MUSIC THERAPISTS' MUSIC LISTENING AND SUBSEQUENT MUSICAL DECISION-MAKING

By

Mi Hyun Bae

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ABSTRACT

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This qualitative multiple-case study investigates three experienced music therapists' perceptions regarding their musical decision-making processes in clinical music listening. According to my theoretical assumptions, the whole process of research question formation, participant recruitment, data collection, and data analysis proceeded on the basis of a model formulated prior to the research. The main research questions were: 1) What do music therapists experience while listening to music in practice? 2) What do music therapists consider while making musical decisions in clinical music listening? and 3) How do music therapists' listening experiences and clinical considerations influence their musical decision-making?

The research participants were three experienced music therapists, one each in the areas of Guided Imagery and Music, Nordoff-Robbins Music Therapy, and cognitive behavioral music therapy. The data were collected through initial interviews, session observations, review sessions using Think Aloud Protocols, another set of session observations and review sessions, and final interviews. Using the propositions in the *a priori* model, I interviewed the therapists about their music listening experiences in practice (i.e., existential listening, auditory listening, and reflective listening) and their perceptions about the influences on their musical decision-making (i.e., their music therapy orientation, their musical traits, case information, and situational immediacy). Their verbal accounts were transcribed and analyzed along with my observational data, using the computer software, HyperRESEARCH™. Based on my analysis of the data, I

present each therapist's musical decision-making process within the bounded system of each case. I also attempted to elucidate the three cases collectively through a discussion of the similarities and differences among the cases.

The results of the research suggest that all of the three music therapists had in-depth experiences in various listening areas; however, the individual therapists from different approaches tended to put different weights on each listening area. Second, the therapists' perceived influences on their musical decision-making shared commonalities as well as differences in responses to each inquiry item. Lastly, the research suggested a strong relationship between the therapists' music listening approaches and their own perceived influences on their musical decision-making. They indicated that those internal thinking processes are considered critical factors for their musical decision-making in their music therapy practice. The research contained implications for improving the model upon which the study was based, so as to be more logical and applicable to decision-making in music therapy.

DEDICATION

This dissertation is dedicated to my parents,
Jung Woong Bae, and Hyo Gu Lee,
whose creativity in their ordinary lives has inspired me,
in gratitude for their support and faith in me.

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A short conversation with a parent of the client after each session concerning the child's achievement in the session and my intentions for the music therapy activities was a routine protocol in my work. Since my initial music therapy training, music therapy rationales for my sessions have been the part I liked to think and write about the most, and I also enjoyed such conferences with parents. They were actually self-educative for me. Through these discourses, I could look back on what I was thinking in the session. But, sometimes, I did not have a lucid explanation for all of the decisions I made. Although I might have spoken effectively to the parents, I knew that some of my music and music activities did not fit perfectly with my by-the-book and hands-on knowledge. I just did not know where my decisions came from.

After being a music therapist for about seven years, I started to pursue my PhD studies. Thinking and writing about theoretical and philosophical topics became my main job, and naturally, I got to revisit my thinking about when I had worked with clients' parents. I started diagramming what my thinking process would be like when making musical decisions—it was a project for my Advanced Research class. Looking at this visual representation, I wondered whether it was only the product of my own mind and how other therapists would draw their own thinking process. Such was the humble beginning of this research.

CHAPTER I

INTRODUCTION

Across various music therapy approaches, a music therapist's attentive and active music listening has been highly stressed as important to successful music therapy practice. The quality of a music therapist's music listening can be perceived from two standpoints. First, attentive and active music listening is a music therapist's attitude towards music therapy and music therapy clients (Arnason, 2003) and music listening plays a part in his/her competence for developing a therapeutic relationship and making therapeutic progress (Ansdell, 1995; Grocke, 1999; Pedersen, 1997). Second, attentive and active music listening is a pre-conditional process for music analyses and decisions about music intervention (Aigen, 1998; Bruscia, 2001; Gardstrom, 2001). Based on what they listen to in the music that is used or created in a session, music therapists make subsequent clinical decisions. Namely, attentive and active music listening is an important personal and professional activity that affects the music therapy process directly and is involved in the antecedent process of evaluating and selecting music in music therapy.

Although the two conceptions have not been dealt with separately and interactively, the consensus about the importance of a music therapist's attentive and active music listening has been found in many essential writings in different music therapy approaches. In this light, I will take music therapists' viewpoints, which stress the importance of a therapist's music listening, from three music therapy approaches: improvisational, receptive and cognitive behavioral music therapy.

First, in improvisational music therapy, Bruscia (2001) articulated that a music therapist is required to be a "quintessential listener" in order to attend to and understand a client's improvisation. Particularly, the following statements explain the weight of listening in terms of a music therapist's work and the protocol of improvisational music therapy.

> [A music therapist's listening] precedes, shapes, and monitors how the therapist responds to the client. Listening is the only way a therapist can understand what the client is accomplishing therapeutically in the improvisation, and as such, is the prime requisite for assessment, treatment, and evaluation. For this reason, when the therapist fails in this basic responsibility, the client-therapist relationship and the very effectiveness of therapy are at risk (Bruscia, 2001, p. 7).

In the quote, Bruscia describes the function of a therapist's listening as a decisive, procedural process that "precedes, shapes and monitors" an individual therapist's understanding of a client's music and the therapist's decisions about the following therapeutic intervention. Throughout the improvisational music therapy protocol, which consists of assessment, treatment and evaluation, Bruscia wrote that a therapist's listening plays a role of "prime requisite." As seen in the last sentence in the quote, it is a therapist's listening as a crucial quality of a therapist that can either lead to a sound therapeutic relationship and therapeutic progress or put those processes at risk.

Ansdell (1995), who elucidated the therapeutic process of Creative Music Therapy by explaining each step descriptively and interpretatively, also made a case for the significance of a music therapist's listening. He eloquently stated that the "hidden focus of the approach is about listening rather than playing." Although one is often preoccupied with what to play and how to play in learning and doing Creative Music Therapy, it is what to listen for and how to listen to it that one eventually reaches to for meaningful music-play. From musical relationships with a client, a therapist listens to and learns about his/her musical moves for the next step in the whole process of Creative Music Therapy. Ansdell described this quality of listening as "close living listening" and "social listening" beyond mere hearing (Ansdell, 1995, p. 156).

Introducing his improvisational music therapy approach, Aesthetic Music Therapy, Lee (2003) articulated that, as a core phenomenon related to human relationships, music listening lets a person reflect him/herself inwardly and lets the person relate to others. With respect to a music therapist's listening, which he called clinical listening, he wrote:

> "Clinical listening is the art of the therapist's attunement to the client's sounds, listening to the reality and beyond; listening to every nuance from the client's first utterances to the final sounds as the session ends. Every sound, musical contribution, of an improvisation is a moment of clarity and emotion that should be heard with exactness and insight" (Lee, 2003, p.87).

A therapist's listening in this approach is as important as producing musical sounds, and listening for the delicate qualities described above is as "intricate" as developing musical interactions and mutual improvisations with a client. Particularly, for Lee, who viewed the structure of music and music therapy as an analogy of real life, a music therapist's listening should be precise from a musicological perspective as well as being sonorous and insightful from the therapeutic standpoint. Indeed, in that the aesthetic approach to music in music therapy is an essence of the Aesthetic Music Therapy, a therapist's ability to listen to musical materials in practice and understand their aesthetic values would be a driving force for success in this approach.

As an exquisite condensation of music therapists' views regarding the importance of music listening as their vital work and a conditional procedure for successful therapy process, I quote Skewes' study (2002) based on her interviews with nine experts in improvisational music therapy.

