided a sense of reality to all therapists about the expectations or fantasies of clients. Using raw data and thematic coding highlighted a pattern of comments that could help readers understand the ideology of new clients to therapy, regardless of therapeutic approach or creative arts therapy modality. The researchers acknowledged that as they practiced from a person-centered approach, their findings might have been biased towards a grounded theory of person-centered therapy, in this case, client agency. To alleviate this, it would have been beneficial if the researcher also interviewed participants who did not engage in person-centered therapy, and perhaps included in the participants pool clients who sought psychoanalysis or a creative arts therapy. This would have clarified whether the experiences and opinions of clients differ across the therapeutic spectrum. Nevertheless, this study provided a clear indication of what clients expect from therapy.

Heatherington, Constantino, Friedlander, Angus and Messer (2012) assessed client perspectives of change during psychotherapy. Heatherington et al. used a qualitative design
using questionnaires with 76 clients. The questionnaires were open ended and the participants wrote their subjective answers descriptively. The answers provided the researchers with data that was not pre-composed answers, but the actual words of the clients. Levitt and Piazza-Bonin used a narrative approach in qualitative research to explore change processes for clients during therapy (2011). Gallegos (2005) conducted in-depth interviews to assess clients experiences of symptom relief during therapy. This study assessed the subjective changes the client made during therapy.

*Diary Design Research.*

As part of this study, the therapist participants kept a diary to gauge their experiences throughout the study. This was used as part of the interview to explore associations and potential changes of opinion as the study progressed. Using a diary during therapy has proven effective in understanding clients’ responses both between sessions, as well as during therapy. Laurenceau and Bolger (2005) stated the benefits of using a diary design in researching, “Diary methods allow researchers to study within the context of daily lives” (p. 86). Johnson and Bytheway (2001) stated that when conducting interviews as part of a qualitative method, the questions are answered in retrospect and dependent on what the participant recalled from their experience, however “the diary has the potential to offer the researcher an accumulating account of such actions” (p. 184). Therefore, the diary of the therapists will accomplish the researcher’s aim of exploring the lived experience of facilitating the sessions.

Mackrill (2007) used a diary design to investigate clients’ and therapists’ experiences during treatment. This study sought to research whether there was a correlation between the change in the therapy setting and change in the lives of the client. The clients were offered free, open-ended therapy, and were asked to keep a diary for the first 10 weeks, and then the diary was exchanged with the therapist on week 11. The therapist also kept a diary during this time, and the client was able to read the therapists diary of the same time period. After the therapist and
client responded to each other's diaries, these were submitted to the researcher for data analysis. The results were aimed at highlighting this method of inquiry, rather than the themes produced. However, an outline of results were produced, and showed that clients felt that the therapy contributed to the feelings of getting better, but therapy was not the sole arbitrator of this. This research design demonstrated that the diary can contribute to understanding what the client experiences between sessions and how thoughts may change from session to session. It also gauges how and in what context change can occur, and how this change is then brought back to therapy for further discussion. In the article, extracts from the diaries were not included, nor were there direct links between the diary and therapy sessions to establish key links in the change process. However, the objective of this study was to demonstrate diary design research, and this study showed that a therapist and or client keeping a diary can provide further examination of clients’ experiences of therapy in greater detail, and provides a non-evasive way of gauging clients’ experiences of the entire duration of therapy.

**The Current Study**

In music therapy literature, the consideration of utilizing other creative arts modes is minimal. There have been calls to incorporate and recognize other creative arts modalities into music therapy (Bruscia, 1999; Knill, 1978), although these have not been repeated often or even by other authors. This has led to the discussion not being extending further in the published literature. However, based on the literature, it seems Bruscia’s and Knill’s theories have not been put into practice. Therefore, the current study aimed to bridge the gap in the current literature, and explore the application of other arts materials and modalities into a music therapy session.

Music therapy has been effective with adolescents. Various music therapy techniques have been applied with adolescents, however none have used the multi-arts approach, therefore the current study will fill a gap in the literature.
This review also explored client experiences of music therapy. The recognition of clients’ experiences in this study will build on the development of previous studies that focused on clients’ experiences of music therapy (Hibben, 1999; Logis, 1999, 2011) and art therapy (Quail & Peavy, 1994; Spaniol, 1998).

This study used a diary design approach to investigate the experiences of the music therapists participating in the research to explore their thoughts of using an intermodal therapy approach. The intent was to gauge how the intervention introduced assisted them in their clinical practice. Diary designs have also proven effective in monitoring the clients experiences and consideration between sessions. This has allowed the therapists and researchers to understand those periods between therapy, and how the therapy is impacting their daily lives.
CHAPTER 3

Method

Research Design

The aim of this research was to study the clients’ and therapists’ experiences of using other arts modalities in addition to a music therapy approach in music therapy, and thus the method was phenomenological. The client participants were interviewed following five consecutive sessions of therapy. The therapists were interviewed after working with all of their clients who participated in the study. In addition, each therapist was asked to keep a journal throughout the duration of the study. This journal was submitted to the researcher prior to the therapist’s interview with the researcher.

Research Questions

The purpose of this study was to explore experiences of music therapy as an intermodal rather than a unimodal practice. The study addressed the following questions:

What were the experiences of the client participants having other arts modalities available during a music therapy session?

How can having other arts modalities available change the music therapy session for the client and the therapist?

What were the experiences of music therapists attempting to offer other arts modalities in music therapy sessions?

Recruitment and Training of the Music Therapists

Prior to the study commencing, the researcher recruited the music therapists. The criteria used for recruitment and selection were that each therapist held a Masters degree from an accredited music therapy program and had at least two years post qualification experience. A willingness to use other arts modalities was desirable, but no experience using arts modalities within sessions was required. The researcher contacted each therapist personally and had
previous professional knowledge of him or her. The researcher had previously worked with two of the therapists in a group practice situation. The therapists were approached because it was known that each trained at a different training program from the others, and adopted different theoretical approaches to music therapy. The researcher met with each therapist individually and asked if they had a waiting list of clients in the target age group (11-19 years old). The age range of the client participants was chosen because of their ability to dialogue with the researcher during the interview process and reflect on their experience of taking part in the study. Also, using this age group allowed access to schools that would usually seek the services of creative arts therapists, education psychologists and psychotherapists.

The researcher, prior to the clinical treatment commencing, trained each music therapist individually. Training focused on the set up of the therapy room and what materials and equipment to include. The researcher provided arts materials, such as a sand tray, dollhouse, paper, etc. for both the training and clinical study. The dollhouse was included in the arts and play materials to offer the clients a pre-composed set if they wished to engage in role-play using the figurines or wished to refer to their home life. It was thought that the dollhouse, in addition to the other arts materials available, might assist in this creative expression.

The training focused on the therapist allowing the client to use any of the materials on offer, engaging with the client when music was not being used, offering ideas for musical accompaniment and how to verbally dialoguing when the client used materials other than musical instruments. The training was experientially based, allowing the therapist to explore the non-musical materials to become familiar with them and to consider how they could be incorporated into their music therapy practice. Role-play was part of the training, and both the researcher and therapist participant took turns in playing both the client and therapist using the various arts materials and equipment to explore potential interventions. This was followed by a discussion about when it might be appropriate to use different arts modalities and why a shift
towards another arts mode might enhance the session. The training did not focus on a particular established theoretical framework. This was because the researcher wanted the therapist to feel freedom in their choices of how to use the arts materials on offer and reflect on these experiences, as part of the current study. The researcher emphasized that there was no right or wrong way of providing the intervention, and that it was the therapist’s own judgment that was key in providing the intervention.

At the end of the single training session, which lasted two hours, the researcher asked each therapist to begin a journal to log their thoughts of using arts materials outside of their music therapy specialization. Excerpts from the journal were incorporated into the data analysis and included in the results section, as a way of providing evidence of the lived experience.

**Therapists Theoretical Approaches and Training Background**

Whilst the study did not define a particular theoretical framework for the clinical approach, the researcher recruited the therapists because of the difference in their training and theoretical frameworks.

Two of the therapists trained in the UK and one in Canada. The UK trained therapists facilitated the study in London, England, whilst the Canadian trained therapist facilitated the study in Toronto. A brief profile of the therapists will describe their theoretical approach.

**Therapist 1.**

Therapist 1 trained in London, England. Therapist 1 was a female in her 30s, and had been practicing as a qualified music therapist for five years. Therapist 1 trained from a psychodynamic perspective, using music to engage the client in an active relationship. Improvised music making between the client and therapist was used to communicate the dynamics of their relationship, and how this relationship was mirrored with others in the client’s private and professional life outside of therapy. Therapist 1 had experience working with adolescents in schools and with adults in both a purpose built music therapy studio and
community settings for mental health service users. Talking is actively used in sessions to reflect on the musical experience and how this impacts the clients’ emotional responses. Since qualifying as a music therapist, Therapist 1 had undertaken additional day and three-day courses in other creative arts therapies, such as drama therapy and play therapy, and had been interested in incorporating other arts modes into practice.

