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Nicole Frederick
Lesley University, nfrederi@lesley.edu

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Using Music to Recognize and Regulate Emotions with At-Risk Adolescent Girls

Capstone Thesis

Lesley University

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Nicole Frederick

Music Therapy

Donna Owens

Abstract

Emotional regulation can be difficult for adolescents with histories of complex trauma. Listening to music is a useful coping mechanism when dysregulated. However, some children with complex traumas struggle to find appropriate music for this purpose, let alone listen to it with the intention of emotional regulation. This capstone is a reflection of an individual music therapy session focused on emotional regulation. Previous research on this topic has proven the efficacy of music as a tool for emotional regulation, but none approached in the way presented here. The sessions were held in a residential school for biologically female students unable to safely live at home and attend school. Each session, the client provided songs to add to various *emotion* (happy, sad, frustrated, content) playlists. After processing the physical and mental effect of the song on the client, the client shared the contextual significance of the song. This approach was successful in creating an independent emotional regulation mechanism due to the structure an individual session provides. The support of both a therapeutic relationship and space, facilitated the development of a new skill, and allowed for processing of difficult feelings and experiences.

Keywords: emotional regulation, adolescent girls, residential, music selection, trauma

Using Music to Recognize and Regulate Emotions with At-Risk Adolescent Girls

Humans can develop the ability to reflect on their inner experience over time and often with assistance. Having the capacity to regulate and relay that experience is a further developmental step. When a person experiences trauma at a young age, growth of both skills is interrupted, sometimes permanently (Green, 2011). This consequently requires assistance to build them. The young women I work with at my internship were exposed to traumatic events and living environments during the latency stage of development. In keeping with the current understanding of exposure to trauma, this has caused a rupture in their abilities to recognize their inner experience (Sutton & Backer, 2009). It is more difficult for a person to regulate their emotions if they are not able to identify them from the start. My capstone is focused on demonstrating how music therapy is an appropriate approach to developing these skills and bridging the gap between what they are currently exhibiting and what I believe they are capable of. Researchers have previously found success using music therapy interventions with adolescents, specifically with trauma histories or from at-risk backgrounds (Shuman, Kennedy, DeWitt, Edelblute, & Wamboldt, 2016; Sutton & Backer, 2009).

Music has the capacity to elicit emotions and provoke meaningfulness (Craig, 2008), which makes it an ideal tool for emotional recognition and modulation. Adolescents can be influenced by music in such a way to alter personality traits; however, it can be a maladaptive coping skill in clients with depression or depressive personality traits because they may choose music that deepens their feelings of depression (Miranda, Gaudreau, & Morizot, 2010). It can also be challenging to use music productively and independently as a coping skill for people with impaired mood regulation capacities (Garrido, Schubert, & Bangert, 2016). Therefore, I propose a collaborative approach between the client and music therapist to develop music as a tool for

emotional validation and regulation. Selecting music for therapeutic and clinical use can be tedious because appropriate material for each unique client must be identified from the vast source of existing music. Identifying music preference has been reviewed and analyzed within the field of music therapy (McFerran, 2010; Austin, 2007; Craig, 2008; Garrido, Schubert, & Bangert, 2016), but primarily as an independent task of the therapist or client. I suggest collaborating with the client can make the process more effective. It is now understood that both the contextual, cultural, and mental characteristics of the individual, and the intent of the song used, influence song preference. A more efficient approach might be developed by reviewing literature on client and music therapist song preference, and reflecting on this collaborative process in a clinical setting.

The intervention used in this project involved several steps over the course of a semester of weekly therapy. I first identified various emotional states with the client. The next step was identifying songs that matched each emotional state for the client to put into a playlist. We discussed how each song makes their mind and body feel, and collaborated on any association with the song. We collaborated on how to identify emotional states, clearly labeling how each feel in the body and what thoughts accompanied them. The resulting playlist was used by the client to match their current emotional state, or transition to a target emotional state. The use of music as a facilitator to actively change emotional states is a common intervention in a music therapy session. The critical difference with my thesis proposal is the selection of music by the client, followed by collaborative understanding of mood states, and resulting in independent use for regulation.

To relay my findings and reflections, I present a review of the current literature on this topic. My goal is to highlight the existing understandings and interventions and expose the need

for the intervention I have proposed. This is followed by the methods I used with the client, and the results of this intervention. I discuss my reflections and findings, which stem from the journals I kept from sessions, and conclude with a deliberation of my experience throughout this exercise.