> It is possible that musical listening is a central tenet of music therapy practice (Ansdell). It is the first stage in understanding music therapy interactions, and occurs prior to the application of a psychological perspective as an aid to understanding or interpreting the client's process (Bruscia, Shapiro). Not only do music therapists listen for the information that can be heard in the way a client

> plays music (Fidelibus, Ritholz), but they also listen because being witness to somebody's therapeutic process is the basis of successful therapy (Turry). Clients are aware of the therapist's intent listening to their journey and this becomes the basis of their musical communication (Ritholz). The music therapist is present, listening, noticing and responding to every aspect of the group (Stephens). The culture of listening enhances creativity, interaction and self-awareness as each person becomes flexible in their musical roles (Ansdell). By listening to what the music sounds like, the music therapist perceives the potential for creative growth and responds musically or via words (Ansdell, Marcus) (Skewes, 2002, p. 51).

In addition to improvisational music therapy, the agreement on the importance of therapists' music listening has been ubiquitous in another music therapy approach, receptive music therapy, in which listening to music and responding to it in various modalities are clients' core tasks (Bruscia, 1998a). Music therapists' attentive and active music listening plays a vital role in providing proper music, which is intended to induce music therapy clients' responses as well as in deriving therapeutic progress. In particular, considering the fact that music listening is the most prevalent musical intervention in this approach and that therapists listen to a music selection themselves as a session preparation before using it with clients (Grocke & Wigram, 2007), therapists' music listening is greatly stressed in receptive music therapy. However, a clarification should be made here.

Slightly different from improvisational music therapy, in receptive music therapy, therapists' clinical attention during music therapy sessions is largely devoted to clients' music listening responses in various forms (e.g., verbal and non-verbal feedback, music-making, and expressions using other art modalities) rather than analyzing the music itself. A therapist's music listening in a session also may not call forth active musical interventions, such as music performance or improvisation.

Nevertheless the selection by the therapist of what music a client is going to hear is a paramount factor that influences clients' listening responses. Assessing a music selection for its suitability for a client is crucial work for therapists who work in the receptive music therapy approach. Through this listening practice, therapists would be able to learn for themselves what music could work for clients and what clients' listening experiences might be like as well as be able to establish their own music repertoire for clinical uses (Grocke & Wigram, 2007). Because of this protocol of receptive music therapy, therapists' music listening usually occurs before music therapy sessions although the actual musical choice is made in the session based on therapists' music repertoire and/or music therapy clients' immediate requests.

Furthermore, in one type of receptive music therapy, Guided Imagery and Music (GIM), training programs require trainees to have a series of GIM sessions in which they become active listeners as clients; this listening experience facilitates trainees' personal and experiential learning about the therapeutic mechanisms of GIM, specifically how music works in a psychotherapy setting (Lewis, 2002). Trainees also learn GIM music programs and how to choose music programs for clients (Brooks, 2002). The music analysis method of Kasayka (1988), introduced in her doctoral dissertation, has been incorporated into GIM training institutes and more techniques have been developed to help trainees and practitioners understand GIM music programs, based on different therapeutic intentions (Bonny, 1993). The continuing appearance of music analysis methods for GIM music programs in scholarly journals is indicative of GIM practitioners' needs and interests in listening to and analyzing music programs (e.g., Dutcher, 1992; Skaggs, 1994; Ole Bonde, 1997; Booth,1999; Bruscia, et al, 2005).

The writings of Bonny, the founder of GIM, about the listening modes of practitioners show her emphasis on practitioners' attentive and active music listening, particularly in light of both subjective/experiential and objective/cognitive listening modes.

> Within the actual practice of giving session the music therapist assesses the most favorable music to use with each client. Adequate assessment depends upon knowledge gained about the musical selection from both cognitive (left brain) and experiential (right brain) levels of experience. Kasayka (1991) has provided us with a useful format for cognitive understanding. We have as yet relied on the personal session required of each facilitator—personal experience within the GIM mode—to supply us with experiential data. We presume that through using the GIM process, both as facilitator and traveler, we will somehow "learn" how to acquire a deeply felt mode of listening, an intuitive grasp of the deeper workings of the music we have chosen to play for our clients. Hopefully, this listening mode has been learned as an integral part of the two to three year training period which is required to be accepted by the Association for Music and Imagery at the competency level of "Fellow" in the GIM process (Bonny, 1993, p. 4).

In an interview about GIM practitioners' music listening for their spiritual process, Bonny also articulated that practitioners need to work on their emotions through music listening without limiting them to the spiritual realm (Bonny, 2001). Considering the accounts within GIM discourse, practitioners' music listening seems to direct their self-therapeutic or self-maturing process as a psychological preparation for successful therapy sessions. As a protocol in GIM, practitioners listen to music programs in order to analyze and appraise them so that they become able to choose adequate music for a client in session.

Last, in cognitive behavioral music therapy, attention to therapists' music listening has not been a central topic as it has been for improvisational and receptive music therapies. There is no literature related to therapists' music listening and analysis skills. This lack of related discussion may stem from the different music therapy orientation of cognitive behavioral approaches. Their theoretical orientation may be referred to as the concept of music *in* therapy

(Gaston, 1968) as opposed to music *as* therapy. When music is conceived *in* the realm of therapy, the use of its unique qualities contributes to effectively dealing with clients' non-musical, therapeutic issues (Bruscia, 1998b). In the case of cognitive behavioral music therapy, music treatment is an important medium to bring about behavioral changes of clients (Sears, 1968). That is, music therapy clients' music does not limit its meaning to music itself, unlike music *as* therapy in which clients' musical involvement, process, and achievement in music listening or making, as such, are understood as the most significant therapeutic process which need not be translated to non-musical behavior. Rather, under the concept of music in therapy, clients' experiences within structure, self-organization, and relating to others while committing to music directly leads to their behavioral changes within and beyond therapeutic settings (Sears, 1968).

Due to the notion of music in therapy, therapists and researchers in cognitive behavioral music therapy might have concentrated on how to systematically facilitate clients' successful experiences. However, this need not imply that therapists' careful music listening and good understanding of music are not a critical part of their success in planning, implementing, and evaluating music therapy practice. Didactic writings abound on principles of and considerations for the proper use of music as well as about examples of musical interventions and techniques (e.g., Hanser, 1999; Thaut, 2005; Unkefer, 1990). One might assume from these writings that a therapists' listening practice is a pre-condition for the suggested use of music. Namely, when music therapists' careful listening and clear-headed appraisal of music are secured, the systematic, functional use of music would likely be more successful.

In sum, although different music therapy approaches have different levels of emphasis, therapists' attentive and active music listening practice is assumed to be a therapist's vital work and a crucial procedure in music therapy protocol. The music therapists' remarks, ultimately,

lend themselves to the ultimate goals of therapists' music listening: that is, their successful job performance in building therapeutic relationships and making therapeutic progress as well as an informative procedure to be done to collect proper information from music for the following musical decision-making.

As music therapists' music listening is geared toward the next step of making best musical decisions that would induce successful client experiences within a therapeutic setting, the spotlight of therapists' listening in this writing moves to therapists' musical decision-making processes. First of all, therapists' musical decision-making is a complex phenomenon. It is neither a purely musical decision about what to play nor an exclusively non-musical clinical decision related to clients' pathological or functional issues. This coexistence of dissimilar aspects of music and therapy makes defining the phenomenon of therapists' musical decisions difficult and makes studying it intricate.

There has been a lack of discussion about therapists' musical decision-making in clinical practice, in spite of its perceived importance in the effective use of music for clinical purposes. There have been investigations by music therapists related to their clinical decisions through which we can get some hints about their musical decision-making. Therapists' professional endeavors to provide individual clients with the most efficacious service has led to the development of music therapy assessments that aim to generate information about clients in musical and nonmusical areas to help music therapists make decisions regarding clients' needs and treatment protocol (Wilson, 2002, p. 156). Despite its paucity, research assessing clients' musical responses using test instrument tools also exists (Gregory, 2000). However, the *foci* of those studies were not on music therapists' internal thinking processes while conducting music therapy, but only while implementing music therapy assessment or evaluation tools. In that the

informative resources for deciding music treatments for clients are limited to the pre-set items in the assessment, those studies are not particularly relevant to investigating music therapists' decision-making processes in general.