**Therapist 2.**

Therapist 2 trained in Edinburgh, Scotland. Therapist 2 was a female in her 20s, and trained from a Nordoff Robbins perspective. Therapist 2 used music from a creative perspective, and refrained from analyzing the music or response from the client. She used improvised music for interaction with her client. Therapist 2 defined her approach as using music to encourage the client to self-express and communicate with the therapist through music. Therapist 2 did not use verbalizing with her clients, but actively sang to her clients’ words and reflections during the sessions. Since qualifying, she relocated to London and worked in schools with children aged five years old to 12 years old. Therapist 2 did not have clinical experience working with adolescents, but expressed an interest in developing further with this age group. Therapist 2 primarily worked with learning disabilities and non-verbal clients, and worked in association with local schools and educational professionals. Therapist 2 did not have any experience using other arts modalities, but was keen to work with a different perspective. She noted in her recruitment interview that she experienced a pattern that some of her children communicated a wish to use other arts and play materials that were stored in the therapy room during sessions, but she tended to not use them because of lack of experience and some personal conflicts towards the identity of music therapy.

**Therapist 3.**

Therapist 3 was a male in his 20s and a recent graduate. Therapist 3 trained in Quebec and practices in Toronto. He worked with adolescents in high schools and also with adolescents
in palliative care. Therapist 3 defined his approach as music centered. It should be noted that therapist 3 had not engaged in any personal psychotherapy, whereas the British trained therapists had been in psychotherapy during their training. This is mandated in the UK as part of the training program. Both Therapists 1 and 2 continued in personal therapy post-qualifying. Therapist 3 did not place any psychological perspective on the clinical practice, but was interested in learning more about psychoanalytic theories. Therapist 3 had used song writing with many of his clients, and tended to use pre-composed music with clients, instead of improvising. Talking was a key part of this practice, but in general, talking was in relation to the music and songs that were created within therapy. Therapist 3 had no experience in using other arts modes prior to the study, but responded enthusiastically to the researcher’s invitation as part of his further development as a therapist.

Recruitment of Client Participants

The recruitment of the participants took place in consultation with the therapists. The referring state-funded schools with which the music therapists collaborated had a list of referred children to music therapy. Reasons for referrals were based on social and emotional concerns, behavioural management, therapeutic support with personal and family difficulties, educational support, support with transitions and adjustments in the school setting, language and communication support and focus on positive well being. The researcher discussed with each participant the nature of the study and what was required, and the participant was asked to sign a consent form. Each participant was given the contact details of the therapist and researcher. The researcher also contacted and discussed the study with the parent and or guardian of the participant.

Sample of Client Participants

Nineteen client participants, between the ages of 11-19 years old were originally recruited in consultation with the therapists conducting the sessions and consent of the
participants and or guardian. However, only 17 clients completed the five sessions and were interviewed. Two clients did not continue with the study. One client attended one session, but due to personal reasons, was not able to commit to therapy. The second client completed two sessions, but became medically ill for an extended period of time, therefore the study was terminated with this client. However, this client was offered therapy with the therapist after recovery. This therapy was not included in the study due to time constraints of the project. As these two clients did not complete the full five sessions, neither was interviewed as part of the research study.

Each client-therapist dyad was unique but several dyads with the same therapist were used. The researcher discussed the objective of the study with the participants prior to the five sessions commencing. At the time of agreement, the participant was asked to define their racial background. This was used to assess the heritage, ethnicity and cultural background of the participants and contribute to the socio-cultural aspect of the study. This question was not asked of the therapists, nor did the researcher inquire the therapist participant’s racial background.

The client participants were not engaged in treatment with any form of creative arts therapy or verbal psychotherapy during the time of the study.

Confidentiality.

In order to protect the clients’ anonymity and confidentiality, no identifying information will be disclosed. Each client was asked to sign a consent form that was also signed by the parent and or guardian. In addition, the researcher applied for Institutional Review Board (IRB) permission that was granted. Each client was given the contact details of the researcher, as well as direct contact information to the lead supervisor of the project and dissertation. Each client also had the contact details of their therapist, and was encouraged to work with the therapist as much as possible, and bring their concerns to the therapy. There were no reported issues, concerns or problems that arose from the study that required the researcher, lead supervisor or
IRB to intervene. The researcher stayed in contact with each therapist during the study to continually manage the ongoing project and review competency and attendance. The therapist participants were not asked to sign a consent form. It was agreed with the therapists that their participation in the study acted as consent towards the inclusion of data from interviews and journal writings.

**Procedure**

Participants underwent individual music and intermodal therapy sessions for 45 minutes for a total of five weekly sessions. Sessions took place once a week. The participating qualified and registered music therapist conducted the sessions, with the researcher observing through a one-way window for some of the sessions. These observed sessions were chosen at random and were at various stages with different clients in both London and Toronto. This random selection was largely due to when the researcher was available to attend these selected sessions. The aim of observing the sessions was to assess the fidelity of the therapists using the range of materials and equipment on offer. The researcher did not make personal notes of these sessions as part of the data collection, but monitored what the therapist was doing and whether the therapist needed additional guidance or training. Following the observed session, the researcher discussed with the therapist some thoughts about what was observed and the use of arts materials. Ideas for further use of the arts materials was discussed, however these discussions were not used as part of the data collection, not did they contribute to the data analysis and results of the study. The aim of the random observations was to liaise with the therapist and offer support. The researcher did not interact with the client participants during the observations.

The sessions with the participants took place in two private clinics, one in London, England and one in Toronto, Canada. Each session was improvised and non-structured in approach, and the client was able to utilize all of the arts materials and instruments on offer.
Therapist 1 worked with eight clients, therapist 2 worked with four clients and therapist 3 worked with five clients.

At the end of the five sessions, the client participants were individually interviewed once for one hour per participant. The research assistant interviewed 10 client participants, and the researcher interviewed seven client participants. These interviews were audio recorded and later transcribed. Participants were not given the guiding questions in advance, and the interviews were an informal, open-ended discussion. With some of the client participants, there was additional time added to introduce the format of the interview and have a brief discussion about how they were feeling on that day, in order to make the client participant feel comfortable with the interview process. Client participants were offered something to drink and told that the interview could be stopped for a break if they needed it, although no client participant expressed discomfort or requested the interview to be suspended.

In addition, the therapists logged their thoughts in a journal from training to the end of the study. This was based on a diary-design method of qualitative research, as stated by Gunthert & Wenze (2012), Johnson & Bytheway (2001), Laurenceau & Bolger (2005), Mackrill (2007) and Symon (1998). The researcher conducted a single interview with each therapist, which followed the completed sessions with all client participants to assess their experience of using other arts modalities within music therapy. The researcher encouraged the participants to elaborate on specific areas outside of the standard questions, in order to further the investigation. The transcribed narratives of both the clients and therapists were used as the primary data for phenomenological analysis, as described by Forinash (2004).

**Equipments and Materials**

A full range of musical instruments was used, including a piano, guitar, melodic and percussion instruments. Art materials such as paper, paints, facemasks, coloring pencils, glue, colored paper and glitter were available. A sand tray with small objects and models was in the
room. A large dollhouse and models figurines were available as well as dressing up materials and fabric. Play therapy materials were included as a way of encouraging role-play to assess whether using tactile equipment, other than musical instruments and art supplies, would encourage the use of other arts and play materials and encourage creative expression and imagination. A full list of materials in included in Appendix B. The therapy room was a large space for movement. The researcher provided all materials and equipment where necessary. This selection of materials was chosen by the researcher and was standard for all of the therapists and sessions, in order to provide continuity and validity to the overall study. All of the materials and equipment were on display in the therapy room and easily viewed and accessible by the participant. These materials were selected from the researcher’s own clinical experience and training with them, and formed the basis of the environmental phenomenon the researcher aimed to replicate for this study. The rationale for choosing these materials and equipment was to represent as many arts modalities, sand tray therapy and play therapy equipment as possible to represent a holistic intermodal approach.

Data Collection

The lead researcher and research assistant carried out the interviews. The research assistant was a colleague of the lead researcher from a previous professional project. The research assistant attained a PhD in Psychology with ample experience in qualitative research and interview techniques. The lead researcher discussed with the research assistant the context of the study and the objectives of the interviews. The research assistant contacted the lead researcher by email following each interview to confirm its completion and report any challenges in the data collection. The research assistant interviewed all of the London based clients, and there were no reports of problems arising from the interviews. The recordings of the London based interviews made by the research assistant were forwarded to the lead researcher and transcribed in full by the lead researcher. The lead researcher interviewed the Toronto based
clients and the three therapists. After consultation with therapists 1 and 2, it was felt that clients would benefit more from being interviewed by someone external to the study face-to-face, rather than using Skype or telephone by the lead researcher or by their therapist. Skype or telephone interviews were being considered due to the researcher not being in England at the time of the interviews, therefore it was decided that the research assistant would be able to be engage in person with the clients and this would enhance the dialogue.