Literature Review

Music therapists treat people of all ages. Each age group is further divided into specific qualifiers that lead them to treatment. For example, the research on adolescents with histories of trauma is robust. The benefits of music therapy for this client group have become more evident and supported through the reports of this research. The articles reviewed in this paper give context of what practices have previously been reviewed. I present how those methods and discussions are relevant to the independent emotional regulation intervention I have developed, and expose the gap I propose to fill.

Kerig, Bennett, Chaplo, Modrowski, and McGee (2016) researched the concept of emotional numbing in adolescents who were exposed to trauma and involved in judicial programs. In their study, youth self-reported experiencing numbing of general, positive, sad, fearful, and angry feelings. "General emotional numbing and the numbing of the negative emotion of anger were the facets of numbing that were most strongly associated with [posttraumatic stress symptoms]" (p. 117). Due to these findings, creating an intervention to mediate this deficit would be appropriate. My intervention is designed to help clients develop the capacity to recognize and regulate their emotions.

Emotional Regulation Development

In order to create an intervention, music therapists must first understand the psychological or behavioral goals of the client. In Marik and Stegemann's (2016) article regarding the uses of music and music therapy for emotional regulation, the authors defined emotion, mood, and affect, and how they operate in the body. Emotions are dynamic and changing, and reflect a reaction to an event or experience. "Emotions are not linked to specific functions; rather, their functions always depend on the context (Tamir, 2011)" (p. 54).

Marik and Stegemann (2016) provided justification and explanation for the use of music in the context of emotional and mood regulation. The authors found “music can help with learning new strategies for emotional regulation” (p. 63). The use of music in this context should be monitored and structured with the assistance of a trained music therapist. The clients I work with struggle to identify and communicate what regulation and dysregulation feel like. This article provided the language I used when discussing these terms with them.

James Gross (1998) defines emotional regulation as “the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions” (p. 275). Gross took a multi-lensed approach by reviewing literature from biological, cognitive, developmental, social, personality, clinical, and health psychology. This created a more detailed understanding of emotional regulation.

Modern research in biological psychology has further explored the involvement of the pre-frontal cortex in the function of emotions. The role of cognitive functioning in emotional regulation reminded me to simplify my directives and set clear expectations for my clients, because feeling overwhelmed could impede their capacity to fully participate in interventions (Gross, 1998). One of my primary goals with each client is to create a consistent and healthy therapeutic relationship. I utilize this trust to set examples for them to follow regarding their emotional development by attuning to myself and the client, demonstrating affect management, and using approachable language to appropriately communicate my feelings.

Specialists in the field of social psychology study why and how culture plays a role in emotional development. “In order to feel proud, or to avoid feeling shame, individuals may introduce obstacles or withdraw effort, thereby diminishing the objective probability of success” (Gross p. 279). This reduces the feeling of negative emotion, but is completely dependent on

social stigmas and interactions. I do not seek to change this, nor do I think it is incorrect. Rather I recognize this to better understand my clients.

Health psychology illuminates how lack of emotional regulation can lead to physical symptoms, as "tight control of negative emotions may adversely affect physical health" (Gross, 1998, p. 280). Personality psychology acknowledges both the individuation of each client and places some of the responsibility for growth on the client. Ultimately, therapists guide and offer, they do not actively change the client. Clinical psychology teaches "that difficulties with emotion regulation must be re-experienced in therapy (Cicchetti et al., 1991; Greenberg & Safran, 1987) where the therapist can help the patient develop the capacity to regulate emotions in new ways (Averill & Nunley, 1992; Folkman & Lazarus, 1988)" (Gross, 1998, p. 280).

While my clients are not ready to re-experience their trauma to integrate it in their narrative, they are capable of creating and imagining dysregulating scenarios. For example, pretending to become frustrated with a staff member or peer creates an emotional reaction; and we can work through this in the safety of a clinical session to develop the ability to healthily experience and express those emotions outside of session.

Approaching the Client Population

To effectively reach my clients, I must understand their development and what brings them to treatment. Katrina McFerran (2010) reflected upon the use of music therapy with adolescents in her book *Adolescents, Music and Music Therapy*. McFerran discussed the benefits and implications of using music with adolescents. "When music therapists use songs as a part of therapy, they are accessing deeply personal aspects of the teenager" (p. 78). She recognized the power of musical choice, stating, "[their] songs will then be used to motivate the client and encourage the achievement of therapeutic goals" (p. 87).