More recently, there have been more active probes of music therapists' perceptions of musical phenomena in practice. Some qualitative research profoundly investigated clients' music experiences in session as well as therapists' interpretation of and situational reaction to clients' music experiences (Amir, 1999; Ansdell, 1996; Arnason, 2003; Bruscia, 2001; Keith, 2007; Lee, 2000; McFerran & Wigram, 2005). The research findings provide some snapshots of what music therapists would listen for and how they would understand it. Qualitative inquiry methods in the studies also seem successful in capturing therapists' perception and internal thinking process in music therapy practice. Considering the fact that research techniques such as Think Aloud Protocol, which is often used in qualitative research, are also employed to trace decision-makers' multi-attribute decision making process in cognitive psychology research (Harte & Koele, 1997), music therapy qualitative research leaves open the possibility of investigating therapists' musical decision-making process, which might be a complex and intricate topic to research.

To sum up, research on therapists' music listening approaches and their subsequent music decision-making is at a completely nascent stage, and it is important to investigate this critical music therapy phenomenon in various music therapy approaches. The need for inquiring into music therapists' music listening and subsequent musical decisions could be supported with the following reasons. First, scrutinizing and understanding music therapists' listening and the following decision-making would be a decisive key in elucidating the mechanism of musical interventions in music therapy. As has been stressed, a therapeutic process is driven through the mutual and reciprocal listening and understanding between a client, a therapist, and their music

(Ansdell, 1995; Bruscia,1998b; Pavlicevic,1997 ; Procter, 1999). Delving into only a client's music experience—we tend to have been more enthusiastic about knowing clients' experiences and proving a pure effect of music on them—provides only half of the information we need to illuminate the mutual, therapeutic process in music therapy.

From another standpoint, music therapists prescribing interventions without listening to clients and arranging music to their needs cannot best serve a meaningful therapeutic progress. Unless therapists are well aware of what they have listened to in each case and what has made them make specific musical decisions, they would not be able to carry out the music interventions successfully that we have learned from didactic writings and clinical manuals. Therefore, meticulously looking into music therapists' internal process from their initial sound perception to final musical decision is a straight way of getting an explicit, whole picture of the mechanism of musical interventions and their contribution to therapeutic progress.

Second, in accordance with the lack of research efforts in general, we have not been informed clearly about how musical decisions are made by therapists in various music therapy approaches. The scanty resources offering such information come mostly from particular music therapy approaches, such as Guided Imagery and Music and Nordoff-Robbins Music Therapy, although therapists working in other approaches might also have been curious about this phenomenon. However, according to Choi's study (2007), the identified music therapy approaches employed by professional music therapists currently were cognitive behavioral, humanistic, medical, analytic approach, other, and no particular approach in that order (p. 99). We need a comprehensive understanding of how music interventions are selected and implemented and how therapeutic progress develops in on-going music across different music therapy approaches, along with in-depth knowledge within specific methods.

Ruud (2006) articulated that we must establish a "system, a chain of conditions," which would explain the nature and mechanisms of music therapy. With the intent of elucidating this nature and mechanism, I embark on research investigating music therapists' music listening and musical decisions by visiting actual clinical situations in which live musical interactions are going on and by probing music therapists' internal thinking and decision-making processes.

Purpose of the study

The purpose of this qualitative study is to investigate the relationship between music therapists' music listening approaches and their musical decision-making, and to illuminate the therapists' decision-making processes in music therapy practice. In particular, I am interested in examining the experiences and perceptions of three music therapists with different music therapy backgrounds (i.e., improvisational, receptive, and cognitive behavioral music therapy). Based on detailed, in-depth data collected from multiple sources, I describe how each music therapist makes musical decisions based on his/her listening experiences, and I attempt to illuminate the music therapists' decision-making processes in the context of each case as well as across the cases. As part of this process, I also compare the participants' responses against the *a priori* model (Bae, 2010a) of music therapists' clinical music listening described in detail in Chapter II (See p. 52). In this regard, the research questions below were developed directly based on the components of the *a priori* model.

Research questions

The following research questions served as a framework for this study:

1. What do music therapists experience while listening to music in practice?

1.1. What do music therapists feel in terms of existential music listening (e.g., their own emotions, body sensations, retrieved memories, and other associated images)?

1.2. What do music therapists listen to and attend to in terms of auditory music listening (i.e., recognition of acoustic and musical properties)?

1.3. What do music therapists listen to and attend to in terms of reflective music listening (i.e., empathetic listening, awareness of different music listening purposes, and evaluation or interpretation of music)?

2. What do music therapists consider while making musical decisions in clinical music listening?

2.1. How do music therapists' music therapy orientations (e.g., knowledge of general music therapy and of major/specific therapeutic approaches, and personal beliefs in music therapy) influence their musical decision-making?

2.2. How do music therapists' musical traits (e.g., music skills, music resources, and music preferences) influence their musical decision-making?

2.3. How does music therapists' information about clients (e.g., psychology/pathology related to a client and non-musical and musical information about a client) influence their musical decision-making?

2.4. How does situational immediacy influence music therapists' musical decision-making?

3. How do music therapists' listening experiences and clinical considerations influence their musical decision-making?

CHAPTER II

LITERATURE REVIEW

Music therapists' music listening

Music therapists' music listening is an indigenous musical phenomenon in which they listen to music or sound purposively to make clinical decisions. Throughout the music therapy procedure—selecting a piece of music for a client, performing or improvising music with a client in session, and analyzing a client's musical tasks in a post session—therapists' music listening practice plays the role of a natural and essential apparatus through which therapists attend to the music and understand non-musical, therapeutic qualities of the music in order to make clinical judgment and decisions for clients. It is distinguished in terms of the purpose, process, and outcome from the music listening of other general listeners or experts in other music fields. Regarding terminology, several writers called music therapists' listening "clinical listening," which is a fundamental condition of the therapeutic process and an important learning goal for music therapy trainees (Lee,2003; Priestley, 1994). In other writings, music therapists' listening has been illuminated under various names and with different emphases, for example, "listening phenomenon" (Forinash & Gonzales, 1989, Grocke, 1999; Kasayka, 1989), "listening perspectives" (Arnason, 2003; Perdersen, 1997), "listening techniques" (Bruscia, 2001), "listening strategy," (Verney & Ansdell, 2010), and "systematic listening" (Erikkilä, 2000). These terms are largely from studies, the theoretical foundations of which are several types of improvisational music therapy or receptive music therapy such as Guided Imagery and Music

(GIM). In this writing, music listening does not mean that in specific therapeutic approaches, but in a broad context across approaches, with the intent of describing it comprehensively.

Various music listening phenomena

Music therapists' music listening is multidimensional in which therapists' various listening experiences are entirely interwoven and in which they listen for certain qualities of music in diverse listening modes, which work sometimes simultaneously and sometimes serially. Such music listening involves therapists' responses to as well as knowledge and critiques of the music itself that contribute to their clinical judgment of what they have heard. I have categorized these qualities of music therapists' listening into *existential listening*, *auditory listening* and *reflective listening*, which together I have called EAR (Bae, 2009). The three modes in the EAR listening training are used here as a theoretical framework for reviewing the literature related to various music listening phenomena in music therapy.

Table 1. The framework of the EAR listening perspective

EAR listening	Existential listening	Auditory listening	Reflective listening
Components of the listening perspectives	1) Physiological/bodily responses 2) Personal impression of music 3) Non-ordinary listening experience	1) Perception of musical elements 2) Perception of structural aspects of music	1) Empathetic listening attitude 2) Awareness of listening purposes 3) Critique and interpretation

Existential listening

Existential listening is music therapists' personal listening in which they inwardly collect subjective information about the music they listen to through their direct experience. This type of listening requires therapists' close attention to and conscious awareness of their experiences occurring moment-to-moment in physiological, affective, and cognitive realms as well as at various conscious levels. In specific, *existential listening* includes three main types of listeners' experience: (1) physiological and other bodily responses to music, (2) personal impression of music including emotional feeling as well as related memory and thought, and (3) non-ordinary listening experience, for example various types of images and insights (Bae, 2009).