The therapists completed journals were given to the lead researcher prior to the interviews commencing. This allowed the lead researcher to ask questions relating to comments, observations and artwork that were produced in the diary. The researcher transcribed all of the interviews for both clients and therapists, and thematic analysis was used. The researcher used online data analysis software, ATLAS Ti. All of the transcriptions were added to the software, and the researcher coded the direct comments from the interviews and categorized them into themes. The researcher used this software for all of the interview transcripts. The use of ATLAS Ti was successful because of the large amounts of interview data that was produced across total 20 research participants, and was a beneficial way of recognizing common themes that were produced as part of the results. A more detailed description of the data analysis will be integrated into the next chapter.
CHAPTER 4

Results

The results section is comprised of two sections. The first is an analysis of the results from the interviews with the 17 client participants. The second section is an analysis of the results of the interviews and journals of the three therapist participants. This chapter concludes with a summary of the combined sections for all 20 participants of the study.

Client Participants

There were 17 client participants who completed five consecutive sessions with their therapist. Attendance was good, although there were some clients that arrived late for the sessions, therefore these individuals received shorter sessions. Table 1 shows the age, gender and racial background of each client participant.
Table 1

*Summary of Client Participants Demographics*

<table>
<thead>
<tr>
<th>Client Participant</th>
<th>Racial Background</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>White</td>
<td>11</td>
<td>M</td>
</tr>
<tr>
<td>B</td>
<td>White British</td>
<td>11</td>
<td>M</td>
</tr>
<tr>
<td>C</td>
<td>Black British</td>
<td>12</td>
<td>M</td>
</tr>
<tr>
<td>D</td>
<td>Black Caribbean</td>
<td>13</td>
<td>F</td>
</tr>
<tr>
<td>E</td>
<td>African English</td>
<td>13</td>
<td>F</td>
</tr>
<tr>
<td>F</td>
<td>English</td>
<td>13</td>
<td>F</td>
</tr>
<tr>
<td>G</td>
<td>Canadian</td>
<td>13</td>
<td>F</td>
</tr>
<tr>
<td>H</td>
<td>White Canadian</td>
<td>14</td>
<td>M</td>
</tr>
<tr>
<td>I</td>
<td>Arabic</td>
<td>14</td>
<td>M</td>
</tr>
<tr>
<td>J</td>
<td>Indian</td>
<td>15</td>
<td>M</td>
</tr>
<tr>
<td>K</td>
<td>White</td>
<td>16</td>
<td>M</td>
</tr>
<tr>
<td>L</td>
<td>White English</td>
<td>16</td>
<td>M</td>
</tr>
<tr>
<td>M</td>
<td>Bangladeshi British</td>
<td>17</td>
<td>M</td>
</tr>
<tr>
<td>N</td>
<td>White</td>
<td>17</td>
<td>M</td>
</tr>
<tr>
<td>O</td>
<td>Cantonese</td>
<td>17</td>
<td>F</td>
</tr>
<tr>
<td>P</td>
<td>White</td>
<td>18</td>
<td>M</td>
</tr>
<tr>
<td>Q</td>
<td>Black</td>
<td>19</td>
<td>M</td>
</tr>
</tbody>
</table>

Seventy percent of client participants were male. Four participants were 13 years old, representing the most frequent age with 17 years old being the next most frequent age. Each client participant was asked to define his or her own racial background in his or her own words.
Nine clients used color (either white or black) to define their ethnicities, whilst 11 used their nationalities to define their ethnicities. The words in the table are direct quotes.

Ten of the client participants were interviewed face to face by the research assistant. Seven of the client participants were interviewed face to face by the researcher. The researcher transcribed the recordings of the interviews. Using ATLAS Ti., the researcher performed a three-step process of analysis, as used by Makik-Frey et al (2009). First, key words or phrases were highlighted from the interview responses. Second, these words and phrases were grouped together by common concepts. Thirdly, the common concepts were then grouped together to develop themes. This developed 12 themes. The frequency of each theme was counted across the 17 interview responses to distinguish the consistency of each theme. Table 2 shows the results.
Table 2

*Frequency of General Themes from Clients Interview Responses*

<table>
<thead>
<tr>
<th>General Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preference to multiple choice of arts</td>
<td>17</td>
</tr>
<tr>
<td>Trying/learning new arts materials</td>
<td>17</td>
</tr>
<tr>
<td>Playing with therapist</td>
<td>15</td>
</tr>
<tr>
<td>Independent play</td>
<td>13</td>
</tr>
<tr>
<td>Preference to dialogue with therapist</td>
<td>12</td>
</tr>
<tr>
<td>Preference to sand tray and models</td>
<td>12</td>
</tr>
<tr>
<td>Preference to 45 minute sessions</td>
<td>10</td>
</tr>
<tr>
<td>Dislike to lack of structure</td>
<td>10</td>
</tr>
<tr>
<td>More than just musical instruments</td>
<td>9</td>
</tr>
<tr>
<td>Developed creative expression</td>
<td>7</td>
</tr>
<tr>
<td>Preference to gender-neutral materials</td>
<td>5</td>
</tr>
<tr>
<td>Dislike of therapist repeating clients words</td>
<td>3</td>
</tr>
</tbody>
</table>

Following the grouping of themes, the lead researcher returned to interview responses to perform further data analysis. Interpretative phenomenological analysis (IPA) of the general themes created three core themes that proved important to the lived experiences of the total participants. It was felt IPA would be beneficial to explore further the meanings of the lived experiences. These three themes were choice of multiple arts and play materials, the role of the therapist and unstructured approach to therapy sessions. Extracts from the interview responses will further highlight these results.
Choice of Multiple Arts and Play Materials.

All of the client participants spoke about the choice of arts and play materials on offer to them in the therapy sessions. The participants spoke positively about having the choice of options to express themselves creatively. The participants also spoke about the potential to try and or learn new arts materials, including musical instruments and drawing.

Client E

*It was really nice to have lots of different things to try. I liked that I did not have to play music all the time.*

Client G

*The only time I have ever played with sand is when I went to the beach, and that was when I was kid. It felt great to tell my story using sand and the little models.*

Client I

*I learnt to use paint without being in an art class. I never liked art because I can’t draw, but just being allowed to draw and paint for fun made me feel like, ‘yeah, I can do this and I like doing this’.*

Some responses for having the option of not making music or having more arts options other than music were expressed.

Client A

*You know what I liked the best? I liked that I could do stuff that was not music. I had music therapy before, when I was young, like 3 years ago, and I kinda liked it, but I used to just play music. Now I kinda feel like I can make music when I feel like it, but when I don’t, I can do something else and it’s OK to do that.*

Client P

*There are times when I just don’t feel like music is making that connection with my soul. I feel like, I am just making music because that’s what the teacher wants me to do. After*
seeing [therapist’s name] I feel like I can make music when its good for me, and I can use other things [therapist’s name] brings and it’s totally OK for me to do that.

Client Q

I like having choice. I like making the decisions on what I am going to make. And whatever I choose, it is allowed. I can play drums really loud and then make a drawing when I need quiet time. There was a day when I really liked having my therapist play with me, and then there was another day when I just wanted [therapist’s name] to leave me alone and let me do my thing.

The overall responses demonstrated a preference for having the option of using music and other arts. The decision of what arts modalities each client used was dependent on how they were feeling before and during the session. The responses demonstrated that if the client was feeling like he or she wanted an interactive session with the therapist, music was the modality of choice. If the client felt the need to be more self-explorative and reflective, without the intervention of the therapist, the client preferred a less live interactive modality, such as using the sand tray or making art.

Client H

There was this one time when I really couldn’t deal with adults and teachers, and I knew my music therapist would want me to play and talk. I just told my therapist that that was not where my head was, and knowing that I had the choice to make art and be left in my own world was what I needed... but I also felt that my therapist was nearby, so I did not feel alone.

Client O

Music is OK when I want to play with someone. But there are times when I just want to have time out for myself. That doesn’t happen a lot. Writing and drawing did that for
me. I have started keeping my own journal now, so when I want time out to think, I use my journal. I never had that idea before I met [therapist’s name].

Three of the clients had engaged in music therapy prior to the study with a different therapist. This was known at the recruitment of the participants. Each responded to their experience of having multiple arts materials on offer.