In the fourth chapter, she presented several interventions using prerecorded music. The one occasion she utilized a song sharing intervention was in a group setting. The students were expected to bring in one song to share. They explained their association with the song, which led to a discussion with the group members. McFerran (2010) focused on using shared songs to build acceptance among group members, rather than as a tool for emotional regulation. The teens were responsible for bringing in a song to share, rather than engaging in a collaborative effort to find appropriate song choices. However, this led to many members not participating because they were unprepared. This chapter supported the concept of song sharing and the importance of the safe space created by a therapist when sharing these associations. I have taken this further in individual sessions because the client can more deeply process the memories, emotions, and somatic reactions they experience.

Laiho (2004) focused on the importance of music in the lives of adolescents, therefore making it an ideal tool for this population. The relevance of themes in music, and its ability to mirror the tumultuous moods humans experience, creates a safe and reflective space for teens to share and learn about themselves. The three major categories of the "psychological functions of music in adolescence" (p. 51) were identity, interpersonal relationships, and agency. These match aspects of adolescent social emotional development as it is generally understood (Farrell, 2014).

The clients I work with come from low socio-economic communities and are survivors of trauma. In *Healing the Inner City Child: Creative Arts Therapies With At-Risk Youth* Camilleri (2017) substantiates the need for support in the lives of adolescents from disadvantaged communities, stating "the circumstances . . . can accumulate in a child's life to create serious and debilitating physical, emotional, behavioral, social, and academic outcomes such as anxiety,

learning difficulties, and poor social skills" (p. 41). The first several chapters addressed the social constructs creating and sustaining these environments, outlined the challenges and outcomes for these growing children, and justified the validity of expressive arts therapy for this specific population. This book helped put into perspective what my clients might be carrying, and provided approaches to processing this heavy load. Camilleri further highlighted several case studies of various expressive art therapy interventions.

Chapter Eight consisted of reflections by music therapist Diane Austin (2007) while she was working with adolescent girls. One of the interventions involved listening to music brought in by the clients. Austin justified her decision of allowing violent and inappropriate music, "since they were listening to them, I believed it was better if they listened to them with me so that we could talk about the feelings that the songs evoked" (p. 99). The listening intervention led to productive processing about difficult topics for the members, in a safe space created and contained by a music therapist. This is the environment I created when I implemented the intervention of my capstone. Austin's work highlighted the clinical implications of listening to and talking about themes that are unacceptable to address in the milieu, which further validated the work I did, and justified my methods to colleagues at my internship.

Effective Methods in the Literature

Shuman, Kennedy, DeWitt, Edelblute, and Wamboldt (2016), presented research about the effect of music therapy on mood changes in adolescents with a variety of psychological challenges, including posttraumatic stress disorder. After the description of why this research was necessary and credible, there were examples of common music therapy interventions and an example of an appropriate population for the intervention. The data for this study was based on pre and post self-report mood measures. The results did reflect, "that a group music therapy

intervention … elicited change in the self-reported mood state of the participants" (p. 55). The Shuman et. al (2016) study is crucial for my capstone because the researchers found effective mood change due to music therapy interventions. They did not research whether moods shifted toward positive or negative, but the ability to have consistent results is necessary to validate my curiosity and questions.

Uhlig, Dimitriadis, Hakvoort, and Scherder (2017) used a mixed methods approach to research effectiveness of vocal music therapy with adolescents from disadvantaged communities. They specifically focused on vocal music therapy interventions utilizing rapping and singing. The researchers used surveys with open ended questions and collected that data along with numeric ratings to summarize their findings. They found, "both singing and rapping engagements seem to be appealing treatment approaches for at-risk youth and young adults to affect their emotions, to enhance self-esteem, and increase awareness of emotional engagement" (p. 53). Just as with any population, working with adolescents in music therapy requires the therapist to be aware and reflective of the client's musical interests. Rap and Hip Hop are both popular amongst this age group, specifically within the at-risk youth demographic (Uhlig, et al., 2017). Understanding the efficacy of these genres is relevant because the clients I work with may prefer, and according to this study can benefit from, this music.

Sutton and Backer (2009) discussed the implications of trauma in music therapy. They bring to the forefront the way a person who was a survivor of trauma could experience a break from reality and time. They argue this significant difference should force the music therapist to hyper-focus on sound and silence. If "the therapist can be at the same level as the affect of the patient, waiting for a moment to arise in which his or her musical play can come into resonance with the different layers of the trauma" (p. 76), a space can be created for the client to begin the

healing process. Because music has the capacity for infinite repetition, and endless variety, the lapse in traditional experiences of time and reality can be artificially induced, allowing clients who have been traumatized to interrupt previous ways of being. Music is temporal, therefore understanding the way survivors of trauma experience time and reflect on experiences is crucial to best understand and serve their needs. Sutton and Backer provided insight to this aspect of my work and research. While clients process their trauma or report about traumatic events, I keep music playing to ground them in temporal reality. "When we connect with a process of receiving internally a music from outside ourselves, the past and the present sit together in relationship . . . in motion towards a future that is experienced as it is being shaped (Sabbadini, 1996)" (p.77). Sutton and Backer utilized two case studies to illustrate their findings, which informed my own research process since I too reflected on my clinical work as is reported in this capstone.