Existential listening, which is rooted in listeners' awareness of their lived listening experience, is a common musical phenomenon that can occur in every person. First of all, when listening to music, one may feel his/her shoulder muscles relax and his/her heartbeat and breathing calm down. One may sense his/her foot tap and head shake, and also notice behavioral changes, such as speaking louder or walking faster.

Regarding these general human responses to music, the music therapy literature is a fertile ground. For example, in order to examine listeners' physiological responses to preferred or relaxing music (Davis & Thaut, 1989; Strauser, 1997), stimulative/sedate music, or different types of music (Burns et al., 2002; Iwanaga, Ikeda & Iwaki, 1996; Iwanaga, & Moroki, 1999), measures of muscle tension, skin temperature, heart rate, respiration rate, blood pressure and so on, have been frequent dependent variables in many studies as evidence of this listening phenomenon. Such physiological and bodily responses of listeners have been a key rationale and mechanism of music therapy. In particular, music therapy research working in the paradigm of neurological, medical, and behavioral approaches may find it advantageous to pay more attention

to listening phenomenon, in that the assumption for this research is that these biological changes in research subjects induce further changes in other functional areas such as motor skill, social/affective adjustment, or attention and memory.

Next, personal impressions in existential listening encompass listeners' affective reactions to music and some related cognitive involvement. Like other general music listeners, a music therapist's emotional feeling, thought, and memory are evoked by the music he/she hears. For example, while listening to the same piece of music, one may feel that the music is happy and cheerful, but another may feel it makes him/her agitated or even restless. Another may remember a pleasant memory from his/her childhood, and this may make him/her strongly in favor of the music. From the aesthetic standpoint, therapists' exploration of their own personal impression in music listening would be a direct way of inquiring into music therapy clients' aesthetic experience. Music therapy clients' personal, emotional experiences in music shape their aesthetic experiences, which require neither exceptional musicianship nor exquisite musical products (Bruscia, 1998). This aesthetic value has been discussed by music therapy aestheticians (Aigen, 1995, 2007, 2008; Ansdell, 1995; Kenny, 1998; Ruud, 1998; Salas,1990; Stige; 1998a, 1998b). In terms of being sensitive to one's own affective experience and being able to be in clients' shoes, this listening phenomenon has relevance to music therapists' clinical work.

This universality of the affective experience in music listening also has been a main impetus for the therapeutic use of music. As proofs of this phenomenon, many fundamental studies in music therapy investigated listeners' affective responses: for example, utilizing self-report inventories (e.g., Clark, et al., 2006; De I'Etoile, 2002; Thaut & Davis, 1993) and technological equipment to measure those responses (e.g., Goins, 1998; Madsen, 1997). On the basis of these research findings, clinically applied research has demonstrated the therapeutic

effect of music listening on people with mental disorders (e.g., Bohnert, 1999; Wooten, 1992), emotionally disturbing experiences (e.g., Clark, et al, 2006), and other illnesses (e.g., Burns,2001) as well as on people with no specific pathological issues (Maack & Nolan,1999)

Next, non-ordinary experience in existential listening incorporates listeners' images as well as their intuitions and insights gained while engaging in the flow of listening to music. It differs from physiological, bodily experiences and personal impression discussed above. This non-ordinary listening experience has often been explained in the paradigm of psychodynamics or in the cultural or spiritual realms.

Specifically, Guided Imagery and Music deems it a listening experience in an Altered State of Consciousness (ASC), and listeners' experiences in ASC are largely classified into visual, kinesthetic, and intuitive images (Bush, 1995). Whether or not one demarcates this listening phenomenon as altered or transcendent consciousness, it is a natural human experience that is often seen in cultural or spiritual rituals across time and culture (Dissanayake, 2001) as well as being a type of music listening in general music appreciation (Kaplan, 1948). In Kaplan's writing, the listening experience of "the imaginal listener" is reinstated in images that represent something to the listener (Kaplan, 1948), and it is quite close to this non-ordinary listening experience in existential listening. As an example of using listeners' imagery experience for therapeutic use, a good number of GIM case studies have reported clients' changing imagery experiences and their insights into their life issues that are gained based on their images (e.g., Borling, 1992; Goldberg, 1994; McKinney, 1993; Roy, 1996-1997).

Besides their natural listening experience as human persons, music therapists' introspection in music listening, from bodily responses all the way to experiences in non-ordinary states, would lead them both to an in-depth examination of music listening phenomena

and to a reflection on their own experiences as individuals and professional therapists. In terms of philosophical stance, this perspective and work of music therapists is compatible with the existentialism in phenomenology. Music therapists have paid special attention to phenomenology and consider it to be a proper epistemology and research methodology for exploring and elucidating the nature of music therapy (Amir, 1992; Bonde, 1997; Dutcher, 1992; Forinash, 1990; Forinash & Gonzales, 1989; Gonzales, 1992; Grocke, 1999; Kaysaka, 1988; Marr, 2001). In some approaches, specifically Guided Imagery and Music, music therapists' self-examination and reflection have been a vital part of practice, although research directly dealing with them is still rare. Some autobiographical writings regarding music therapists' own listening experience and personal growth (Bae, 2010b; Booth, 1999; Bruscia et al, 2005; Skaggs, 1994) and research investigating therapists' self-reflection upon music in clinical situations (Grocke; 1999; Kasayka, 1999; Muller, 2008; Summer; 2009) have shed light on what they experience personally and how they process it for their clinical work. Taking the related literature into account, music therapists' existential listening is a central phenomenon, which they should investigate and be conversant with in order to collect lived, experiential understanding of music in clinical context.

Auditory listening

Auditory listening in the EAR listening framework is music therapists' acoustic and musical listening based on their skill, knowledge and ability related to music perception and cognition. As in other general music listening, this auditory listening requires music therapists' recognition of physical properties of music at the micro level and collative properties of music at the macro level (Thaut, 2005). For example, a music therapist, who is reviewing a videotaped

improvisation, hears the loudness, timbre, and pitch of a single sound. He/she also listens to bigger musical chunks, such as rhythmic patterns, melodic patterns, musical forms, and so on.

As seen in the American Music Therapy Association (AMTA) professional competencies, knowledge of music theory and music media proficiency are fundamental music foundations with which practitioners must equip themselves. In relation to auditory listening, the AMTA (2010) identifies "aural dictation of melodies, rhythms, and chord progressions" as an educational requirement for music therapy students and practitioners. This required listening practice may occur naturally and effortlessly for some music therapists. Yet, for some, picking up those musical properties may be painstaking, requiring attentive efforts. Depending on the music therapy approaches and methods that a therapist employs, the extent or degree of analyzing musical attributes would vary: for instance, how many musical properties should be recognized and identified by therapists or how accurate they should be.

Prior to the discussion of the different levels of emphasis on musical properties or formal aspects, I shall discuss the meaning of music in music therapy. Bruscia (1998a) stated that the boundary of music in music therapy is broader than is typical in more traditional approaches within the classical tradition. Regarding formal aspects of music, he also articulated that the meaning of music in music therapy is more in clients' successful experiences with it rather than the quality of clients' musical products (Bruscia, 1998a). Furthermore, both Elliott's Praxialism in music education, in which music is an activity that humans do with intentionality and with the desire for certain results (1995), and Aigen's music centered music therapy support the primary value of a client's actual experience in music (2005).

The meaning of music for music therapy clients aforementioned, however, does not mean that music therapists may neglect making the effort in honing their auditory skill and ability

whatever music therapy approaches a practitioner takes. After all, despite the general meaning of music in music therapy, it would be fair to say that a music therapist should be aware of both a client's experience in music and the musical/formal quality of the music. In clinical practice and research, different foci on auditory facets and the different interpretations of them have been developed in different music therapy approaches such as physiological/neurological and musicological/improvisational music therapy traditions. In Neurologic Music Therapy (NMT), the consideration of individual musical elements, such as rhythm, tempo, and pitch, are stressed in the process of translating non-musical goals into proper music activities and music in order to improve clients' specific functional skills (Thaut, 2005). For example, when facilitating a client's movement in his/her upper extremities, a NMT therapist should employ proper temporal, spatial, and dynamic aspects of music for the client as clear musical cues (Neurologic Music Therapy Training Institute, 2009).

