Principal Instruments in Music Therapy Practice: An Art-Based Research Community Engagement Project

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Principal Instruments in Music Therapy Practice:

An Art-Based Research Community Engagement Project

Capstone Thesis

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Abstract

This community engagement project seeks to question established beliefs concerning the instruments used by music therapists in sessions through an exploration of their impact on therapist ability to interpersonally attune. In the field of music therapy, the competency instruments of piano, voice, guitar, and percussion are widely revered as the most beneficial for clients during active music making interventions. However, many music therapists come to the field with years of professional training on other instruments called principal instruments. Studies show that there is a disconnection between the benefit to clients of using a principal instrument and the frequency with which they are utilized in sessions. Through two stages of art-based research, a focus group of four advanced level music therapists and students, as well as this researcher, explore the quality of interpersonal attunement while improvising on each kind of instrument. For these participants, findings reveal that therapist training and relationship to the instrument in use have an impact on interpersonal attunement within the therapeutic relationship. These results can be taken into consideration for future development of music therapy curriculum, the music therapy competencies, and therapists who desire to use their principal instrument with clients.

Keywords: competency instruments, principal instruments, interpersonal attunement, music therapy, training competencies, art-based research, qualitative research
Principal Instruments in Music Therapy Practice:
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Introduction

Her mallet, weakly supported by frail fingers, strikes the wooden bars of the large xylophone placed between us. The dull sound of the first two notes of the C major scale fill the space. It is unclear if she knows who is in the room or what she is playing. Her constricted affect and quality of sound tell me her lack of awareness and ineffective ability to communicate is causing deep distress. I match her notes on my flute, as if to say, “I am here, I understand.” We continue in this call and response pattern until, as if a light turns on, she begins to play more consistently and with purpose. I quickly follow her lead as a faint smile spreads across her wrinkled lips. As the music lifts us out of the deep gloom previously surrounding her, my harmonies and timbre match her joy at connecting with another person for the first time in who knows how long. She makes eye contact with me as the music comes to a close and I can see her relief.

The true story above about a woman with advanced stage dementia is an example of the magic that happens when music therapists combine their highly trained skills on a principal instrument with their music therapy training. Flute is my principal instrument and I have studied it for over 20 years. This training has taught me how to take emotions and communicate them through timbre, melody, rhythm, and dynamics. This relational ability is central for many musicians. It also plays a key role in the success of music therapists, credentialed individuals who are trained to use clinical music interventions to help clients achieve therapeutic goals. However, many choose not to use principal instruments within treatment sessions. A survey of 249 music therapists conducted by Voyajolu in 2009 found that 62.9% of woodwinds, 57.1% of strings and
76.9% of brass instrumentalists did not use their principal instrument in music therapy sessions within the last year. While this reference is 10 years old, it is likely this is still true.

There are many possible reasons for this disconnection, including the emphasis placed on piano, guitar, and vocal skills within the American Music Therapy Association professional (AMTA, 2013) and advanced training competencies (AMTA, 2015). This lack of attention could be due to the historical divisions within music therapy programs over whether to place more emphasis on the skills of a therapist or those of a musician (Garham, 1974; Lee, 2015). Another possible reason is the lack of research available on the topic. There are relatively few studies that highlight the benefits of using an instrument other than voice, piano, and percussion as the primary communication tools within a session (e.g. Ang, 2016; Berends, 2014; Suzuki, 2018). However, this number has been rising in the last few years with most of the research coming from PhD and master level students, many of whom choose to focus their research on a specific instrument and clinical population (Ang, 2016; Berends, 2014; Suzuki, 2018; Yates, 2015).

The most comprehensive body of work to date about the use of principal instruments in practice is a book of clinical stories and interventions compiled by Amelia Oldfield, Jo Tomlinson, and Dawn Loombe (2015). Each chapter covers a different orchestral instrument and how the author uses it to assist clients in achieving a variety of behavioral, emotional, and physical goals. Reading through these stories, it is apparent that principal instruments play a key role in the development of stronger therapeutic relationships between therapists and clients. However, there are only a couple studies that explore this topic. Most notable is an analysis of three interviews with flutist music therapists conducted by Hadar and Amir (2018). Their findings reveal a deep connection between music therapist and instrument. Participants even noted that this relationship enhanced their proficiency, playfulness, and musical freedom within treatment sessions (Hadar &
Amir, 2018). However, because it is a qualitative study, these findings cannot be generalized. The findings only apply to those who resonate with them, flutist or non-flutist.

The therapist’s ability to empathize with their clients and include personal attributes within the treatment session is central for developing the trust and rapport necessary for a strong working alliance (Kottler, 2005). This is widely researched within humanistic psychology and there is a large body of information that supports this opinion (e.g. Farber & Lane, 2001; Gordon & Toukmanian, 2002; Thorne, 2003). In her dissertation on the subject, Nemeth (2014) talks about the “you” factor, which is compiled of therapist personality, intuition, disposition, and insight. She argued that these components are the central qualities that allow music therapists to establish and maintain productive interpersonal connections with their clients. In music therapy, this ability to connect nonverbally is called attunement.