The Use and Effectiveness of Music

Now that I have presented a better understanding of the population and the goal, I turn my focus to how music works physically and emotionally to meet the client and what they are working toward. Eliciting an emotional response through music is a common experience. When collaborating with a client to create a musical intervention, it is important to understand this phenomenon on a deeper level.

At Tufts University in Massachusetts, research was conducted to measure various emotional responses to musical stimuli in relation to the perceived meaningfulness of the music (Craig, 2008). In the first study, the participating college students were asked to contribute two selections of music. The first selection was intended to induce an emotional reaction, the second did not. The participant was then asked to review each song with a researcher to reflect on the

meaningfulness of the song selection. The second study required participants to select only songs that held some meaning to them, and then identify their emotional reactions with the assistance of a researcher. As was hypothesized, music with the intention of eliciting an emotional response created a stronger sense of meaning to the listener, and pre-selected music with personal attachment elicited one or more emotions.

Kimberly Moore (2013) presented a review of literature supporting the use of music as a tool to develop emotional regulation. After defining terminology such as emotional regulation and the requirements for the implementation of music in this capacity, Moore synthesized her findings, focusing on responses of physical parts of the brain. Moore reported, “there are certain musical characteristics and experiences that produce desired neural activation patterns implicated in emotion regulation” (p. 232). In other words, the physical parts of the brain that are activated to allow for increased control in emotional response can be stimulated by music.

One approach to selecting preferred music entails firstly identifying the mood of the client with the intention of either altering the mood of the client matching that mood. A study performed in Australia focused on mood alteration in University students (Garrido, Schubert, & Bangert, 2016). Rather than the participants contributing their own music choices, the researchers provided prescribed playlists for happy and sad moods. The participants were required to take self-report mood measures, and keep a journal, to measure their moods before and after the listening.

Garrido, Schubert, and Bangert (2016) found the listening activity was effective in temporary mood regulation but not in the long term. The results demonstrated an increased ability for self-reflection among participants since the journaling and mood measures required them to practice recognizing and identifying how the music affected them.

Participants generally reported they "prefer to listen to self-selected music" (Garrido, Schubert, & Bangert, 2016, p. 53), which indicates some participants potentially already use music as a form of mood regulation. Ultimately, the authors found the prescribed music was an effective short-term mood regulator, with the selected happy music being more influential than the sad. Garrido, et al. (2016) validated the necessity for a music therapist to assist in the process of selecting music for mood regulation. "The requisite skills to select music effectively may be compromised [in people with impaired mood regulation capacities]. Therefore, further attention, advice, and support in choosing music listening selections is needed" (p. 52).

This point directly supports a critical aspect of my proposed intervention. Because the clients I work with have impaired mood regulation capacities, selecting music to assist in this process might be impaired. Therefore, assistance and support to prepare this coping mechanism before the client is dysregulated is required to ensure their success. Other researchers studied the independent use of music by clients for regulation, but did not facilitate music selection prior to dysregulation (McFerran, 2010; Craig, 2008; Moore, 2013).

Miranda, Gaudreau, and Morizot (2010) presented research on personality traits of adolescents and their use of music as a coping skill using a bottom-up approach. "The aim of this study was to examine whether three styles of coping by music listening could significantly predict changes in adolescent neuroticism over a 6-month period" (p. 248). The researchers utilized point scales for the participants to self-report regarding frequency of coping by music listening, and the applicability of statements about neuroticism. The results did reflect music-listening to be effective in predicting changes in neuroticism of adolescents. However, as presented in the discussion of this article, there is a potential for music listening to be used as a maladaptive coping skill. This reinforced the importance of a music therapist in facilitating the

use of music as a coping mechanism. This research focused on the ability for music choice to influence personality as opposed to personality influencing music choice. This is precisely the approach I would take in my own intervention, whereby music would directly influence the ability for my clients to manage emotions and behaviors by utilizing previously selected musical selections.