In improvisational music therapy, for example, Creative Music Therapy and Nordoff-Robbins Music Therapy, musical analysis of a clinical improvisation is a vital protocol of the clinical procedure. While improvising vocally and/or instrumentally, a therapist spontaneously uses his/her musical resources to facilitate a client to be awake to, to respond to, and to be involved in music, and then to be more independent musically and therapeutically (Bruscia, 1987). In this vein, a therapist' accurate aural recognition would be a pre-condition for the therapist to be effective musically as well as clinically in accordance with the sound and music a client is making. Furthermore, with a stronger emphasis on musicological analysis, Lee (2003) introduced an intensive, multileveled music analysis method for music therapists in his Aesthetic Music Therapy (AeMT). In his approach, formal aspects of the music used or created in session are an analogous to the therapeutic process. In that from a sporadic bunch of sounds, which

might not have musical/therapeutic meaning yet, therapists and clients build up their musical and therapeutic relationships throughout music therapy sessions, therapists' attention to and comprehension of the architecture of the music from short rhythmic/melodic patterns all the way to the musical form of the whole is crucial for clients' therapeutic progress and therapists' successful practice.

Again, the amount that therapists work at analyzing musical attributes and the extent of the musical properties they scrutinize vary depending on music therapy approaches, the theoretical foundation and therapeutic technique of which are different. However, regardless of the therapeutic approach, music therapists should be capable of recognizing and identifying musical attributes at least at a fundamental level as the AMTA Professional Competencies affirmed (2010). In that acoustic/musical facets of music are the first events therapists immediately face when listening to and making music in clinical situations, music therapists' descriptions of what they hear in music have great importance for collecting credible, raw musical data for further understanding or interpretation from a non-musical, therapeutic standpoints.

Reflective listening

The last category in EAR listening, *reflective listening* is music therapists' music listening in relation to a specific client and clinical situation. Whereas the *foci* of the other two types of listening—existential and auditory listening—are more on therapists' personal music listening experience, the focus of reflective listening is in reference to a real clinical case. As conditions for reflective listening, therapists must empathize with their clients, listen to music with a specific clinical purpose, and listen to music critically and interpretively.

First, therapists' empathetic listening is about their psychological readiness to listen from a client's point of view. This can be presented as a therapist's motivation to listen to a client's music, respect for a client's musical preference or product, and sincere consideration of the client's musical needs. Second, reflective listening necessitates therapists' awareness of the purpose of music listening in a given therapeutic procedure in relation to therapeutic goals. Basically, the purpose of music therapist music listening is distinguished from other general music listening in that it is listening for a clinical purpose.

Moreover, for example, in an initial session for collecting information from clients' musical responses and in a session preparation of selecting pieces of music for clients, the qualities therapists look for during their music listening might be different; thus they should be aware of the purpose of their listening, which is to make appropriate clinical decisions for the given music therapy situations. Last, reflective listening entails therapist critiques and interpretation of music. Since implementing a music intervention or analyzing a musical excerpt from a session is not simple or formulaic, therapists' critical listening and his/her own interpretation are indispensible. That is, albeit a well-known effect of certain music or possibility of success of the use of certain music, therapists need to exam its personal meaning to each client (Stige, 2010).

Although their *foci* were slightly different from therapist music listening practice, many didactic writings have taught principles and strategies for the use of music, (e.g., Bruscia, 1998a; Benenzon, 1999; Peters, 2000), and these principles and strategies have been the first criterion for therapist musical decision-making in practice. As clinical applications of those lessons, it is crucial that therapists carefully screen the therapeutic relevance, usefulness, and appeal of a piece of music as well as perceive and understand therapeutically important qualities from the

music created in clinical situations (e.g., Bruscia, 1998; Wigram, Pedersen & Ole Bonde, 2002; Clair, 1996; Gardstrom, 2001; Grocke & Wigram, 2007).

More specifically, qualities of music listening like reflective listening have been illuminated in an improvisational music therapy context. Ansdell's exquisite description of musical processing in creative music therapy is all about what a music therapist should listen for in a client's music and also reflect upon in the relationships inherent in the musical process (Ansdell, 1995). Particularly, the concepts of "listening" and "reflecting" in Ansdell (1995) provide rich accounts for "empathetic listening" and "critique and interpretation" in reflective listening in the EAR listening framework. From Arnason's investigation of improvisational music therapists' listening, the listening perspective of "observing, feeling and thinking clinically" is also congruent with the premise of reflective listening, in that a therapist takes an interpretive and analytic stance in music listening (Arnason, 2003). In all, a therapist's reflective listening is a central phenomenon in music therapy, since without such client-centered listening with clinical intentions, therapists are not able to perceive and provide music in a clinically meaningful way.

Summary

As music in music therapy encompasses various aspects of both music and therapy between a therapist and client, what music therapists hear and attend to in their practice is also multifarious. In order to systematically examine the various listening phenomena, the EAR listening perspective of Bae (2009) was used as a philosophical framework of literature review: existential, auditory, and reflective listening. The nature and attribute of each listening phenomenon was described and supported by related literature despite its paucity. The following table is the framework of the EAR listening perspective.

Systematic music listening practice

Music therapists' proper analysis and interpretation of music in practice presupposes their professional music listening practice. Conversely, the need for music therapists' specified music listening practice has occasioned the occurrence of systematic music analysis approaches that allow therapists to listen for specific qualities and to interpret collected data based on the rationales and analysis techniques of the approach. Music analysis approaches, which have appeared in music therapy literature, have their own philosophical, theoretical assumptions about the listening perspectives and listening techniques of analyzers.

Each approach has a different emphasis on different musical/nonmusical phenomena in music therapy. For example, one approach may concentrate more on an analyzer's appraisal of the music based on his/her personal, subjective listening experience—previously described as existential listening in the EAR listening framework (Bae, 2009). Another may require an analyzer's accurate aural skill with a high level of comprehension in music theory—relating to auditory listening. Additionally, another listening approach may not have much concern for musical features but rather for clients' non-musical qualities demonstrated as their response to or expression in music—reflective listening in the EAR listening.

In this section, the music listening approaches, which have been found in the music therapy literature, are collected and summarized into three different music therapy approaches: improvisational, receptive and cognitive behavioral approaches. Some might not have been identified as listening approaches by the researchers or founders. They may be in the form of a music analysis or a list of musical/therapeutic qualities. In terms of their features or organization, some listening approaches contain concrete criteria for specific musical qualities and thoroughly organized forms. However, some listening approaches describe only philosophical assumptions

and theoretical structures while giving more room for individual therapists' appraisal and insight, or may serve as an inspiration for therapists' further investigation. Following, the music listening approaches from improvisational, receptive and cognitive behavioral music therapies are reviewed in terms of their aims and paradigms, the delineated listening perspectives, and therapists' implementing process.

Receptive music therapy

Receptive music therapy approaches include various types of therapeutic methods, such as music and relaxation, song lyric discussion, perceptual listening, musical appreciation, and music listening incorporating art media or vibroacoustic devices (Grocke & Wigram, 2007). The review of literature regarding music listening approaches in this area focuses more on Guided Imagery and Music (GIM), because of people's awareness of it as a major method in receptive music therapy and because of its relevance to the research focus and a research participant's therapeutic approach.

GIM practitioners analyze and evaluate a music program or a piece of music through their own listening experiences, specifically, their affective, bodily and intuitive listening. Bonny's Profile of Affective/Energy Dynamics (Bonny, 2002) is a seminal, systematic listening approach in GIM. It is a graphic diagram on which a therapist draws the contour of the dynamics of the music as perceived through his/her own affective experience (Bonny, 2002). Bonny's "Body listening" is another important experiential approach for GIM practitioners. This is music listening through the senses, body, affection and intuition, although the approach does not include categorized listening concepts or substantial analysis tools for use (Bonny, 1993, 2002).