This project is a pilot study that informs future research exploring the topic of principal instruments in clinical practice. It explores if therapist relationship to principal instrument can impact the quality of attunement between therapist and client within the therapeutic relationship. My hope is that these findings contribute to the body of research that already exists in this area and encourages music therapists to attempt using their principal instrument more often within their work. Here, principal instruments are defined as any instrument the therapist has received formal long-term training on how to play. The therapist also considers this instrument to be part of their self-identity (i.e. flutist, trumpet player, violinist, etc.). Competency instruments are defined by the American Music Therapy Association (AMTA) as any one of the four instruments (piano, guitar, voice, percussion) music therapists are required to demonstrate proficient technique on in order to be certified (AMTA, 2013).
My study is a community engagement project meant to engage masters level music therapy students and professionals. I use a qualitative approach called art-based research (ABR), which is a research methodology allowing participants to use the arts as a way to research. I seek to recreate the experience of being in session with clients in order to help my participants reflect on the quality of their attunement depending on the instrument they are using. This is explored through two stages of intermodal exploration.

In Stage one, I use the arts to reflect on the quality of my personal relationships to principal instrument and a competency instrument. This initial reflection helps structure the experiential for my focus group in Stage two. Both research stages use the same progression: improvisation on a musical instrument, reflecting on the recorded music through visual art, using sticky notes to assign words to the art, and finally journaling to reflect on the entire experience. This process is completed in two phases, one for principal instrument and another for a competency instrument of the individual’s choice.

**Literature Review**

The purpose of this literature review is to explore the research and writings already available on music therapy training requirements, the relationship between musician and principal instrument, and the therapeutic value of attunement. Art-based research (ABR) is also discussed in order to make a case for this method of research. My intention is to synthesize the literature on these topics in order to provide the reader with a foundation of knowledge for understanding the results and their implications.

I have chosen to conduct my research as a community engagement project (Option 3) as it does not meet the criteria for developing a method to use with a clinical population (Option 1). Option 2, writing a literature review, would have been challenging since very little information
exists on the value of incorporating principal instruments (especially alternative instruments to the competencies) into clinical practice.

**Music Therapy**

The American Music Therapy Association (AMTA) describes music therapy as, “the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (AMTA, 2019). Music therapy is an established health profession where physical, emotional, cognitive, and social goals are achieved through the use of music within the therapeutic relationship. Music therapists use music to strengthen their client’s abilities in all areas of life (AMTA, 2019).

In 2005, in order to ensure quality of education and clinical training, the Education and Training Advisory board of the national organization developed the Advisory on Levels of Practice in Music Therapy. This document distinguished two levels of practice within the profession: Professional Level of Practice (AMTA, 2013) and Advanced Level of Practice (AMTA, 2015).

At the professional level, a music therapist has achieved a bachelor’s degree or its equivalency in music therapy, the professional credential (MT-BC), and has developed the skills to provide supportive treatment interventions to clients (AMTA, 2013). At the advanced level, a music therapist has not only fulfilled the requirements for the professional level, but also has extensive professional experience (e.g. clinical supervision, professional work experience), further education (e.g. graduate degree, advanced training), and demonstrates a “comprehensive understanding of foundations and principles of music, music therapy, treatment, and management in clinical, educational, research, and/or administrative settings” (AMTA, 2015).
Professional and Advanced Training Competencies. The Professional Competencies currently list Music Foundations, Clinical Foundations, and Music Therapy as the main headings. Areas of musicianship that the professional music therapist must achieve under the ‘Music Foundations’ header are: Music Theory and History, Composition and Arranging Skills, Major Performance Medium Skills, Functional Music Skills, Conducting Skills, and Movement Skills (AMTA, 2013). Under ‘Major Performance Medium Skills’ the individual must demonstrate “musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice.” It is also designated that the individual “demonstrate a basic foundation on voice, piano, guitar, and percussion” under ‘Functional Music Skills’ (AMTA, 2013).

The Advanced Competencies expand upon these requirements by listing Professional Practice and Professional Development as the main headings. The ‘Professional Development’ section is separated into Musical and Artistic Development as well as Personal Development and Professional Role. Under ‘Musical and Artistic Development’ the advanced music therapist is expected to demonstrate advanced musical skills on two of the four options provided: keyboard, voice, guitar, or percussion (AMTA, 2015). Neither level of competence highlights principal instruments as a main area of mastery. Therefore, although it could be assumed that this is a requirement, it is not explicitly stated within the competencies.