Client D

I love my music. But when I went to music therapy, at my school, I liked seeing the music man, it got boring sometimes. With [therapist’s name], I was hoping for a computer, but I liked having toys and coloring stuff that meant I could have other things to play with. It wasn’t as boring.

Client K

I like the music best. I didn’t use the dolls’ house or the sand. But I just stayed with the music. I don’t think I needed all the other stuff in the room. At first, I thought they were for someone else, and they were left there. I did not know until [therapist’s name] told me they were for us too.

Client P

Music therapy works for me, but I liked having the chance to try new things. I liked that I could start with music, and then try something else, and take the art I made back to music. It felt like I could express myself in a different way. I definitely prefer having more choices.

The role of the therapist.

Each participant was asked about what they thought of their music therapist, and how this related to the multiple arts choices.
Client C

*I liked my therapist and I liked that she let me choose what I wanted to do and helped me. But she did not show me. It wasn’t like ‘this is how you do it’. So, I didn’t feel like I was in a class and I might not get it right.*

Client H

*My therapist was cool, but kept repeating everything I said. [Therapist’s name] knew loads about music and the guitar, but couldn’t really tell me about how to use art stuff and all the other things in the room.*

The responses all demonstrated a good relationship with their therapist, using words such as ‘trust’, ‘friendly’ and ‘helpful’. All of the responses demonstrated that when the clients used music, they felt that the therapist was more knowledgeable and helpful compared to when the client used other arts modalities. All of the responses demonstrated the clients felt an uneasiness or lack of understanding from the therapist about the non-music arts modalities and materials when they enquired their function within therapy.

Client G

*My therapist knew loads about the guitar and showed me how to play. But [therapist’s name] did not know how to draw. I asked [therapist’s name] why there was a sand tray, but I never really understood why. [Therapist’s name] couldn’t really explain to me, just said ‘if you want to use it’.*

Client Q

*[Therapist’s name] is a terrible dancer. I thought I was bad, but now I know I am not. Does that mean therapy worked for me? (Laughs).*

**Unstructured approach to therapy sessions.**

The responses demonstrated a dislike, and sometimes difficulty, towards the lack of structure to the therapy sessions. There was a trend in the responses that showed that the older
the client, the more this was a challenge. The younger clients tended to favor the unstructured approach, which enhanced creative expression.

Client A (youngest client)

*I liked not being told what to do and when we are going to do it. I like that [therapist’s name] is not like my teacher. It’s my playtime.*

Client P (eldest client)

*I was, like, waiting to be told what to do next and when we were going to do it. In the end, I said to [therapist’s name], ‘are you going to tell me when we play music’.*

Thinking back now, I already knew that it was my free time to do what I wanted, but I think if I had some kind of guide to what I could do, I might have used more of the stuff [therapist’s name] had on the table.

The responses showed that unstructured therapy did not necessarily translate to creative expression. The older the client, the more challenging the unstructured approach became. Some felt that if they had been given an exercise or example, they might have been more creative. However, the youngest clients demonstrated that the unstructured approach enhanced creativity, thus using more of the arts modalities. The responses demonstrated that the older clients experienced the most difficulty with the unstructured approach to the therapy sessions were less likely to explore multiple arts modalities and materials, and remained loyal to one core arts modality, in particular music or art. This is in contrast to the youngest client, who tended, in general, to utilize various arts materials and modalities at least once per session.

Summary of clients responses.

The general consensus was a preference towards having multiple arts modalities and materials on offer, however, this did not translate to all of them being used or favored. ‘Choice’ was a key component to working with the adolescents. Whilst the youngest clients tended to prefer the unstructured approach to the therapy sessions, the clients felt they could be creative in
the modality of their choosing. A trusting and positive relationship with their therapist was key in promoting creative expression and freedom of self-exploration. Talking with their therapist added to this trusting relationship, and all of the clients reflected that they felt they could verbally dialogue with their therapist, although the three clients who saw the Canadian based therapist all reported that they felt this therapist verbally repeated back to them everything they said. All of the clients asked, at one stage, permission to use the arts materials, whilst one client reflected that he did not realize everything in the room were available for his use. This contributed to some confusion and anxiety for this client, and he reflected that had he understood this, this might have enhanced his creative expression. Three of the clients had engaged in music therapy before (without other arts modalities on offer). These sessions were with another music therapist prior to this study. Two of the three clients preferred the intermodal approach, whilst the third felt that music was enough for him to engage with, however this client appreciated the opportunity to use the other modalities if he wished. The eldest client felt satisfied to learn that his therapist was a worse dancer than him, and he spoke about learning about other people’s insecurities and inabilities as helped him understand his own difficulties.

Client Q

Seeing that someone, who is meant to be older and wiser, look uncomfortable and not knowing what they are doing, makes me realize that we cannot be good at everything. Seeing [therapist’s name] admit that [therapist’s name] cannot dance was so funny, and [therapist’s name] laughed with me, but it was real. Now I think about it, [therapist’s name] taught me to accept my limitations and not be ashamed of them. It’s better to admit you can’t do, rather than try hard and feel like a failure. There are things that I can do and I like to do, and that’s fine with me. Dance is not one of them.
Therapist Participants

There were three therapists who worked with the client participants. Each therapist was interviewed once after they completed their five sessions with each client. During the study, each therapist was asked to keep a journal and log his or her thoughts and experiences. This was submitted to the lead researcher prior to the interview. The interview related to the journal entries, and each therapist was asked to think retrospectively. However, the journal was also used for independent data analysis, separate from the interview data. The journal, prior to the interviews, was analyzed and four core themes were developed. Table 3 shows these themes.
Table 3

**Summary of Therapists Journal Entries**

<table>
<thead>
<tr>
<th>Core Theme</th>
<th>Therapist 1</th>
<th>Therapist 2</th>
<th>Therapist 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of experience with other arts (non music)</td>
<td><em>I have no training in this; I have no experience, and yet I meant to know how to do this.</em></td>
<td><em>Learning new arts modalities is one thing, applying it in the clinical setting is another.</em></td>
<td><em>Out of my depth.</em></td>
</tr>
<tr>
<td>Lack of understanding context of other arts materials</td>
<td><em>Not sure what sand or art can do that music cannot.</em></td>
<td><em>I felt frustrated with my client today… he could have done what he was trying to do with music. I feel frustrated with myself because I should have offered music.</em></td>
<td><em>If I knew why I was going to use another arts mode, I would use it. But today, I did not know what I was trying to gain from using the art materials. So, I could not see the purpose.</em></td>
</tr>
<tr>
<td>Feelings of disrespect to non music modalities</td>
<td><em>Feel like I am creating a disservice to the other CATs</em></td>
<td><em>I feel like I have no identity. I try hard to be a music therapist, and that’s the same for an art therapist. We are one or the other, but combined as an overall profession</em></td>
<td><em>I’m a musician and music therapist. That’s what I have to offer my clients.</em></td>
</tr>
<tr>
<td>Feelings of unprofessional conduct</td>
<td><em>Is it right to practice something you have not trained in?</em></td>
<td><em>Am I breaking any rules?????????</em></td>
<td><em>Training = Professional.</em></td>
</tr>
</tbody>
</table>

Following the analysis of the journals, the lead researcher interviewed each therapist and recorded the interviews. Following transcription and data analysis, seven general themes developed. Table 4 shows these themes.
Table 4

*Frequency of General Themes from Therapists Interview Responses*

<table>
<thead>
<tr>
<th>General Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of experience with other arts (non music)</td>
<td>3</td>
</tr>
<tr>
<td>Lack of understanding context of other arts materials</td>
<td>3</td>
</tr>
<tr>
<td>Feeling disrespectful towards non music modalities</td>
<td>3</td>
</tr>
<tr>
<td>Feeling disrespectful to music therapy</td>
<td>3</td>
</tr>
<tr>
<td>Preference to dialogue with client</td>
<td>2</td>
</tr>
<tr>
<td>Preference to offering choice of arts</td>
<td>2</td>
</tr>
<tr>
<td>Dislike of using non musical materials</td>
<td>1</td>
</tr>
</tbody>
</table>

Many of the themes developed from the journal entries were reiterated in the interview responses. The themes developed focused more on negative responses and experience of facilitating the intermodal sessions, with an emphasis towards lack of experience and knowledge of non-music therapy materials. The therapists felt as if they were disrespecting the professions of both music therapy and the other creative arts therapies. The interview responses produced a main theme that related to lack of experience and knowledge of the non-music modalities, however, from this central theme developed further sub-themes that related to professionalism and clinical skills.

**Lack of Experience and Professional Conduct.**

The three therapists spoke in depth about their lack of knowledge or experience using the non-music therapy materials. Although they commented that the experiential training, provided
by the lead researcher prior to the clinical study, was useful and informative, once they were in the clinical setting and working with clients, they all felt ‘insecure’ about their abilities.