Kasayka's phenomenological music analysis, which consists of "open listening," "semantic listening," "listening for syntax," and "listening for ontology," includes both an experiential analysis and musicological analysis of GIM music programs (Kasayka, 1988). A practitioner examines GIM music programs, in "open listening," through his/her immediate impressions of the music in a first-time listening and in "semantic listening," by being aware of his/her own feelings, images, physical responses, and so on (see Table 2 in this chapter).

Bruscia (1996) investigated the image potentials of music using a phenomenological methodology, which included both listeners' written reports of their experiences (e.g., states of consciousness, sensory/kinesthetic experiences, memories, metaphoric fantasies, transpersonal experiences and healing experiences) and listeners' descriptive analysis of music, which was not music theory-based analysis. His listening approach also has been used as a GIM music program analysis and a research methodology (Bonde, 1997).

GIM practitioners also analyze musical/musicological features of a music program or single piece to be accustomed to it, to evaluate its applicability, or to develop a new program. Bonny examined the most influential musical components on one's imagery experience within her music programs; they were pitch, rhythm and tempo, differences between vocal and instrumental music, melody, harmony, and timbre in that order (Bonny, 2002).

In Kasayka's approach discussed above, the latter two parts—"listening for syntax" and "listening for ontology"—require close attention to musicological features of music, and knowledge of the history of music (see Table 2 in this chapter). Particularly, for "listening for syntax," one fills out each grid with short descriptions of salient musical characteristics in terms of key and mode, pitch, rhythm, tempo, dynamics, melody, horizontal/vertical texture, dissonance/consonance, chromatism, orchestration, instruments, and intervals (Kasayka, 1988).

Grocke's Structural Model of Music Analysis (SMMA), which consists of 15 musical elements comprised of 63 sub-features, is another example of systematic, musical analysis, (Grocke, 1995). Along with general musical elements such as tempo and key, it incorporates musical features related to expressive, associative qualities of music as listening objects for practitioners, for instance, embellishments, the timbre and quality of instrumentation, and performance quality (see Table 3 in this chapter).

Marr's music listening approach (2000), which was used in his research to investigate the influence of music sequences on listeners' image production, also includes in-depth musicological analysis techniques (see Table 5 in this chapter). In conjunction with clients' reports regarding imagery experiences, the approach includes listening to a work completely and also section-by-section, and analyzing the syntax of the music, which is also used in Kasayka (1988).

A summary of music listening approaches in receptive music therapy follows below, and it will be beneficial to notice what aspects of music listening the receptive music therapists pay attention to when listening to music.

Table 2. Kasayke (1988)

Open listening	Immediate impressions to music
Semantic listening	Consciousness, experienced feelings, images, memories, and physical responses to music
Listening for syntax	Musicological features of music
Listening for ontology	Historical information about the music

Table 3. Grocke (1995)

Structural Model of Music Analysis (SMMA)	
Style and form	Period of composition Musical form Structure: simple/complex
Texture	Thick/thin texture Monophonic, homophonic, polyphonic
Time	Meter Complexity and variability in meter
Rhythmic features	Underlying rhythmic of the work-consistent/inconsistent Important rhythmic motifs (notate) Repetition in rhythmic motifs Variability in rhythm-predictable/unpredictable Syncopation
Tempo	Fast, slow, moderate, allegro, etc Alterations in tempi
Tonal features	Key structure, diatonic, modal Major/minor alternations Chromaticism Modulation points of significance
Melody	The main themes in the work Significant melodic fragments of each melody/theme The structure of each melody/theme Intervals of each melody/theme Shape of each melody/theme Length of phrases in each melody/theme Predominant pitch range of the melody/theme
Embellishments, ornamentation and articulation	Trills, appoggiaturas Marcato, accents, detached bowing, pizzicato Legato Use of mute
Harmony	Predominantly consonant or dissonant Consonance/dissonance alternation within the work Significant harmonic progressions Rich harmonies Predictable shift in harmonies Unpredictable harmonies Cadence points-perfect, imperfect, interrupted
Timbre and quality of instrumentation	Vocal-male or female solo, SATB or other combination Instrumental-solo Instrumental-orchestral Small group-e.g. quartet, combinations of instruments Instrument groups used in orchestration (strings, woodwinds, brass, percussion, harp) creating distinctive timbral color

	Interplay between instruments and instrument groups Layering effects (adding and reducing instrument parts) Resonance
Volume	Predominantly loud or soft – alternations between/ gradation between Special effects of volume: pianissimo, fortissimo, and sforzando
Intensity	Tension/release Crescendo, building to peak, and resolution Tension in harmony, texture etc. and resolution Delayed resolution or absent resolution Ambiguity in whether resolved or unresolved
Mood	Predominant mood, as depicted by melody, harmony, and predominant instrument Feelings and emotions represented
Symbolic/associational	Culturally specific associations Metaphoric associations Symbolism in motifs (leitmotifs), and their imagery potential – visual, auditory or kinesthetic
Performance	The integrity/authenticity of the performers Excellence of performance (technique of the performers) Stylistic interpretation – artistic merit Articulation of feeling and emotion Authenticity with composer's intent

Table 4. Bruscia (1996)

Description of music (syntax) and personal imagery (semantics)	Syntax 1: Time
	Syntax 2/ syntax 3: Motive/ phenomenological description
	Semantic 1: Personal imagery
Syntactic, ontological and semantic characteristics	Syntax 4
	Ontology
	Imagery potential

Table 5. Marr (2000)

Transcription of a client's imagery	Transcribing a client's imagery experience onto a music score
Therapist's analysis Musical analysis	Listening to a complete work Analysis of musical elements and structure, marked onto music score
	Listening to section-by-section More detailed musical analysis, marked onto music score
	Descriptive analysis of each music based on Ferrara's listening concepts, Syntax and semantics

Improvisational music therapy

Music therapists' listening approaches in the area of improvisational music therapy tend to put more weight on demonstrated musical interactions and relationships as a framework for observing the therapeutic process and determining a client's growth, rather than on a therapist's hermeneutic analysis and the strong employment of other psychological references. That is, music therapists in improvisational music therapy concentrate on what they play with clients, where their music goes, and thus where they are in therapeutic process, by following the strand of musical events in the improvisation.

On the other hand, since expressive music playing, which mostly employs musical instrument or voice, is the main therapeutic medium, a therapist's music listening focuses on his/her perception of the musical quality of clinical improvisation as an indication of an improvising client's inner experiences. That is, it is indispensible that a therapist has a wide range of music abilities, including aural skills, to understand clinical improvisation and to actively facilitate a client's successful music experience (Wigram, 2004, p. 28).

Bruscia's listening approach , Improvisational Assessment Profiles (1984) is a systematic, objective analysis tool for clinical improvisation, and it has been used and tested by many other music therapists in research and practice (Keith, 2007; Wigram,2007; Wosch, 2007). IAPs contain six assessment profiles of what qualities therapists should listen for (i.e., integration, congruence, variability, salience, tension, and autonomy), and these are scored by using a rating scale.

Bruscia (2001) also proposed a qualitative analysis approach to clinical improvisation, which shares basic concepts of the musical process in improvisation with IAPs but is methodologically different from IAPs. The steps of this listening technique are (1) free open

listening, (2) focused open listening, and then (3) positioned listening. Through free open listening, therapists naturally recognize the most important or relevant features of the improvisation to be analyzed. The next step, focused open listening, concentrates on entirely musical aspects, requiring therapists' recognition of prominent musical attributes and elements; the profile "salience" in the IAPs can be utilized for this focused open listening. Last, positioned listening contains three specific techniques: emphatic, complementary and reactive listening.

This listening approach has a lot to do with some of the research questions of the present research, which center around improvisational music therapists' music listening and the following musical decision-making. Although his qualitative analysis approach may be seen like a research model, it has substantial implications for practice; in that it provides therapists with a wide scope of listening perspectives, from which they can understand the nature of clinical improvisation, and with related listening techniques, which they need for their successful music therapy practice.