The effect of music on the brain, therefore emotional state, can be researched in a physical approach. Weisgerber, Bayot, Constant, and Vermeulen (2013) explained the cognitive processing of music and emotion in this fashion. These authors presented a model by Juslin and Västfjäll (as cited in Weisgerber et al., 2013) using "six mechanisms [that] underlie the induction of emotions through music listening: (1) brain stem reflexes, (2) evaluative conditioning, (3) emotional contagion, (4) visual imagery, (5) episodic memory, and (6) musical expectancy" (p. 381). After a brief explanation of each mechanism, Weisgerber et al. presented a variety of research on music as a cue for emotional processing. This was followed by a presentation of how impairments in psychopathology may or may not affect emotional processing of music. Additionally, they discussed the benefits of music for people with impaired psychopathology. They referenced "recent research [that] showed . . . music could be used as a way to enhance emotional competencies (mainly the identification component) and ameliorate emotional affect as well" (p. 392).

Conclusion

The current literature regarding emotional and mood regulation is expansive, particularly in people who have experienced trauma. People working in the field of human services have approached teaching these skills in various ways. Music therapists have explored this goal with live and recorded music, preferred and non-preferred music, independently and with clinical

assistance. They have collected data and reported using case studies. The research supports the concept that emotional and mood regulation can indeed be developed, even in those individuals who struggle intensely. I have used these results to bolster the progress of my intervention and to inform my clinical practice while in session with clients working through trauma.

Methods

Through creating an intervention, I intended to explore the efficacy of collaborating with individual clients to create playlists that help develop emotional recognition and regulation skills. The client with whom I implemented this intervention used music as a coping skill before I began working with them. I expected them to have difficulty relating songs to emotions at the start. I hoped this would become easier over time, both identifying the emotion a song evoked and thinking of a song when prompted with an emotion.

Project Setting

I implemented this intervention at my internship site. The site was a 27-bed residential facility for biologically female adolescents, ranging in age from 12 to 22. The clients were placed in this setting because they were unable to successfully live at home and attend school. Most of the students were survivors of trauma from young ages, and/or had a mental health diagnosis. The facility was staff secured rather than utilizing locked units. They maintained a ratio of three students to one staff, and kept students safe and contained using body proximity or physical restraint when necessary.

The children attended class downstairs and lived on the upper floors. Twice a week in the afternoons, the clients were required to attend clinical groups. Every client had a clinician who managed their case. I had three individual clients I saw weekly for music therapy sessions. We would meet either in a small office, or in the Music and Art room. Two of my three clients were at different places in their treatment, therefore Karina (a pseudonym) was the sole participant in the study of this intervention.

Participant

Karina was a 15-year-old cis-gendered female from an urban neighborhood near the school. She identified with her Hispanic culture, which influenced her music selection. Karina held a DSM-5 diagnosis of posttraumatic stress disorder, not specified and major depressive disorder, recurrent episode, in partial remission, not specified. Her baseline affect was closed and defensive. She presented older than her biological age due to the way she regarded herself and addressed others. Karina had a personal history with presenting and making music from a young age, and therefore held music in high regard. She used a personal iPod to keep herself regulated for most of the day, including in classes, at lunch, and in her room.

Therapeutic Process

Before meeting with Karina, I sat down with her primary clinician. She shared important information about Karina: she had poor self-esteem and a lack of identity; she preferred instant gratification and struggled with things going differently than planned; she expected to not meet expectations and had a strong shame response; she liked to be a leader and craved structure; and, most important, she needed to know I was real. This discussion prepared me for the person in the paperwork, and only so much for the child in the room.

At the start of our work together, Karina was actively resistant to treatment. The first time I met her, she was in a sensory room in the downstairs of the school because she was dysregulated. I brought a ukulele and entered with her primary clinician. Karina declined my offer to make music with her, and she shared her strong negative opinion of the ukulele. The second time I met with her, she was in a different regulation room, but simply taking alone time. I brought a notebook and paper. I described my role as a music therapy intern and asked what kinds of things she hoped to do with me. She acknowledged her rude comments the previous

week, and explained that when she is angry she struggles with treating others respectfully. She agreed to start with a 60-minute session during the time of the day the students wait in their rooms for the afternoon shift to begin. Karina made it clear she did not want to miss anything else for these music therapy sessions. I left with a list of ideas and a head full of hope, looking forward to the following week.