Therapist 1

*I felt like I was out of my depth. I felt like I was not able to offer the best interventions.*

Therapist 3

*I felt insecure in my own abilities, because I was involved in an arts-based exercise that I had no idea where it was going to go.*

This insecurity developed into a topic of professionalism.

Therapist 2

*I felt it was unprofessional of me to provide an intervention that I had no experience as a client or therapist. I also felt it was unprofessional as a trained music therapist and believer in music therapy to utilize the other arts therapies. It was like I was stepping on their toes.*

Further inquiry into these feelings of professional insecurity developed into a discussion that the therapists felt they were being disrespectful to both music therapy and other creative arts therapies.

Therapist 1

*I thought about my friend who is an art therapist, and thought, she would not consider this art therapy.*

Therapist 3

*I felt like I was not being true to myself as a musician, because that’s what I am first and foremost. I consider myself a music therapist second, because that’s what I am as a healthcare professional. When doing the study, I felt like I was neither, and that did not sit well with me for my clients and my profession.*
The researcher enquired whether formal training in intermodal therapy would have made the therapists feel more confident in their professional skills. Therapist 2 considered that it is the client and not the therapist who chooses the modality.

Therapist 2

*I think some kind of training that exposes the clinician to all of the arts would help, but I can’t see how it can be done, because ultimately, it is your client who chooses the arts modality. You could train in using music as an intermodal therapy, and end up working in a setting where all of the clients are not able to engage in music. If that’s the case, you are still ill equipped.*

Therapist 3

*To me, this was more about play therapy and not creative arts therapy. So, maybe we need to consider more what play therapy does rather than arts therapy. I chose to be a music therapist, not a play therapist. Yes, there is play in music therapy, but it’s a completely different context and objective.*

Therapist 1 spoke about her uneasiness dancing with a client Q.

*I felt uneasy and quite stupid too. I felt like, I should know what I am doing, but I am not trained in this, and I think it shows. My only way of using this was to demonstrate that I could not do it; therefore showing the client it was OK to not be capable. In a way, this opened up the therapeutic relationship, so actually, I have just contradicted myself, because by doing something I could not do and showing my vulnerability actually helped the relationship progress. So, maybe there is value in using arts modes you are not trained in.*

Towards the end of the interviews, the researcher asked for the therapists to each reflect on their experience.
Therapist 1

After the first session, I wrote in my journal that I could foresee I was going to struggle, and I did. But I really loved having the chance to try this method. I can see value in it, but I think the value is more for the client than the therapist.

Therapist 2

I am pleased to have had this experience, but it’s not for me as a clinician. I feel like I cannot identify myself with this, so for me, it’s all very jumbled. I have no identity as an intermodal therapist. I have identity as a music therapist.

Therapist 3

Music offers choices. Why do I need other arts to offer choices?

The researcher inquired whether the sessions had value for the clients.

Therapist 2

Yes, but mainly because they seemed to enjoy the offerings and I think I was lucky that I had a good rapport with the clients I saw.

Therapist 3

I think there was value and appreciation in being respected and holding that space open for them, but I don’t think each client valued one arts modality over another. Each had a preference, for sure, but that’s different to valuing an arts mode.

Journal Entries and Reflections.

During the interview, the researcher related journal entries back to the therapist and asked whether the journal was a useful tool.

Therapist 1

I found it useful because I could track my own thoughts. It has helped me to recall those experiences from a few weeks ago to you now for this interview.
Therapist 2

*I have kept a personal diary for many years, and see the value in it. But how I felt then, when writing my entry, and how I feel now has not changed.*

Therapist 3

*What I have found useful is by you mentioning things I wrote and giving me the chance to reflect further. I think in some ways, that using the other arts was not so bad after all, I just felt out of my depth during the study. I am going to look into taking more workshops in play and arts therapy, and decide whether I want to incorporate other arts into music therapy.*

The journal seemed to have provided a positive support for all the therapists during the study. It also helped them reflect on their experiences during the interview process. Whilst therapists 1 and 2 felt as if their journal entries were a true representation of how they felt both during and after the study, therapist 3, who spoke openly about struggling during the study, seemed to use these written entries as a way of encouraging further training in other arts modalities. Therapist 3 felt that by reflecting on what felt difficult, the journal encouraged him to inquire further about the other arts modalities towards professional development.

Therapist 3

*You don’t always think about it when you’re in it, you think about it afterwards.*

**Summary of therapists’ responses.**

The therapists’ experiences were in contrast to the clients’ experiences. Whilst, for the clients, there were more positive responses for the use of the music and intermodal approach that centralized on choice of arts modalities, the therapists’ responses were less enthusiastic. The therapists main concerns related to lack of training, identity and professionalism. The therapists felt that they were being disrespectful to both music therapy and other creative arts therapies by using the intermodal approach, therefore their ambivalence had more to do with their own
abilities rather than the experiences of the client. Each therapist felt that every client had their own personal preference of arts modality, so whilst the therapy sessions offered choice with regards to arts materials, the singular approach became the focal point of the therapy. When the focal point was not music, this is when the therapists each felt insecure about their abilities and skills. Therefore, offering choice within therapy sessions does not mean that all of the arts materials will be used.

Each therapist commented on the whole experience as being positive to try an alternative method, and each were appreciative of being exposed to intermodal therapy. Each therapist, however, commented that training was key in providing the integrated approach, rather than short workshops, but could not consider what should be of utmost importance for that specific training. However, therapist 1, after reflecting the experience of dancing with a client, suggested that the lack of experience actually helped develop the therapeutic relationship. The therapist used her psychodynamic music therapy training in empathy to think about how she could model one’s own lack of ability to best serve the client.
CHAPTER 5

Discussion

The objective of the study was to investigate the experiences of clients and music therapists using other arts modalities in a music therapy practice. The client participants included 17 adolescents between the ages of 11 and 19 years old, who participated in five consecutive individual therapy sessions with a qualified music therapist. The study took place in London, England and Toronto, Canada. The three music therapists were from different training programs and theoretical backgrounds, and each therapist had no previous experience using other arts modalities, such as art, movement or drama. Following the study, each participant was interviewed to assess his or her experience of the intermodal arts approach. In addition, each therapist was asked to keep a journal during the study to gauge personal feelings towards using other arts forms in clinical work.

There has been scarcity in the overall creative arts therapy literature about how and why an integrated arts approach can be utilized. This is in conjunction with a number of discussions and debates in the literature both for and against the idea of incorporating all of the arts rather than using singular modalities (Agell & McNiff, 1982, Bruscia, 1989, Knill, 1978, 1994; Knill, Barba & Fuchs, 2004).

The study findings were in favour of the intermodal approach from the clients’ perspective, but not from the therapists’. The clients preferred to have a choice of arts materials available during the sessions. The therapists noted that although there was choice of arts materials, each client preferred one specific modality and utilized this preferred modality throughout the total sessions, and if the preferred modality was not music, the therapist was left working in a modality in which they had no training. Both the clients and therapists believed that a trusting and positive relationship was key to the therapy being a positive experience. The study findings recognized that more substantial training in the other arts modalities, such as art,
movement or drama was key for the therapist to facilitate an effective intermodal arts approach, and the therapists’ ambivalence and lack of knowledge was also recognized by the clients who noted that their therapist seemed to lack an ability with some of the arts modalities on offer. Furthermore, the therapists had anxieties about their own capabilities and skills that contributed to questions about their own professionalism and identities as music therapists. The younger clients felt more at ease with the unstructured approach to the therapy, which encouraged their own creative expression, whilst the older clients felt that the unstructured approach did not stimulate creative expression and they felt they were waiting for the therapist to give them guidance.

The heart of the study was to investigate whether music therapy should or could include other arts modalities, and whether an intermodal approach provided a positive experience for adolescent clients. In addition, the study examined whether experienced music therapists could see value and potential in including other arts modalities into their established music therapy practice. This approach was designed from the researcher’s own clinical experience of using multi-disciplinary rooms to practice music therapy in school settings.

In summary, three of the clients had previous music therapy experience. Two spoke highly about their intermodal arts experience, whilst one expressed preference for using the single modality. The feelings expressed by the clients mirrored the overall experience of the three therapists. Intermodal therapy is based on the idea of offering choice for the client (Atkins & Williams, 2007; Estrella, 2005). Choice was the core theme for all of the clients. However, the therapist’s responses to this were that choice was not taken by the clients once they decided upon their preferred arts modality. Each client remained loyal to their chosen arts modality and tended not to deviate from it. The therapists also remarked that the concept of choice is utilized in music therapy, by offering a range of musical instruments. Choice in music therapy is also represented by the various well-established techniques and approaches, such as live improvised
music making (Wigram, 2004), song writing (Baker & Wigram, 2005), receptive music therapy (Grocke & Wigram, 2007), and singing and vocal psychotherapy (Austin, 2007, 2009).