History of Competency Instruments

As listed above, the four essential instruments outlined within the music therapy training competencies are piano, guitar, voice, and percussion. This focus has evolved over centuries of music being utilized for medical treatments. It is worth considering how these instruments became so popular in the first place. The original competencies developed by Bruscia, Boxill, and Hesser (1981) placed more emphasis on principal instrument skill development than the current
competencies require. For the majority of the competency instruments above, it took individuals who played these as their principal instrument to advocate for their therapeutic value before it became popular as a medical tool.

**Voice.** Voice has been extensively researched and findings are linked to qualitative and quantitative research in neurology and human development. Diane Austin (2008), founder of the music therapy approach Vocal Psychotherapy wrote, “singing meaningful songs often produces a catharsis, an emotional release, due to the effect of the music, the lyrics and the memories and associations connected with the song” (p. 20). Researchers have also found that singing with clients can improve mood by stimulating the release of endorphins, relieving stress, lowering heart rate, lowering blood pressure, and boosting the immune system (Gaynor, 1999; Krutz et al., 2004 as cited in Austin, 2008). This impact can be linked to the role a mother’s heart beat and voice play in the development of the human brain and central nervous system (Minson, 1992; Storr, 1992 as cited in Austin, 2008). Singing for wellness can also be traced back throughout human history (Graham, 1974).

**Piano.** Piano first appeared in conjunction with medical treatments during the mid 1800s (Graham, 1974). At the time, many believed music had a “tranquilizing effect” on the mentally ill. This theory was first tested in 1878 when a thirty-minute piano-music concert was performed for 1400 psychotic patients in a New York City asylum. Although inconclusive, these results eventually led to the organization of music therapists in the greater New York area (Graham, 1974). Since then, piano has become a central instrument in several music therapy approaches (e.g. Analytic Music Therapy, Nordoff & Robbins). The piano’s unique ability to express all musical elements including melody, harmony, and rhythm are most likely the reasons behind its popularity today (Gilboa et al., 2011).
**Percussion.** Percussion instruments have been utilized for wellness across cultures and throughout human history. Native Americans and other indigenous peoples have long used these instruments to support healing rituals (Decker-Fitts & Rybak, 2009). Modern medicine first mentions the use of percussion in the 17th century as a cure for “melancholy” brought on by spider bites. The German scholar Athanasius Kircher (1601-1680) wrote, “Melancholic people or those who have been bitten by a tarantula, filled with an especially great amount of poison, are cured by loud and sounding drums and tympani or other similar instruments rather than by more subtle ones” (Graham, 1974). Although this theory no longer holds relevance today, it shows how one widely accepted belief can lead to the beginning of an instrument being used for treatment purposes. Modern music therapy research shows that percussion instruments promote wellness through their accessibility, sensory stimulation abilities, physicality, and ease of rhythmic expression (Matney, 2014; Matney, 2007).

**Guitar.** Guitar, although not originally a focus of music therapy training (Bruscia, Boxill, & Hesser, 1981), has become popular as a more transportable option than piano for providing harmonic support. The instrument’s versatility and rhythmic qualities are also very appealing for clients and music therapists alike (Krout, 2003; Oden, 2015). The increase of guitar training within music therapy education programs is notable. In 2003 Krout wrote, “unfortunately, university music therapy training programs do not usually allow for in-depth student guitar study due to course and programme credit limitations” (p. 2). However, since then, at least three publications have been released intended to help music therapy students achieve guitar proficiency (Krout, 2009; Meyer, De Villers, & Ebnet, 2010; Oden, 2015). This is one example of how advocacy for an instrument’s clinical benefits can increase its accessibility and popularity amongst professionals.
Prominent Music Therapists and Principal Instruments

A few prominent music therapists have written of their experiences as musicians and music therapists. These individuals recognize the role of principal instrument in their success as a music therapist.

**Helen Bonny.** Helen Bonny, founder of the music therapy method Guided Imagery and Music (GIM), grew up in a musical household and studied violin as her first study instrument (Vaux, 2010). Although she did not use violin in her clinical work, she was a life-long musician and often played with colleagues and GIM trainees. Bonny attributes her ability to ‘get inside the music’ and communicate emotions to her training as a violinist (Vaux, 2010):

> The player must add his depth of person- his unique combination of feeling and experience to the playing of the music. If the performer is able to ‘get inside the music,’ to reach the heart of the composer’s intent while adding the depth of his own spirit and sensitivity, the music will ‘speak’ to the listener in a way that words cannot. (Bonny, 2002, p. 4 as cited in Vaux, 2010)

Helen Bonny believed that the quality of a music therapist’s relationship with music was integral to their ability to practice music therapy. Throughout her career she advocated for music therapists to continue developing their personal relationship with music and often included moments of spontaneous music making within her GIM trainings (Vaux, 2010).

**Mary Priestley.** Mary Priestley, another prominent music therapist and founder of Analytic Music Therapy (AMT), also grew up playing violin. However, she hardly used her instrument in sessions blaming her lack of an accompanist and the instrument’s vulnerability to damage as her primary reasons (Priestley, 1985). Despite these remarks, Priestly (1985) acknowledged that the music therapist’s ability to communicate effectively outweighed the disadvantages of using certain
instruments. She wrote, “each instrument has its advantages and disadvantages and the instrument to which a player is drawn is usually the one on which he expresses himself best” (p. 37).