For months, my work was dedicated to demonstrating my consistency and care for Karina. One week, she eagerly worked at learning “Fur Elise” (Beethoven, 1867) on the piano, but refused to look at it the following session. Many weeks I showed up to her room and she would refuse to meet. Other times she would allow me a few minutes in order to get out of her room for a bit. When I missed a session for school vacation or sickness, it was my responsibility to apologize. I tried a variety of approaches I had learned during my music therapy training: give the client a clear structure of what to expect from session, improvise, sing a client preferred song, teach them an instrument, try blackout lyric-poetry, listen to music while doing other activities.

Some weeks Karina would share a brief memory or an experience. In these moments, I would sit quietly and attend by reflecting her energy, her posture, and listening to every word. The turning point of our therapeutic relationship was a session when Karina shared her negative opinion of me and music therapy. I was honest about my care for her, and desire to make sessions as driven by her as possible. She quickly responded with telling me the only possible way I could help her. Since it was a well thought out response, it seemed she thought of it prior to our meeting. Karina only wanted help making playlists on her iPod to listen to when she is feeling different emotions. I informed Karina I liked her plan and could make this happen. I did not share that my capstone thesis was designed around this very idea. Although I had hinted at

similar concepts regarding music listening to plant the idea, I intentionally did not introduce this intervention prior because I knew Karina needed to feel she had come up with it independently.

Methodology

Karina's idea of creating separate playlists was exactly the structure she needed. Each week, we added six songs. The songs needed to have therapeutic value. This was clinical music, so she could choose songs with themes or lyrics typically deemed inappropriate, but it could not be played aloud in the milieu. If she did, she would lose her iPod. Karina chose to select her music prior to sessions since it was faster than selecting them together. To add a song to her iPod, she first had to share how the song made her mind and body feel. I prepared the document in Figure 1 with simple language for use during session. In this way, Karina was developing the ability to attune to her inner and bodily experiences while listening to a song, then building the capacity to communicate those experiences. She became reliant on the lists, asking for them when I didn't already have them out. Rather than a crutch, it became a diving board into deeper meaning.

How Songs Affect Me

Makes my mind

Focused Relaxed Reflective Excited Sad Happy Hopeful

Makes my body feel

Controlled Energized Relaxed Restless Constricted Free

Figure 1. Document created to develop ability to communicate mental and physical reactions to chosen songs

On her own, Karina began to share stories. She processed painful memories through the music. Some of the songs she related to themes in the lyrics. Other songs had specific memories attached because they were playing during impactful events. Karina explained why she was drawn to some music, and resistant to others. After this sharing piece, the final step was for Karina to identify times when she could listen to the song and how it would help her. This intervention eventually opened up the opportunity for live music making. Karina had an incredible natural talent for singing, but was protective of her voice as many survivors of trauma are (Austin, 2008). Because of the trust built through this intervention, Karina was willing to explore and share this precious aspect of herself.

Analysis

During each session, I wrote down what songs she selected, and the responses she shared, in the following format: Title, how it made Karina feel mentally or emotionally, how it made Karina feel physically. For example, "Wake Me Up" (Blacc et al., 2013), made her emotionally excited and happy, and physically free and energized. In order to analyze the information collected from this experience, I reflected upon my thoughts and reactions to Karina's sessions. I kept journal entries with details of observed behaviors and personal internal responses. Each week, I reflected upon the development of the therapeutic relationship, and Karina's growth in the program overall. I noted important details Karina shared with me about her life, and how I responded. I kept this information both as a personal reminder for reflection, and as a document in case the information she shared needed to be further reported to other professionals. In these writings, I included brief notes to remember what I was feeling. For example, one session I felt an intense desire to comfort Karina. I connected this to the information she shared at the time, and her nonverbal communication.

Although we did not get to the point of creating separate playlists to associate with each emotion, I was left with a collection of songs. The collection was a representation of Karina, each meticulously selected and massaged for its relevance and meaning. Not only did they tell her story, they helped her create a more specific and personalized tool. She knew how each song affected her, and could repeat this therapeutic process independently with music in her future. This felt like success because although Karina's fierce independence made her resistant to treatment, she gained a tool that would always be relevant, and she could use it without help.

Results

I did not implement the intervention I originally planned. I modified it because of the relationship with the client and her needs. Despite the deviation from the initial proposal, the resulting intervention and therapeutic process did meet the goals of developing the client's emotional recognition and regulation. Additionally, the intervention facilitated the growth of a therapeutic relationship and assisted the client in processing her trauma.

Proposal

In the original design of this intervention, I sought to learn the following: Would developing individualized playlists to associate with different emotions create an effective tool for emotional regulation? Would the client gain knowledge and understanding of emotional states and how their body experiences them? Would the client gain insight to utilize the playlists effectively when dysregulated?