Study Findings in Relation to Knill’s Theories

The literature review highlighted the work of Paolo Knill and his theoretical development of intermodal expressive therapy. This study embraced some of these initial theories and placed them exclusively in the context of music therapy, thus advancing some of these principal theories. Knill based his intermodal theories on allowing freedom for the client, and that by offering multiple arts modalities; the client would not become stuck and it opened the “range of play” (Knill, 2001, p. 71). Knill considered that the more on offer, the more limitless the client’s experience. However, this study offered multiple arts choices, and yet the client remained loyal to one chosen art form. Both the clients and the therapists did not report any feelings of being stuck with their chosen art form, nor did the results demonstrate a need for changing art form during the therapy session. It may be possible that the client perceived discomfort from the therapist, therefore was not as creatively explorative as anticipated.

Intermodal arts therapy materials as part of an unstructured therapy session did not automatically produce creative expression. For some clients, particularly the older ones, the wealth of arts materials and unstructured session stagnated the creative expression. There is yet to be anything in the literature to support these phenomena, however McFerran, Roberts and O’Grady (2010) reported that music therapy with teenagers permits “opportunities for both freedom and control, altruism and empathy” (p. 546). Therefore, further studies investigating the use of unstructured arts therapies with younger adults between 16-19 years old would be beneficial to develop this finding.

Knill’s theory of low skill-high sensitivity was evident with the experiences of Therapist 1 who felt insecure about dance movement with her client, but later reflected that this lack of skill enhanced the therapeutic relationship. Her low skill in this area increased her sensitivity
towards the client because the therapist was empathic to the experiences of the client during the session. Therapist 1 reflected that being inexperienced in some art modalities could enhance the therapeutic relationship. Therapist 1 felt that it was her psychodynamic training in music therapy that encouraged her to consider empathy in this situation. The psychodynamically informed training allowed her to think beyond the arts and more about the relationship. From this, Therapist 1 used her high-skills in empathy, and related it back to the arts. On the other hand, Therapist 3, who had not had any psychological training or experiences as a client, felt that his low-skill did not add to a high-sensitivity. Therapist 3 felt that by not having a skill set, he was unable to accommodate the wishes of the client. In addition, it was this therapist whose clients reported during the interviews that their therapist repeated all of the words the client was saying. The clients also noted that their therapist seemed insecure with the non-music materials. Therefore, having a low skill in this case did not automatically increase an awareness and appreciation to all of the arts modalities. However, as the therapists were not introduced to the theoretical foundations of Knill’s theory of low-skill, the question whether having more of an understanding about this theory would change this experience in clinical practice would be advantageous. It was within the context of using non-music materials that all the music therapists questioned their own professional conduct when using materials and modalities that they had no experience or training in.

The results from this study mirror the findings of Lev-Wiesel and Doron (2004). Lev-Wiesel and Doron support the theories set out by Knill (1978). They found that college-age clients preferred choice of arts modalities within a therapy session, which was reiterated in this study with the younger clients. However, the therapists in this study noted that once the choice was made, the client remained loyal to this chosen mode.

Because of the lack of training of the music therapists, Knill’s other key theories in his dissertation (1978) regarding intermodal transfer were not examined or discussed. Because the
therapists were encouraged in their training for this study to allow the client to choose arts modalities, the transfer between arts modes was not investigated. Knill defined specific ways to manoeuvre between arts modalities in his dissertation (1978), therefore a further study with an emphasis on Knill’s theories (using intermodal expressive arts therapists) would be advantageous to explore whether the Knill’s theories could be applied in relation to this study’s context, which did not fully establish itself in Knill’s theories of how to apply an intermodal approach to therapy. However, as the therapists all reflected that the clients remained loyal to their chosen arts mode, the theory of intermodal transfer could not be applied to the results of this study, as intermodal transfer is based on “when we work in a particular communication modality and directly move into another modality” (p. 84). If the client does not move into another modality, which was evident in the results from the therapists’ interviews, then the question whether the therapy session is an intermodal approach, even when facilitated by trained intermodal expressive therapists, needs to be explored. For example, if the client remains with the art modality through the therapy, does the therapy become ‘art therapy provided by a music therapist?’ These questions link with the therapist’s feelings of professional conduct and identity in relation to providing a modality that the therapists have not received any formal training in.

Strengths and Limitations of the Study

A key strength of the study is the total number of 20 participants that contributed to it. There were 19 proposed client participants, however 17 clients completed the course of therapy. One of the key limitations of the study was relying on the clients and therapists to report truthfully their experiences of the therapy sessions. Whilst all of the clients were conversational in the interviews, there were some individuals who were less talkative than others, and some of the participants needed further prompting to illustrate their points of view. On refection, a follow up interview may have been advantageous to further develop the interview data. In
addition, a creative technique such as story telling or role-play could have been used to encourage further discussion and dialogue, particularly with the younger clients.

Attendance in the therapy sessions was good, but punctuality was an issue for many clients, particularly the younger clients who were reliant on a parent and or guardian to bring them to the session. Because some of these clients were late for their appointed session time, these individuals received shorter sessions which might have had some impact on the use of arts modalities. The older clients tended to be on time for their appointment. All of the clients stayed for their sessions, without any early departures.

Another key strength of this study was that it took place over two continents. Whilst this allowed this study to be a collaboration of an international network of colleagues, this was made possible due to the researchers own relocation from England to Canada, which took place during the therapy sessions being facilitated in London, England by the two London-based therapists. The Toronto based therapist began facilitating the sessions once the researcher was settled in Canada. However, on reflection, this relocation hindered a number of aspects of the study, in particular, the support to the therapists during their participation in this study. Whilst it is not considered that any of the clients were affected by the researchers relocation, the recruitment of a research assistant to facilitate the London-based client interviews was implemented at the later stage. The therapists suggested this as a way to provide face-to-face interviews with each client, as opposed to a Skype or telephone call, that was initially planned by the researcher to compensate for the researcher absence. Introducing a new person to each client in the latter stages of the study may have impacted some of the interview data, however, the research assistant did not report any form of discomfort or hesitation from the clients.

Training for the therapist was a key limitation that hindered the study. A one-off experiential workshop was provided prior to the study, however, on reflection, a follow up session halfway through the study may have been advantageous to assist the therapist with any
key concerns. Additional training that specifically focused on challenges the clients brought for each therapist might have provided support and guidance for the therapists to take back to their client and progress forward in their therapeutic relationship. It may also have encouraged the therapists to feel more secure of the intervention they provided.

Each arts therapy modality is based on the therapist being an expert in his or her own modality. This study demonstrated that encouraging the therapist to engage in an art form that is outside their specialized training or experience contributed to feelings of being unskilled, unprofessional and lacking in identity. Whilst each therapist felt secure when the client utilized music, the client’s preference to other arts modalities limited the intervention the therapist could provide. A design feature that might have prevented the therapists feeling out of depth with the range of arts modalities on offer would have been if the study focused on using one other art form in addition to music (i.e. visual art or a second modality of the therapists’ choice). It may have been that the therapists would have felt more able to offer art making as a way of complementing the music-making process, as suggested by Grocke and Wigram (2007) who used art making to further the clients’ experiences using receptive music methods.

A further limitation of this study is that the therapist participants were not asked their ethnicity as part of the data collection, as opposed to the client participants who were asked to define their racial heritage in their own words. This omission was not intended by the researcher, and defines a gap between what the inquiry towards the client participants was and that of the therapist participants. The therapist participants were also not asked to complete a research consent form in the same way the client participants were (see appendix A). This was largely due to the researcher having a previous professional relationship with the therapists and a verbal understanding that their participation in this study would act as consent for data to be used and analyzed. However, this difference demonstrated that all participants were not treated in
equal measure, and this has led to an unequal balance of data collection from across the participant pool.

The therapists were asked to retain a journal throughout the process, as a way of logging their thoughts and progress, and providing them with a creative output for these experiences. On reflection, the researcher considers this as another example of an unequal balance of data collection because the clients were not asked to retain this form of research design. It should be noted that the terms diary and journal are interchangeable in this dissertation. This is because the term diary was used as a research method, cited in the literature review, whilst the therapists and researcher referred to the document as a journal for personal and creative expression. Whilst the journal received positive feedback, its use as a research method was underused in this study, and perhaps should have been considered in greater detail as a viable way of collecting data as a standalone research tool. Whilst the journal was recommended for creative expression, the opposite proved to be true. None of the therapists used the journal for detailed artistic or creative expressions, except for small drawings and minimal use of color. The journal was mostly used for written forms of ideas and considerations, and none of the therapists used the journal for music-orientated expression. The therapists did not suggest that as part of their creative expression did they utilize their primary arts modality (music) as a way of self-comfort or support. It could be suggested that because the therapists were being offered the chance to use non-music modalities in their practice as a music therapist, the use of non-music modes became a focal point for their own creative expression in their journal, highlighted by the use of color and sketches.