**Amelia Oldfield.** Amelia Oldfield, unlike Priestley, used her clarinet quite often in music therapy sessions and developed an entire improvisational method around these skills (Oldfield, 2006). She recognized the freedom of mobility, versatility, and ability to create simple melodic lines as strengths of single line instruments. She also noted that although other medical professionals might have some skills on guitar or keyboard, it is unlikely they will have the same abilities to use orchestral instruments with clients. Above all else, she wrote:

> Perhaps the most important reason for using the clarinet in my sessions is that it is my principal instrument [italics in original source], which I love and feel a great affinity for. I am more likely to be able to communicate effectively with this instrument than any other.

(Oldfield, 2006, p. 35)

**Object Relations and Principal Instrument**

As the authors note above, the relationship between music therapist and principal instrument is very special. This instrument, which is typically chosen at a very young age, accompanies the music therapist throughout their life. Music therapists are often highly trained musicians with many years of daily practice on their instrument before deciding to enter this field. As a result, music theory and technique become an integral part of the individual’s persona (Lehtonen & Juvonen, 2012; Macdonald, Hargreaves, & Miell, 2017; Robinson, 1999).

Robinson (1999) compared this relationship to the one between infant and mother. Just like an infant, the beginner musician will initially use touch, sight, and sound to connect with their instrument. It is through this initial physical relationship that the musician learns how to communicate, just as the infant uses the mother to practice relational skills.
This concept of musician as infant is rooted in the object relations theories of D. W. Winnicott. Through his observations of early childhood development, Winnicott (1951 as cited in Winnicott, 1971) theorized that a pattern of ‘transitional phenomena’ begins to occur between four to six months old. This is where a baby begins to recognize ‘not me’ objects and uses them to maintain emotional equilibrium during times of transition (i.e. bed time, travel, etc.). Eventually this ‘transitional object’ becomes internalized and the physical object is forgotten.

Winnicott (1971) wrote that this process acts as a visual manifestation of the baby’s progression towards understanding the difference between internal and external worlds as well as the concept of symbolism. This is very similar to the process a musician goes through in learning how to communicate their internal world to an external audience. Perhaps, this mastery of communication on a particular instrument, can strengthen the music therapist ability to attune with clients within the clinical music.

**Interpersonal Attunement and the Therapeutic Relationship**

Interpersonal attunement is the process of tuning in to another human being in order to create a shared nonverbal connection of mind, body, and emotions. This concept stems from “affect attunement” described by developmental attachment theorists as the relational attachment between mother and infant (Kossak, 2015). In this connection, a type of rhythmic back and forth occurs through sounds, facial expressions, and affect. Developmental attachment theorists believe this loving connection helps the child begin to learn about relational space and themselves as an individual (Kossak, 2015). Although similar to object relations theory, this concept focuses on the quality of relationship between two objects instead of the objects themselves.

Kottler (2005) defined the therapeutic relationship as the connection between therapist and client. By establishing a strong therapeutic relationship, music therapists can achieve this same
level of attunement in order to help clients learn more about themselves. It is a unique bond due to the professional, yet intimate nature of the exchange. In order for the relationship to grow, a certain level of mutual trust, respect, openness, acceptance, and honesty must be achieved. Kottler (2005) wrote that this occurs when both individuals are able to reveal parts of themselves within the relationship. Many music therapists feel that using their principal instrument in clinical work allows them to access a greater range of musical possibilities that enhance their personal contributions within the therapeutic relationship (Hadar & Amir, 2018; Loombe, Oldfield, & Tomlinson, 2015; Oldfield, 2006; Voyajolu, 2009; Yates, 2015).

Yet, the music therapist’s comfort level with attempting something like this may depend on their training and professional identity. Macdonald, Hargreaves, and Miell (2017) theorized that every professional identity is made up of smaller parts called ‘self-concepts.’ Most music therapists come to the practice with a self-concept specific to their training as a musician, such as concert pianist, folk singer, or flutist (Macdonald, Hargreaves, & Miell, 2017). Through their training to become a music therapist, they also gain an additional self-concept of therapist. The music therapist’s ability to access the benefits of using their principal instrument clinically may depend on their ability to combine these two concepts of musician and therapist into one complete professional self-identity (Hadar & Amir, 2018).

Why Art-Based Research?