The original plan was to complete exercises to develop emotional language. For example, creating lists of positive and negative emotions. Then, the client would have explored the physical experiences of each of those feelings. The client would bring in music from their listening repertoire. The client would reflect on the physical experiences felt while listening to each song. The song would then be categorized based on which emotion most closely matched.

After the playlists were sufficient, about 10 songs each, the client would practice regulating by responding to a prompt in session. For example, I would say, "You have been reprimanded for yelling at another student because they gave you a dirty look." The client would then practice finding the appropriate playlist to regulate. In some situations, it would be helpful to remain with an emotion, for example frustrated in this scenario, then move toward a regulated

emotion, like content. In this way, the client would be supported in session while practicing utilizing the tool created.

Revisions

Karina needed to feel autonomy for this plan, so modifications were made in real time. Therefore, we did not take the time to list emotions or explore physical experiences prior to listening. Karina had limited emotional language and struggled to recognize her inner experience at the start of treatment. She initially only chose three emotions to categorize songs: Happy, In My Feelings (reflective), and Angry. In the session immediately following her decision to make the playlists, she arrived with long lists of songs for each category.

We agreed to approach six songs each session. Initially, she identified the song during session. The time this took frustrated her, so she decided to select them ahead of time. Each song required Karina to identify an associated physical and inner experience. After four weeks, Karina easily identified words from each category, and sometimes created her own more descriptive language. When I suggested breaking the songs into playlists, Karina reasoned that since she had an iPod shuffle and no capability for playlists, separate emotion lists wouldn't be as effective. She also explained that many of the songs had multiple uses. It could be used to reflect, because of the lyrics, or to raise her energy in the morning. Instead, we had several conversations about how she chose songs for different scenarios.

Client Response

Ultimately, Karina reported the ability to use music to self-regulate more effectively. This was evidenced by her shift in baseline from emotionally volatile to generally regulated. She also self-reported an increased ability to intentionally listen to music for self-regulation. Karina became more skilled at identifying inner and physical experiences, leaving more time for

reflection on the song itself. She began to respond to each song with a personal story, or I would prompt with questions, such as, "Who do you think of when you hear this song?". This was the root of the work. The music was both a personal aspect of her identity and the avenue through which she shared these parts.

As she became more comfortable sharing the songs, she became more confident revisiting memories and experiences in session. This paralleled with her trust and comfort in the therapeutic relationship. By the end of the sixth month of working together, she advocated for sessions and willingly joined me. She would ask me to make certain decisions, such as the location of session. The stories she recalled became increasingly intense.

Karina shared her child self, both in her words and her body. When telling a story from her youth, her body would become concaved, her shoulders slumped forward and her legs crossed in front of her. Her voice was controlled but not constricted. She spoke at a low volume, expressive at times to convey the intensity of how she felt in that moment. Her eyes reflected that she was reliving that memory, not so much in the room with me. Her recollection of detail was impeccable. Karina could relay minute by minute specifics of events another child might have willingly blocked out.

Interpersonal Response

Another time, Karina told me of a physical injury she endured, which led to flashbacks. The way she told the story made my mind leave the room and suddenly I was there in the story as well. I caught this happening and grounded myself in the chair, refocusing on Karina. I had an overwhelming desire to comfort her. I wanted to pull her from the exercise ball she was poised on, smooth her hair, and tell her I was sorry this happened. Instead, I sat quietly and let her share until she had nothing left. After finishing, she seemed to be emotionally drained. She

wanted to look for a few more songs that she had written down. Karina couldn't find the list and became dysregulated rather quickly. She began to use foul language and expressed her desire for session to be over. At the time, she required another staff member to transition around the house due to behaviors in the milieu. She had to sit with me until this person arrived and I felt completely helpless. I tried to think of anything to comfort her. We discussed her anxiety and how she thinks many steps ahead and becomes frustrated when she feels like she cannot prepare for that many steps ahead. The songs she had written down were supposed to help her over the weekend when she would not be allowed to visit home and acquire more music. The songs she had written down were supposed to be the ones that made her feel okay. I reminded her that she had many other songs to utilize. She was silent until the staff member arrived. I helped her transition back to class, and thanked her for meeting.

Upon reflection, Karina had relinquished control by sharing this particular story. When she sought control of her mind to recall the songs and couldn't, this was potentially too much. Her reaction might have been a way of regaining control. Displaying frustration and asking for session to be over meant she could leave this moment, and perhaps those memories. The following week, she didn't want to meet when I went to get her, but advocated for another time. I perceived this as yet another way for Karina to feel in control and agreed to find a compromise.