**Contributions and Implications to the Expressive Therapies**

The study provided a forum for clients and therapists to speak candidly about experiences with music therapy that provided access to other arts forms as well. This study was intended to utilize the basic functions and theories of intermodal therapy, as defined by Knill (1978).
However, this study demonstrated that when music therapists apply other arts modes to music therapy without the formal training of intermodal therapy, the application of intermodal therapy is more complex than perhaps considered by the researcher and by cited authors, such as Prinzing (2009), who considered all of the arts accessible by creative arts therapists, even without specialized training. Therefore, it should be acknowledged that sessions provided for this research study were, in fact, music therapy with additional arts materials on offer to the client. Whilst this study did not intend to train intermodal therapists, nor suggest that music therapists working in multi-disciplinary settings can or should use other arts modes available, this study does demonstrate that the application of intermodal therapy is more than simply allowing the client to engage in various arts forms within a single therapy session. However, from the clients’ perspective, all of the 17 client participants spoke highly about the experiences in this specific approach of using music therapy with other arts modalities. Whilst much of the focus from previous writings have been from the therapists’ perspective of the use of intermodal therapy, both positive and negative, this study demonstrates that there is a preference for intermodal approaches from the clients’ perspective, particularly younger adolescents.

A topic for discussion within the field of expressive therapies could be about when a music therapist should refer a client to art therapy, or when an art therapist should refer a client to dance movement therapy, and so on. The results from the therapists demonstrated an eagerness to learn more about other creative arts therapies. This was not in the sense of learning how to apply them in their own practice, as the therapists’ wished to remain music therapists without an emphasis on other arts forms, but for the music therapists to understand further the role and objectives of the other arts modalities as a way of gauging further appropriate interventions for their clients and make referrals to these fellow professionals where necessary. Therefore, a focus in the training programs for each singular arts therapy modality could consider introducing students to fellow creative arts therapies, both theoretically and
experientially, may further the communication amongst the creative arts therapies as a whole. Whilst there are some training programs that do offer this, perhaps this could become standard practice in greater context.

From the therapists’ perspectives, the general consensus was that having a specialized training in one core arts modality strengthened the therapists’ professional identity and contributed to a sense of confidence and competence. Having a strong foundation in one arts modality allows for flexibility within that one arts modality. For example, music therapy provides an assortment of interventions from improvisation (Wigram, 2004) to song writing (Baker & Wigram, 2005) to receptive methods using pre-composed music (Grocke & Wigram, 2007). However, the therapists in this study noted that engaging in training and workshops post music therapy qualification might allow the individual therapist to consider ways to incorporate these multiple arts modalities, and consider whether their client might benefit further from an alternative arts modality if music therapy was not in the clients best interest. Therapist 1 would consider further training in play or drama therapy as a way of deepening her understanding of the arts, but more for her own understanding and education rather than as a way of offering more modalities to her clients.

This study is unique in working with three music therapists without any other training in other arts forms, and encouraging the therapists to work with clients using a variety of arts modalities and materials without formal training. Prinzing (2009) suggested that all arts therapists should be able to incorporate modalities that are not their primary training into their practice. Prinzing acknowledged that a personal affiliation with art guided her use of the concrete components of art therapy, but suggested that an artist interested in other art modalities “should be able to adapt these ideas to other artistic media” (p. 11). However, the results from this study demonstrate that this was not the case. The music therapists were unable, and at times uncomfortable, with adapting other arts into their practice, regardless whether they had a
personal affiliation with other arts modalities aside from music. Their personal affiliation with the arts gave them no basis for incorporating these into their professional identity and practice, although the researcher did not inquire whether there were any specific arts form other than music that the therapists might have had a personal affiliation with. If so, perhaps the therapists might have felt inclined to gravitate towards this specific mode, rather than be encouraged to use all of them in the therapy sessions.

The topic of professional identity in intermodal therapy was explored by Speiser (1996) in his doctoral dissertation. This resource is introduced here because the findings of the study indicate that professional identity was an issue provoked by the introduction of multiple media in research sessions. As happens occasionally in phenomenological studies, additional sources are cited following the study to enhance the discussion of the findings. However, the topic of professional identity was not considered as a potential subject of this research study, hence the omission of the topic in the literature review.

Speiser wrote (1996), “[intermodal therapists study] one particular form of expression which concentrates on an integration of multiplicity,” meaning that the therapist is able to extend their primary arts modality into other modalities. Speiser continued, “[the intermodal therapist] is a Jack of all arts and master of integration. One usually is very competent in at least one modality” (p. 135). However, he did not explore how integration was possible, nor address the questions about a therapist’s competency with different modalities. Whilst Speiser agreed that the intermodal therapist was a jack-of-all-arts, he acknowledged that at least one modality tended to be the therapist’s preferred choice of arts mode. Speiser did not investigate whether this preference ultimately determined how much of this preferred mode took precedence in the intermodal context. Speiser did recognize that the therapist “should be very familiar with the particular uniqueness of other modalities” and that a “high level of comfort in modalities which are used together is needed in order for a therapist to adequately and responsibly work with an
integrated approach” (pp. 135-136). This statement raises the question about training. How much exposure and comfort with other modalities is needed was not addressed by Speiser, nor was the process of learning explored. Speiser stated that intermodal training was a “long and complicated affair” (p. 136) and did not explore the idea that perhaps training in all of the arts modalities was a complicated process, but he did state that much of the training process was at the student’s own experience, rather than being taught a specific approach or method to using particular arts modalities. Speiser’s discussion regarding the training of the intermodal therapist supports the experiences of the music therapists in this study. Speiser stated that experiential learning and a personal affiliation to all of the arts is central to the training of an intermodal therapist, but the experiences of the music therapists in this study were in contrast to this, although the music therapists did not have the same type of training that Speiser was advocating, which is a critical difference between Speiser’s findings and the design of this study. Speiser acknowledged that the therapist having an identity with their preferred arts modality would best serve the client, which was reiterated by the music therapists in this study. Speiser considered both the benefits and the problems that arise from aligning oneself with multiple interventions. Speiser wrote his doctoral dissertation as a narrative exploration into his own practice and it offers a historical viewpoint into the development of intermodal therapy, but the results from this study demonstrate that Speiser’s theories were correct, and that there are a number of issues that contribute to the identity of a therapist who offers more than one arts therapy approach.

An investigation into the practice of four intermodal expressive therapists (Hyams, 2011) who each trained at different training programs in intermodal therapy suggested that three of the four therapists originally trained in a single modality, but were unsatisfied with the limits of the modality. This pilot study is being introduced at this stage because it relates to Speiser, however was not a primary consideration when this study was being designed. The primary reason given by the three intermodal therapists (two trained as art therapists, one trained as a drama therapist)
for intermodal training was that they felt their single modality training did not equip them with sufficient skills. They also felt that their formal training in art or drama therapy was too psychological, and that the artistic and creative process was lacking. This is in line with E. Levine (2011) and Rogers (1993) who wrote they felt their psychological training removed their access to creativity. Levine (2011) remarked that where psychoanalytic practice was becoming “problematic” (p. 36), expressive arts therapy was “like a homecoming – a return to my own art making” (p. 37). Levine described her introduction to expressive arts therapy as being able to re-engage herself within the arts, and she promoted the arts as central to her own process from this point on, both personally and professionally. The results from the current study demonstrate that two of the three music therapists could see the benefit of further training in other arts forms to extend their understanding of the different arts modalities, but the music therapists did not feel they needed to formally extend their training to identify themselves as intermodal therapists. However, there have been some arts therapists who have developed their single arts therapy training into an intermodal practice without additional training, such as Halprin (2003) who trained as a dance movement therapist, before incorporating other arts media into her work through her own affiliation of numerous arts modalities.

One of the key contributions to this study was the experience voiced by the participants of their lived therapeutic experiences. Many publications in the expressive therapies consider the views of the therapist, but this study provided an exploration of how clients view therapy, how they use it and what they want from their therapist. It may be that arts therapists, as professionals, could learn more about the field and how it is developing and evolving from the viewpoints of the clients served, as previously researched by Heatherington, Constantino, Friedlander, Angus and Messer (2012) and Levitt and Piazza-Bonin (2011), who researched clients perspectives in psychotherapy.
In summary, the therapists in this study felt they had enough skills to continue working as music therapists, and that music therapy offered enough choices and opportunities for the client to explore and express themselves in the therapeutic setting. Having multiple arts on offer did not necessarily promote any further creative processing; nor did having multiple arts on offer encourage the client to use the arts more freely or without limits, as suggested by Knill (2001). The topic of professional identity was key in this study, and the music therapists felt that they could identify their professionalism with the training and qualification that they had attained, without needing to utilize other specializations for guidance and experience. However, all the therapists did reflect that they were interested to learn more about the other arts therapies, more as a way of assessing whether music is an appropriate intervention for their client, and if not, the experience of other arts would assist the therapist in making referrals to a qualified art therapist or drama therapist or movement therapist and so on.