Mcniff (2008) defined art-based research (ABR) as:

The systematic use of the artistic process, the actual making of artistic expressions in all of the different forms of the arts, as a primary way of understanding and examining experience by both researchers and the people that they involve in their studies. (p. 29)
This qualitative method is a holistic approach that integrates theoretical advances, social justice-oriented research initiatives, and interdisciplinary ideas from the arts and sciences (Leavy, 2015). Despite some controversy, ABR practices have gained recognition for their ability to truly represent the embodied perspective of research participants (Beer, 2016). They also increase accessibility of the data by making it easier to understand for those who are not familiar with how to interpret this information. Leavy (2015) wrote, “the arts have the capability to evoke emotions, promote reflection, and transform the way that people think” (p. 255). This is the goal of arts-based research, to discover previously unknown information in order to bring new awareness to a topic (Estrella & Forinash, 2007).

Visual art, music, poetry, dance/movement, performance studies, and narrative analysis are all methods for uncovering data within ABR practices. Each of these is a powerful communication tool that assists researchers and participants to view data from new perspectives (Leavy, 2015). While music penetrates the body in profound and immediate ways, visual art defamiliarizes ideas and offers multiple avenues for interpretation (Leavy, 2015). Narrative analysis, the most central avenue for uncovering data in qualitative research, allows the researcher and participants to cognitively process this new information so it can be analyzed and discussed.

Unlike other methods, art-based research begins from a place of questioning the accepted norms. This is necessary in order to separate the newly discovered information from cultural, social, and political contexts (Estrella & Forinash, 2007). For this to work, the researcher must suspend any pre-conceived expectations and let the art lead.

In this study, I questioned the established belief among music therapists that guitar, piano, voice, and percussion are the best instruments to use for music therapy treatment. I used ABR practices because I was particularly interested in the information art can access and pull to the
forefront. Through an ABR process that incorporated musical improvisation, visual art, and narrative analysis, participants were not only able to identify the immediate embodied experience of attuning using each kind of instrument, but also the role their training and relationship to the instrument played in these results.

Method

This study set out to explore if therapist relationship to principal instrument can impact the quality of their interpersonal attunement with the client. This was done as a community engagement project using ABR practices. The research also explored what might impact the music therapist’s desire to incorporate their principal instrument into clinical practice.

Focus Group Recruitment and Sample

Participants were recruited by networking within the Lesley University music therapy community. Three email invitations were initially distributed to specific members deemed able and interested in engaging with the above research questions. Criteria included the individual’s level of insight into their identity as a music therapist (determined by their status as a master level professional or student) and if they had previously verbalized an interest in using their principal instrument in practice. All three of these invitees agreed to participate in the focus group.

Additional invitations were distributed using the snowball method, which is when initial invitees recommend other individuals to be contacted. Out of the two recommended, only one individual agreed to participate in the focus group. Another method of recruitment used was word of mouth. However, none of the three people contacted via this method agreed to participate due to schedule conflicts. The intention behind using these recruitment methods was to gather a group of individuals with advanced music therapy training from diverse backgrounds and a variety of musical experiences.
This focus group ended up being compiled of three white women and one woman of color between the ages of 24-48 with 10-36 years of training as musicians and 2-22 years of advanced music therapy training and practice. Two participants were master level music therapy professionals, while the other two were master level music therapy students at Lesley University. Principal instruments included violin, drum set, flute, and voice. All had trained in music performance prior to making the decision to enter the field of music therapy.

Procedure

Data was collected over two stages of ABR. Information, observations, and personal reflections were recorded via journaling throughout the experience. The first stage focused on my personal reflexive process. Through exploring my relationships with flute (principal instrument) and guitar (competency instrument of choice), I was able to discover key questions to ask the focus group during Stage two. Stage one also informed the structure, leadership style, and information I chose to share with the focus group during Stage two. This ABR process was informed by research conducted by Gerge, Warja, and Pederson (2017) and Gombert (2017). Each stage included two phases of back to back methods for artistic reflection (Table 1).

The first phase sought to explore music therapist relationship to their principal instrument. While attempting to interpersonally attune using this instrument, focus group members were asked to explore two questions: ‘does this instrument add or detract from my musical freedom?’ and ‘where is my focus?’ This music was recorded and then played back to participants while they created visual art around a new question: ‘how does this music feel?’ Participants then assigned words and phrases to each piece of artwork using sticky notes. The entire phase concluded with time to journal, solidifying this new information into a cognitive space where it could be analyzed
and discussed. After a brief transition, where participants were asked to keep conversation to a minimum, phase two began.

This phase explored therapist relationship to the competency instrument of their choice. Participants were directed to choose from guitar, piano, percussion, or voice for the musical improvisation. They followed the same intermodal transfers as phase one and explored the same questions. The community engagement experience concluded with a group discussion for participants to process the experience and for the researcher to gather more data. The entire experience lasted less than two hours.