The climax of our time together occurred in the seventh month. Karina had a skilled singing voice despite a lack of training. Singing was a personal activity for Karina. She did not share why, but it was conveyed that she sang to herself or for family and that's where it stayed. Four days before our annual talent show, Karina decided she wanted to sing, and asked me to sing with her.

In the days of preparation, she trusted me with her voice. I gave her feedback and a crash course in proper breathing technique. We did vocal warm ups and stretches. Karina allowed me to make musical suggestions and instruction. She performed flawlessly at the event, and thanked me on stage afterward. The months of consistency and the sharing of her story through music resulted in a healthy therapeutic relationship.

Personal Response

I wrote personal reflections after interactions with Karina to better understand the process of the intervention I designed in the context of the therapeutic relationship. The following are selections from significant intervals of treatment

December 18

Today things came to a head with Karina. [Her primary clinician] and I sat down with her for a mediation because she has been refusing treatment. Karina now knows that if she does not meet with me, she will not earn privileges. She was very frustrated to hear this and shared her opinion on the matter, including her unkind opinion of me. This did not bother me because I knew this was a reflection of her frustration with her treatment overall. I sought her out afterward to check in and make a plan. She was more regulated than earlier, but I still tread lightly, trying to be as real as possible. I told her I am part of her treatment, but also someone who wants to spend time with her and help when I can. She was able to have a regulated conversation about her frustrations with sessions. Karina told me she didn't like the ideas I had brought in so far, and proceeded to tell me there was only one thing I could help her with – making playlists. Looks like I have my in.

February 8

I had a short session with Karina today. She was initially eager for session but then realized she forgot the paper with her songs on it, and couldn't find it. This set her off completely and while she was able to sit and listen to Rise Up by Andra Day, she was visibly agitated and wanted to leave this uncomfortable feeling. I made her sit with it, and she did not appreciate it in that moment. I wonder if I'll be able to reflect this to her the next time I see her. Today didn't seem appropriate because she was dysregulated and not in good space to take feedback. Karina allowed me to check in on her after she was back in her room. She was polite but did not engage.

March 23

Today I felt countertransference with Karina, but in a productive and healthy way. As she told me her story, I felt like I was with her. I saw the faces and could feel the pavement under my feet as I ran. I felt the dread, fear, and guilt. She took me on this journey with her, trusting me to keep us safe. It took great mental strength to keep us rooted in our seats. This followed with a discussion of guilt and responsibility. I had to keep my own struggles with these feelings in check while listening and prompting. She didn't want to hear about my experience, she needed me to listen to hers.

Writing these reflections allowed me to recognize the reality of how unstable her attachments were. This exercise gave me the perspective to recognize how her behaviors toward me were part of a larger theme, and motivated me to continue showing consistency and care.

Discussion

Purpose and Approach

The purpose of this study was to explore the benefits of creating specialized playlists to improve emotional regulation and recognition. This was implemented through a music sharing intervention during individual music therapy sessions. I found this process supported the development of a healthy therapeutic relationship because the client was sharing a piece of her identity. Utilizing the provided lists and taking the time to notice the effect of the songs developed the emotional language of the client. I also found the client increased her ability to utilize music as a coping skill as evidenced by self-report. The intervention reached the therapeutic goals despite a different implementation than originally planned.

Limitations and Future Research

One limitation of this study is the setting required. I found this would work best in individual sessions, which is not always feasible for funding or site parameters. Another limitation is the requirement of technology access. I utilized internet access for the duration of every session, and my client added her music to an MP3 player, which may not always be the case for clinicians and clients. Future research should include recreating this intervention and following through to the individual playlists for specific emotional regulation use. The client in this report did not come to this on her own, and it was not appropriate to force her. However, this intervention could have a different benefit if followed as originally intended.

Conclusion

Utilizing personal collections of music paired with analysis and a healthy therapeutic relationship in individual music therapy sessions increased the client’s emotional recognition and regulation. The unique aspects of this study were the collaborative style in individual sessions, and the individual use of the music by the client whenever she wanted access. There is room for

research with more clients. This could include direct emotional work utilizing separate playlists designed for specific emotions, and practicing recognizing when and which to listen to for emotional regulation. I would reconsider these practices for a group, but I do not anticipate the same impact and effectiveness due to the individuation of clients. Whether this method is followed exactly or other interventions are followed, emotional growth is possible under intentional therapeutic circumstances.

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