It is hoped that this study has provided the foundations for further examination into the relationship between music and the other arts modalities. It is also hoped that further studies that focus the experiences of clients in the expressive therapies will be encouraged across all client demographics and creative arts therapies.

**Final Thoughts and Reflections**

This study was intended to reflect clinical experiences that I, as a music therapist, encountered working in school settings. From the time of my training to working full time with the education authority in England, I became acutely aware of the phenomena of using other arts materials and modalities within a music therapy session. The introduction of an intermodal approach in my own music therapy practice was not preconceived, nor was it an attempt to offer my clients further creative modes beyond music. Personally, I never felt under skilled as a music therapist, but deskilled in the prospect of working with other arts materials that my clients were, by choice, introducing into their therapeutic experience. At the time of this initial awareness of
using non-music therapy techniques in my practice as a music therapist, I felt that both the music therapy literature and some clinical supervisors were unable to recognize, acknowledge and support the phenomena that I was encountering on a regular basis. As a professional, I turned to a network of colleagues also working as music therapists in school settings to seek counsel, only to find that this phenomena was not as unique as I first thought. It appeared that many music therapists working in multi-disciplinary rooms within schools were being asked by their clients whether other arts materials and modalities could be introduced into music therapy. The overwhelming sense of my fellow professionals was that there did not seem to be an adequate answer or resource within the field to support this clinical and ethical dilemma. As a music therapist, I began to undertake workshops and conferences in other creative arts therapies and play therapy, which led to my application to an introductory program focusing on play and sand tray therapy. At this time, I first discovered Paolo Knill’s writings, in particular, *Minstrels of Soul* (2004). This book seemed the first piece of literature that resonated with many of my clinical experiences, yet I still posed many questions regarding the theory of the intermodal approach, and how it was to be applied. This led to my decision to undertake this topic at doctoral level, and my application to Lesley University, primarily because of its historical associations with intermodal therapy.

For my pilot study (Hyams, 2011), I interviewed four intermodal therapists. One of the key findings was that each therapist trained as a singular arts therapist (art or drama), then pursued intermodal training because they felt their primary modality did not fully equip them with the skills to apply in their clinical settings. All four therapists worked with school aged children, and undertook additional training in intermodal therapy to enhance their clinical and artistic skills, to better serve their clients and offer a richer creative experience, thus creating a positive therapeutic relationship. From this pilot study, I began to wonder whether my own intrigue into the intermodal approach, and my own application of intermodal practices (without
formal training) were not only by default, but because there were elements of the practical side of working as a music therapist in school settings that the music therapy training did not, and perhaps, could not integrate into its philosophy of educating.

From these experiences as a music therapist, and the findings from this study, I wonder whether this topic has garnered further questions rather than succinct answers. Does training in a single creative arts therapy, in my case, music therapy, provide enough recognition for the realities of working as an arts therapist in settings where arts therapists are most likely to gain employment, for example, schools, day centres and hospitals? Does the training in each creative arts therapy recognize that clients come to therapy with their own ideas and aspirations, and perhaps, in some circumstances, the modality which each individual therapist offers what the client is seeking for their support? If a client comes to music therapy but wishes to engage in an art making process, what is the course of action taken by the therapist? If the therapist does permit an art-making exercise, merely because the art materials are on offer in the multidisciplinary room that has been allocated for music therapy, how long should the music therapist support this process? And at which point should the music therapist broach the subject of referring the client to an art therapist? The three music therapists interviewed for this study all suggested that they would recommend further understanding and education of what each creative arts therapy offers clients, as a way of making appropriate referrals where necessary. Whilst this study did not intend to train or promote music therapists to use an intermodal practice, it has exposed the music therapists to other creative arts therapies that, perhaps, was lacking in their own understanding of the overall field, prior to the study.

As a therapist and researcher, I think that we have to consider further how arts therapists are working in the settings where arts therapists are being recruited, and explore these realities in a way that not only enhances our profession, but validates some of the key experiences that therapists may be encountering, and question whether the training programs and literature need
to be reflecting these realities. As the global economic slowdown challenges all sectors and industries, we must remember that our overall profession is not immune to these economic challenges, and this will, in my opinion, change the way that we work and how the arts therapies are being applied in both public and privately funded institutions. It may be that because of these changes, the practicalities of working as an arts therapist changes, and what do these changes look like? In addition, as the profession develops in the public eye, what are the expectations of the clients who seek the services of an arts therapist? Has this changed the way we, as individual therapists, practice therapy? It is proposed that the field can learn much from the viewpoints of our clients, and Hibben (1993) has provided a valuable source for this study, and why this study regarded clients and therapists perspectives as part of the data collection. It is suggested that further studies and literature focusing on clients own responses to the work we provide will create an invaluable resource as a way for the entire profession to answer the aforementioned questions posed in this study, and assist in advancing the creative arts therapies.
APPENDIX A

RESEARCH CONSENT FORM
Dear

You are invited to participate in the research project titled “Music Therapy as an Intermodal Practice”. The purpose of this study is to explore the experience of a client and a music therapist using a variety of creative arts therapy modalities, in addition to musical instruments.

Your participation will entail 5 individual sessions with the music therapist in a private therapy studio. Following the 5 sessions, you will meet the researcher for a 1 interview that will last for about 45 minutes. This will be an informal discussion about your experience of the therapy, what arts materials you liked best and what you used the most and why. This will assist in gaining further understanding of the practical use of the modality. During the therapy, you will be free to explore and express yourself with any of the materials on offer, and you are free to talk to the therapist to ask for help, guidance or assistance. However, how you use the materials what you do is your choice, and you are encouraged to be as expressive and explorative as you can.

In addition

- You are free to choose not to participate in the research and to discontinue your participation in the research at any time.
- Identifying details will be kept confidential by the researcher. All of the data collected will be coded with a number, and the researcher will never reveal the participant’s identity. Only the researcher will have access to the data collected.
- Any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., parent/teacher/guardian/your therapist/doctor/nurse) about your decision to participate in the research and/or to discontinue your participation.
- Participation in this research poses no risk to the participants. You will never be asked to do anything you do not want to do, and you can talk to your therapist or researcher at any time if you have any concerns. If any problem in connection to the research arises, you can contact the researcher, Daniel Hyams at 07973185167.
- The researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.)

My agreement to participate has been given of my own free will and that I understand all of the stated above. In addition, I will receive a copy of this consent form.

By entering your name below, you are giving full consent to all of the above:

________________________ ___________  ______________________  _
Participant’s signature             Date                  Researcher’s signature

Date
APPENDIX B

LIST OF ARTS AND PLAY MATERIALS USED IN THE SESSIONS
Upright piano.

Full size keyboard.

2 acoustic guitars.

4 Djembe drums.

Ocean drum.

Percussion instruments, such as tambourines, bells and shakers.

CD player with iPod connection.

White paper of various sizes.

Crayons.

Paints and brushes.

Glue.

Glitter.

Scissors.

Felt pens and colored pencils.

Plain white facemasks.

4 colored magazines with various photographs of places, people and celebrities.

Dolls House.

Figures of men, women and children.

Sand tray with yellow sand.

Figures and objects including shells, cars, people and toy animals.

Role-play costumes and equipment, such as a superhero cape, pirate’s sword, fairy wings, eye mask and spectacles.
REFERENCES


York, NY: Guildford Press.

Frankel, Z., & Levitt, H. M. (2009). Client's experiences of disengaged moments in
psychotherapy: A grounded theory analysis. Journal of Contemporary
Psychotherapy, 39, 171-186.

Gallegos, N. (2005). Client perspectives on what contributes to symptom relief in
psychotherapy: A qualitative outcome study. Journal of Humanistic Psychology,
45(3), 355-382.

Gitman, K. (2010). The effects of music therapy on children and adolescents with mental
or medical illness: A meta-analysis. (Doctoral dissertation). Retrieved from
ProQuest Dissertations and Theses database. (UMI No. 3407897).

adolescents with psychopathology: A meta-analysis. Journal of Child Psychology
and Psychiatry, 45(6), 1054-1063.

Psychotherapy Research, 17(3), 292-300.

with children and adolescents: The role of therapeutic techniques. Psychology and
Psychotherapy: Theory, Research and Practice, 80(4), 577-589.


Rickson, D. J. (2006). Instructional and improvisational models of music therapy with adolescents who have attention deficit hyperactivity disorder (ADHD): A


http://www.artspsychotherapy.org/