<table>
<thead>
<tr>
<th>Phase one-Principal Instrument</th>
<th>Musical improvisation</th>
<th>Visual reflection</th>
<th>Word assignment using sticky notes</th>
<th>Journaling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase two-Competency Instrument (voice, guitar, percussion, piano)</td>
<td>Musical improvisation</td>
<td>Visual reflection</td>
<td>Word assignment using sticky notes</td>
<td>Journaling</td>
</tr>
</tbody>
</table>

Table 1. Phase progression for Research Stages one and two

**Data Analysis**

The following forms of data were included in the analysis: 1) themes that emerged from focus group discussion, 2) researcher reflections of artwork created during each phase, 3) words and phrases anonymously assigned to the artwork by the focus group, and 4) researcher observations and reflections from each stage. This data was then analyzed and organized to inform the findings.

**Results**

In reviewing the data collected from each stage of research, I discovered a distinct disconnection between these music therapist’s self-concepts as musicians and as therapists. This was directly related to their relationship to each kind of instrument as well as the musical form of
improvisation. These findings are broken down into Therapist Relationship to Instrument and Therapist Training.

**Therapist Relationship to Instrument**

One of the most fascinating discoveries from this research was the impact therapist relationship to an instrument had on their ability to focus on attuning. This was initially uncovered during my own reflexive process in Stage one. While improvising in Phase one, I experienced greater musical freedom. I could easily attune to myself and express a range of emotions and sounds. I could also draw upon a variety of scales such as the major, minor, and pentatonic to diversify the musical experience. All were possible because technique from my years training as a flutist had become intuitive.

My visual art reflection (Figure 1) was filled with flowing lines, spirals, bright soothing colors, and a variety of shapes with smooth edges. This image made me feel calm and playful. A few of the words I chose to describe this phase of research included communication, peace, and playfulness.

![Figure 1. Principal Instrument Stage One Reflection](image)
While improvising in Phase two, I noticed that my focus was consumed by thoughts of technique and how to best convey my inner world non-verbally. My musical freedom and ability to diversify the experience, both important elements of interpersonal attunement within music, had been lowered. This was reflected in my visual art, which showed reduced color choices, sharp edges, and straight, ridged lines (Figure 2). Overall, I felt irritable, bored, and disconnected when looking at this art and listening to the musical reflection. Word choices for this phase included frustration, rigid, and boxed in.

**Figure 2. Competency Instrument Stage One Reflection**

My Stage one findings were confirmed in Stage two. During the focus group discussion, a common opinion of Phase one was that principal instruments increased participant ability to intuitively listen and respond. The familiarity of the instrument was believed to helped with this. However, one comment implied that an individual’s training background and familiarity playing with the other instruments may impact their comfort level.

Artwork from Phase one corroborated this feedback. Many of the drawings included spirals, wavy lines, and color choices of greens, blues, purples, and pinks. One participant drew
something that looked like DNA, while another appeared to have drawn an image that represented plants growing out of the earth. As a whole, the group chose to assign the following words to this experience: Safe swirling chaos, entwined, seeking, natural, listening, and concentric containment.

My own artwork featured the same large spiral in the center as my art from Stage one, Phase one (Figure 1). However, this time there were four smaller spirals surrounding it (Figure 3). Each spiral represented the quality of my attunement to each of the four group members. The large spiral at the center represents the high level of attunement I felt to myself during this improvisation.

![Figure 3. Principal Instrument Stage Two Reflection](image)

In the focus group discussion concerning Phase two, individuals expressed deep discomfort attuning to each other using the competency instrument of their choice. Everyone verbalized a desire to fix the music. One participant even reported wanting to flip over her guitar to use it as a drum in order to conduct the improvisation.

Feelings of insecurity, frustration, and fear were all expressed in relation to this phase of research. One participant expressed feeling incompetent and noted that she was not able to listen in the same way as she could in Phase one. Everyone reported not wanting to influence the music
and a high level of resistance to taking on a leadership role. Above all else, participants identified that it was the lack of structure during this improvisation that was impairing their ability to attune. I found this notable, not only because all participants agreed, but also because no one had identified this lack of structure as an issue in Phase One.

Again, visual art corroborated the feedback provided during the focus group discussion. Ominous images of urban landscapes with black clouds floating overhead, black doors hanging in mid-air with no structure to support them, and a shape similar to a flying saucer were all observations I had of the art. There was very little spirals or flowing lines within these images. My own artwork included the same themes as Stage one, Phase two (Figure 2): reduced color choices, sharper edges, and straight, rigid lines. Although I attempted to draw a spiral, the center was left empty (Figure 4). This indicated the emptiness I felt during this improvisation. The focus group chose the following descriptive words and phrases to describe the experience: together and apart, more, on a pathway moving forward, ambiance, disconnected, Ahh!, seeking, and circling.

Figure 4. Competency instrument Stage Two Reflection
Following Phase two, it was clear that participants were struggling to move forward from their intense disconnection and feelings of incompetence. Therefore, the group agreed to do a third unplanned improvisation. Unlike the last two phases, participants were given complete freedom in how to conduct the improvisation and their instrument choice. This resulted in certain group members claiming leadership roles and others supportive. All, except for myself, chose not to play their principal instrument; an interesting result considering the intense discomfort verbalized by everyone during Phase two. However, in this third improvisation, participants communicated clear expectations to each other before and during the improvisation.