Ansdell's exquisite illustration of each musical phenomenon in Creative Music Therapy improvisation has shed light on music therapists' listening practice inside and outside of improvisational music therapy approaches (Ansdell, 1995). Roughly speaking, a therapist is aware of whether they are isolated or are meeting in the music and how they musically connect with each other (meeting). Second, a therapist senses that music triggers a client's active engagement in music, and the therapist needs to find right music for the client (quickening). Third, a therapist understands that a client's creative music-playing with others is a manifestation of his/her natural ability and musical needs (desires) and has therapeutic effects on the client. Thus, the therapist's active and creative facilitation is necessary for the creative process (creating). Fourth, a therapist helps a client explore his/her feelings and enjoy music itself with

the eclectic understanding of music as self-expression as well as artistic form (expressing). Fifth, a client's improvisatory music can be understood as recalled materials from various levels of time, place, and consciousness, and a therapist witnesses the establishing musical logic and integration that brings the materials to the client's current improvisation (recalling). Sixth, along with physical hearing and music listening, a therapist needs to open him/herself to a client when listening, and the client should be heard and understood by the therapist (listening). Seventh, a therapist analyzes an improvisation through his/her music therapy lens using extrinsic or intrinsic references. For the interpretation, the therapist may employ a specific psychology, such as psychodynamics, or he/she may try to purely describe musical events and musical experiences (reflecting). Eighth, in terms of music therapy evaluation, a therapist may reach the difficult question of measured proofs of or described experiences in music therapy. As a genuine picture of the person, a therapist illustrates a client's musical and therapeutic experience as such with an inter-subjective understanding of the experience (evaluating)—the seventh and eighth have to do with another thesis of Ansdell, which follows in the next paragraph. Last, an ultimate issue for a therapist is to make the connection between a client's musical presentation and the client's real state as well as the shared musical meaning between a client and therapist (connecting).

As another investigation of this phenomenon, Ansdell (1996) conducted qualitative research investigating listeners' accounts of clinical improvisations—research subjects were a non-musician, an amateur musician with/without knowledge of music therapy, a non-musician well-informed in the field of therapy, and a Nordoff-Robbins trained therapist. Based on the close-focus analysis of listeners' language, Ansdell presented the listeners' ways of accounting for (1) musical components, (2) musical qualities, (3) tendencies in the improvisation, and (4) their own inferences.

Lastly, Lee (2003), who created Aesthetic Music Therapy (AeMT), defined clinical music listening as "the art of the therapists' attunement to the client's sounds, listening to reality and beyond" (Lee, 2003. p. 87). In his improvisational approach, AeMT, Lee considers the structure of music and the structure of music therapy as an analogy of our lives, and emphasizes a therapist's understanding of the structures. With the emphasis on musicological aspects, he introduced six levels of intensive clinical music listening with which a music therapist should be equipped. The suggested listening levels require a therapist to recognize and understand various levels of musical complexity in clinical improvisations, and these are surface listening, instinctive listening, critical listening, complex listening, integrated listening, and listening beyond (Lee, 2003, p. 90).

Table 6. Bruscia (1987)

Improvisational Assessment Profiles (IAPs)					
Profiles	1	2	3	4	5
Integration	Undifferentiated	Fused	Integrative	Differentiated	Overdifferentiated
Variability	Rigid	Stable	Variable	Contrasting	Random
Tension	Hypotense	Calm	Cyclic	Tense	Hypertense
Congruence	Uncommitted	Congruence	Centered	Incongruent	Polarized
Salience	Receding	Confirming	Contributing	Controlling	Polarized
Autonomy	Dependent	Follower	Partner	Leader	Resister

Table 7. Bruscia (2001)

Free open listening	Focused open listening	Positioned listening
Phenomenological emphasis To notice what captures the ear or imagination Attention to music itself, extra-musical or nonmusical association	Focal listening to musical attribute Use of "salience profile" in Improvisation Assessment Profiles (IAPs, Bruscia, 1997)	Empathic Complementary Reactive

Table 8. Ansdell (1996)

Perspective A	First hearing: descriptive, verbatim summary using musical terms Second hearing: listening to music with many tape-stop, identifying events using musical and metaphorical descriptions Third (complete) hearing
Perspective B	Correlation of stop-points
Perspective C	Closure-focus analysis of listeners' language

Table 9. Lee (2003)

Levels of listening	
Surface listening	Identification of fundamental musical form and therapeutic relationship
Instructive listening	Identification and interpretation of further complexities of musical form and therapeutic relationship
Critical listening	Identification of fundamental musical resources
Complex listening	Identification and interpretation of further musical complexities of musical resources
Integrated listening	Identification and interpretation of links between therapeutic and musical aspects
Listening beyond	Identification of the incorporeal nature of the music and relationship

Cognitive behavioral music therapy

In the area of cognitive behavioral music therapy, music functions more exclusively as the therapeutic medium through which music therapists promote clients' changes and improvement in non-musical, behavioral areas. Such a clear clinical focus has required a scientific, systematic therapy service, and thus, music therapy assessment, treatment planning, implementation of music activity, and evaluation have been routine clinical protocols in music therapy (Wilson, 1990).

In this regard, music therapy assessment is an informative tool to examine clients' non-musical characteristics and functional skills using music, for further use in the course of therapy. Although music therapy assessment may include a small number of items, such as a client's music skill or preference, music therapists' assessment focus still stays within non-musical areas. There are some music-centered test instruments, which focus more on clients' musical behaviors or musical traits, for example, music perception (e.g., Waldon & Wolfe, 2006) and music skill (Lipe & York, 2007). Such music-centered test instruments have more relevance to therapists' listening practices, while making what they need to listen for clearer. However, as seen in Gregory's research (2000), the number of such musical test instruments is still extremely small, and music therapists' music listening approaches seem not to be a main concern in cognitive behavioral music therapy.

Other than that, in terms of the functional use of music in practice, many didactic writings have taught music therapists and students in detail, based on research regarding the effect of particular musical elements (e.g., slow/fast) or overall musical characteristics (e.g., stimulative/sedative). Nevertheless, there is no specific literature about music therapists' systematic music listening approaches.

Summary

In this section, music therapists' clinical music listening approaches in the three areas of receptive, improvisational, and cognitive behavioral music therapy were discussed. As each type of music therapy approach employs different musical approaches and clinical foci, the ways these music therapists perceive music and the listening characteristics they attend to also seem to be quite different. Related literature regarding therapists' clinical music listening in receptive and

improvisational music therapy was reviewed; however, in the area of cognitive behavioral music therapy, directly related literature was not found.

Decision-making

This section briefs information about decision-making research by reviewing related literature in cognitive psychology, sociology, mathematics and so on. With a focus on decision-making in music therapy practice, general concepts and types of decision-making are summarized. Then, a review of studies investigating professional decision-making in music therapy-related disciplines follows: i.e., research in health care professions, such as nursing and speech therapy and research in music performance and education. In addition, due to the extreme paucity of related music therapy research, the writings of Amir (1999) and Bae (2010a) become the exclusive grounding work for the present decision research in music therapy.

Decision-making

Decision-making is both a fundamental and complicated human mental process. In daily life, we make an enormous number of decisions at an automatic, unconscious level and at a more purposeful, conscious level. As the societies to which we belong develop, we face more complicated, convoluted decisions at an individual as well as a societal level such as institutional decisions and country-wide or international decisions. Encompassing decisions with different purposes at different levels, it has been said that decision-making is the way that decision makers reach their final choices to solve given problems. Decision makers have alternative courses of action, and depending on the states of the environment in which these actions are carried out, different outcomes occur (Kellogg, 1995, p. 383).

Decision-making can be largely classified into decision-making under conditions of certainty and under conditions of uncertainty (Kellogg, 1995). Roughly speaking, in the case of the former, a particular course of action produces a known outcome. For example, if a student knew that there would be an exam, he/she would know what to do, namely he/she needs to study to be successful on the exam. However, there are some situations in which a known probability still leaves a risk. Hypothetically, if a student decides which class to take by flipping a coin, there is 50 percent risk of him/her having different studies for the semester.