One group member claimed a leadership role on guitar, setting the tempo and directing the chord changes. Other group members fell into a variety of roles depended on their instrument and personal needs. Those who chose guitar followed the leader in establishing a clear rhythm and harmonic structure. Piano played the role of emphasizing these harmonies. Everyone chose to use their voice and contribute to the melody, which was a noticeable change from Phase two where no one sang. Flute harmonized this melody and wove in-between the different parts.

The resulting music was joyful, grounded, and connected. It was infused with structure, which appeared to reduce insecurity and provide a sense of freedom for participants to intuitively express themselves. Therefore, it appears that structure within the music can have the same effect on therapist ability to attune as using a principal instrument. Either can increase intuitive listening and responding, which is the key to quality interpersonal attunement.

**Therapist Training**

Another important discovery from this research was the impact a music therapist’s training history can have on their comfort level using a principal instrument to attune in sessions. The participants of this study all came from music performance backgrounds. From personal
experience, I know this training can be rigorous, extremely competitive, and centered on technique and music theory. It focuses on teaching musicians how to translate already composed pieces of music into moving non-verbal expressions that are controlled by an outside source. In some ways, this type of training separates the individual from their personal intuition.

Auditions, performances, and competing for chair positions mean the musician is constantly being judged by their peers and those who have paid to see them perform. These pressures often cause an internalization of anxiety, stress, and guilt in association with the individual’s self-concept as a musician. It is possible that these internalizations also become associated with the musician’s principal instrument.

These theories were confirmed through focus group feedback. During the discussion, individuals vocalized fears of being judged by clients when using their principal instrument in sessions. Everyone agreed that the pressure to sound perfect was greater when using a principal instrument than when using a competency instrument. Principal instruments were even associated with the feeling of anxiety.

These self-imposed pressures were not only associated with the instrument, but also the musical style of improvisation when performed on it. Some felt there was more room to be wrong when improvising on their principal instrument, even though the beauty of improvisation is there is no wrong way. Most agreed that composed music is less anxiety producing because there is a clear right and wrong way to play the music. However, this unforgiving mindset changed when discussing competency instruments and improvisation in the context of music therapy.

Many supported the belief that it was important to make mistakes with clients. The overall opinion from focus group members was that they observe increased outcomes and improved rapport with clients when reducing their own musicianship. However, it was notable that this
acceptance and forgiveness of self could not be applied to their self-image as a musician. I wonder if this would change overtime as the music therapist practiced using their principal instrument in sessions? This has certainly been true in my own experiences with using a principal instrument in practice.

Perhaps this complete separation between the two self-concepts is a result of the difference between focus and goals for each training program. While music performance teaches the individual that perfection is the goal, music therapy shows them how to use music as a conduit to connect with self and other. The music does not have to be perfect because it is relational. Focus group members reflected that success in music therapy is about connecting the client’s music with your own. It was noted that over time the professional music therapist learns to embody their instruments and choose which to use based on the needs of the client. However, if the principal instrument is never used in practice, how can the music therapist learn to embody it for therapeutic purposes? Other comments added that success is determined by if the therapist can become the music and show their clients how to do the same. So, in many ways, music therapy training unteaches the limited perspective of music performance.

However, findings from the research show that participants in this study are facing challenges holding these polar opposite views of music. They appear to have disconnected from their musician self-concept in order to practice this new orientation. I believe this disconnection is what prevents music therapy students and professionals from using their principal instrument more frequently in sessions. Their contradictory views of music performance and music therapy create an anxiety response that turns the client into the critic.
Discussion

This community engagement project set out to discover (a) how music therapy competencies have developed over time, (b) why therapists do not use their principal instrument more often in sessions, and (c) if therapist relationship to instrument impacts the quality of their interpersonal attunement within the therapeutic relationship. The individuals recruited for my focus group were between the ages of 24-48 years old, with a range of experiences as musicians and advanced trained music therapists. All specialized in music therapy at Lesley University and came from music performance origins.

Findings include:

- Increased ability to attune when using a principal instrument;
- Decreased ability to attune using a competency instrument that is not a principal instrument;
- Increased ability to attune using a competency instrument when infusing the music with structure;
- Music therapists are dissociating from their self-concept as a musician in order to hold the new self-concept of music therapist.

All participants agreed that, just like any other intervention, principal instruments are not appropriate for all populations and clients. Their use should be goal oriented and determined based on the size of the group and tolerance level of the clients.

These outcomes relate to the existing literature as they confirm the opinions of Bonny (2002), Priestly (1985), and Oldfield (2006) that principal instruments allow the music therapist to express themselves more authentically. They also confirm Robinson’s (1999) theory that a musician’s principal instrument acts as a ‘transitional object.’ Without the relationship that builds
up over time between the individual and the instrument, it is much harder to focus attention outwards. Perhaps, this is the reason structure is more important when using a competency instrument to attune. Results also support Hadar and Amir’s (2018) theory that a music therapist’s ability to access the benefits of using their principal instrument depends on the development of their professional identity.

The most surprising discovery from this research was the anxiety response verbalized by focus group members in relation to the concept of using their principal instrument in sessions. This response was so intense, that afterwards I was confused, thinking perhaps the project had dissuaded participants from using their principal instruments in practice. However, I was able to make sense of this resistance and draw conclusions by taking a deeper look at my own experiences.

Although I felt the same frustration as my participants in Stage two, Phase two, these emotions pushed me closer to my principal instrument. Evidence of this included the choice I made to play flute during the third improvisation. Also, during the discussion portion, I verbalized the opinion that flute was an extension of my being, while most others reported feeling a separation between themselves and their principal instrument. This left me questioning why I was the only one feeling this way and curious about the anxiety expressed by my participants. I found answers through reflecting on my own training history.

After four years of undergraduate experience in an intense music performance program, my self-concept as a flutist was filled with memories of stress, anxiety, and self-deprecation. To get away from these feelings, I took two years off from playing music and pursued a completely different professional career. When I returned to music, it was through improvisation.

This form of musical expression forced me to address the blockades I had built as a performer. With no outside directives, I had to confront the internalized perfectionistic opinions
of my teachers and the voices in my head telling me excuses such as: “you are not good enough,” “flutists aren’t supposed to improvise,” or “you are going to ruin the music.” Through this practice of looking inwards, I was eventually able to connect with my intuition in order to express myself in the most authentic way on my principal instrument.

These experiences made it possible for me to conceive of incorporating flute into my music therapy practice when I began this training. It also made me determined to find supervisors who would allow me to gain experience doing this. However, during my time as a student, I have discovered that this motivation is not necessarily shared by my peers. This is exemplified by the disparity between my personal response to the community engagement project and that of my participants. The outcome of this research – specifically the separation of self-concepts – suggests a gap in the music therapy curriculum. Perhaps, by increasing opportunities for music therapists to actively engage with clients on their principal instrument and explore creative ways of using the elements of this instrument to achieve wellness goals, more would choose to use them as another tool in their music therapy tool box.

Limitations of this research included access to participants from culturally diverse backgrounds and a variety of advanced music therapy training programs. Although the New England region includes three music therapy programs, Lesley University is the only one with a master’s degree. Of the students that attend this program, the majority are white woman. Because of this, all my participants were trained in the same theoretical foundations and may have had similar life experiences. In the future, it would be interesting to explore this research with a focus group comprised of individuals who attended different programs and have different cultural backgrounds and gender identities.
Another limitation was the amount of time allotted for research to take place. Ideally, Stage Two would have been conducted multiple times for the largest pool of data from which to draw conclusions. However, it was only possible to hold the community engagement experience once. This also limited the number of individuals available to participate in the focus group. Although 8 individuals initially agreed, 4 had to withdraw due to schedule conflicts.

Recommendations for future research include applying this art-based research method to other expressive art therapy modalities. For example, it would be interesting to discover if a ballerina experiences the same dissociation as a musician when becoming a dance/movement therapist or a sculptor when becoming an art therapist. These findings could lead to important improvements for our expressive art therapy training programs as a whole.

The client’s perspective is another avenue for future research. Perhaps, through a qualitative method of conducting surveys, the researcher could determine if client comfort is connected to the instrument choices of the therapist and why. This would help the music therapist be more intentional about the instrument they choose to use with specific clients or at certain times within the session.

I also wonder how this topic could impact inclusivity within the profession. Music therapy is a growing field of study with many international students attending programs in the United States and around the world. However, our competencies and programs are created for therapists working with clients who prefer Western music. Including more of a focus on principal instruments could help those returning to non-western countries practice using the instruments of their culture during their training for greater success upon their return.
**Conclusion**

Based on the results of this research project, principal instruments are a valuable addition to the music therapists’ tool box. For these participants, principal instruments increased ability to intuitively listen and respond, which allowed for increased interpersonal attunement. However, it appears music therapists must face their own insecurities and self-imposed pressures before they can access these benefits. This research also supported that music therapists, by infusing the music with structure, can achieve the same level of intuitive listening and responding with competency instruments. In fact, these music therapy professionals believed competency instruments had the added benefit of helping them become more approachable.

With these findings, those working towards future development of the Advanced Music Therapy Competencies could consider adding language under the ‘Personal Development and Professional Role’ section addressing professional identity development. Under ‘Musical and Artistic Development,’ they could also consider adding more detailed language around the use of principal instruments in clinical practice. Additions like these may lead to increased openness within the field towards a broader range of instruments and harmonic tools that will ultimately benefit music therapy clients. Overall, as the field grows, it will be important for those who want to use principal instruments clinically to clarify the benefit for their clients of doing this and continue to conduct research in support of this method of practice.
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