On the other hand, we make decisions under conditions of uncertainty when we are not informed about the probabilities of outcomes arising from different actions (Kellogg, 1995, p. 384). This type of decision-making is the most complicated and realistic one. If the decision-making environment changes as a function of the sequence of decisions or independently of them or both, the task of decision-making becomes more dynamic and complex (Edwards, 1960, p. 205). Music therapists' clinical decisions, which are made contingent upon changing clinical situations, would be a perfect example. In order to proceed with decision-making effectively, in general, the decision maker arrives at a subjective probability of the various possible situations. The task is done based on his/her past experiences, related examples, advice from others, and so on. Then, the decision maker estimates probabilities subjectively and reaches a determination of the best course of action. If it occurs in a dynamic environment like music therapy practice, the course from the decision maker's internal thinking process to his/her determined action would involve a more knotty and complicated process.

Evans and Over (2007) illustrated the mental process of decision makers' subjective probability estimation. The process was epitomized by a dual-process model, which consists of a decision maker's heuristics for probable decisions and the following analysis of the hypothetical

probabilities (Evans & Over, 2007).The heuristics that can be used in the course of estimating subjective probability have been discussed by many researchers and categorized into four: representativeness, availability, simulation, and frequency (Kellogg, 1995, pp. 384-391). Transferred into music therapy situations, the four heuristics can be roughly explained.

Suppose that a music therapy student tries to decide upon music activities, which can be used in his/her initial assessment session with an adult client whose diagnosis is cerebral palsy. First, the student may use the representativeness heuristic. Based on his/her knowledge of representative activities or principles of the use of music for clients with physical disabilities, the student may perhaps pick a performance activity using a hand-held musical instrument or a movement activity using the upper extremities —it should be noted, however, that the representative events or cases do not guarantee the occurrence or reoccurrence of successful outcomes. Second, the student may employ the availability heuristic. A music activity that the student saw when observing a professional therapist's music therapy session may pop up in his/her mind. His/her retrieval of the successful, impressive, or recent activity from his/her long-term memory may play a decisive role for his/her decision-making. Third, the student may use the simulation heuristic. In this strategy of decision-making, the student develops a mental model of hypothetical events. In specific, the student imagines possible scenarios and tries to assess which is the best course (see the hypothetical thinking model of Evans and Over (2007), which was mentioned above). If the student has no previous related observation or hands-on experience and, thus, is not able to imagine relevant clinical situations, he/she may not be able to predict probable events when he/she executes the chosen activities as well as possibly choosing music activities with a very low probability of success for his/her music therapy session with the client.

Last, a decision-making strategy based on the frequency of the occurrence of events can be used. Although they are not based on a thoroughly estimated probability, people choose the events that have been stored as frequently occurring events in their memories. In the case of the music therapy student, he/she might decide upon the music activities, which were more frequently successful, in his/her session observations, own music therapy sessions, reading, or information collection from others. In essence, through his/her subjective, mental processing of probabilities based on the frequency of an activity's use, the student may choose the music activities for the client. So far, although the music therapy examples were rough due to the elimination of many other variables that may influence a therapist's decision, the four heuristics of decision makers (Kellogg, 1995) were presented with the intent of providing a plausible explanation for music therapy.

Decision research

In an attempt to explore this mental activity, decision-making research investigates how to go about the decision-making process optimally. It was originally done in the area of mathematics as a probability estimation of the best case (Kellogg, 1995). However, decision-making has also been a popular research topic in many fields, such as psychology, economics, politics, medicine, and so on, while creating gigantic implications for people's real lives. Regarding research methodology in decision research, there are mainly two approaches: normative and descriptive (Bell, Raïffa,& Tversky, 1988; Harte & Koele, 1997). First of all, the research from the normative decision theory aims to examine rational persons' ideal decisions by relying on axiomatic rules for maximized outcomes. As an example of normative decision-making, regardless of their ability, experience or personality and their music therapy clients or

given clinical situations, music therapists are expected to make the best decision in terms of probability. This is on the assumption that they are knowledgeable of the optimal decision. They should follow the therapeutic method, which has been identified as the most statistically effective, or should use the musical intervention, which was successful for the client in a case study that was done by a very experienced therapist. Despite its explicit explanation of the rational decision and its role of setting standards for decision-making, it is obvious that individuals' decisions in reality do not comply with these norms or paragons all the time (Evans & Over, 1996). Therefore, normative research approaches do not seem to fit probing clinician's decision-making process in real practice in which they often need to make subjective decisions to satisfy individualized therapeutic goals in the given context.

On the other hand, decision research using the descriptive approach is focused on the structure or process of decision-making. Specifically, in that the present research aims to investigate which information music therapists consider when making musical decisions and how they process the considered information to reach a decision, it is more relevant to process tracing research dealing with multiattribute evaluation situations. This is a type of descriptive decision research that monitors cognitive information processing (Harte & Koele, 1997).

Process tracing research and verbal protocol

The present study shares common ground with process tracing research that particularly employs verbal protocol techniques, in terms of the focus of investigation, research method, and further research function. First, to discuss the investigative focus, the aims of process tracing research are reiterated in this section in order to contrast them to those of structural modeling, which is another approach in descriptive decision research. Payne (1976) introduced process

tracing methods from the necessity of developing a new approach that can provide insights into decision makers' cognitive process in actual decision-making situations. He discussed the limitation of linear, structural models of decision-making, the main focus of which is to describe a linear relationship between information inputs and decision outcomes. He, then, examined information processing strategies—specifically, the number of available alternatives and the number of dimensions of information available—when research participants chose an apartment building (Payne, 1976).

In the seminal process tracing research (Payne, 1976), decision-making was dealt with not just as a mathematical judgment, which can be predicted by focusing on the things that are highly valued by decision makers, but as the problem solving process of a human in which decision makers' psychological processing works with great influence. That is, process tracing approaches probe the "pre-decisional behavior," which encompasses what information decision makers have, how they acquire the information, and how they process the information to reach final decisions (Payne, Braunstein, & Carroll, 1978). Although tracking the decision process in research may yield extensive, and some irrelevant, data and although inconsistent decision-making may be observed, process tracing is considered an empirical, realistic approach, which would shed light on the human decision-making process in doing complicate tasks in actual situations (Harte & Koele, 1995). In this regard, the focus of the present research, which aims to investigate possible influences on and processes of decision-making in clinical situations, conforms to that of process tracing research. Additionally, it should be noted that process tracing methods and structural models, which many researchers have reviewed and examined, have been considered to supplement each other since each provides different, valuable information about the decision process (Ford et al, 1989; Harte & Koele, 1995; Svenson, 1996).

Second, methodologically, the present research employs verbal protocol analysis, which is one of the major process tracing techniques. In his research, Payne (1976) used the two methods of verbal protocol analysis and the information board in order to examine research participants' strategies when making preferential choices. The information board, which is a structured data collection method used in process tracing research, displays the matrix of alternatives and the dimensions of attributes considered in decision-making. Through examining the chosen information cards on the board and the sequence of the cards—this technique has been developed for computerized programs—a researcher attempts to identify research participants' decision-making strategies (Crozier & Ranyard, 1997, p. 9).

The verbal protocol analysis, which is used for the present research, is a technique frequently used in qualitative inquiries. It is conducted by asking research participants to share how they go about doing given tasks and leads to holistic, qualitative descriptions of the participants' thinking process based on the rich verbal data collected. In process tracing research, concurrent Think Aloud Protocols (TAPs), introduced by Ericsson and Simon (1980, 1993) are intended to decrease possible divergences between the strategies used and the subsequent verbal reports on them (Crozier & Ranyard, 1997, p. 9). Retrospective Think Aloud Protocols (TAPs) in which research participants share afterwards their thinking process during decision-making may circumvent research participants' aforementioned divergence, namely conscious or unconscious changes in verbalizing their decision-making process (Harte & Koele, 1997, p. 23). Since certain kinds of decision-making may not be tracked instrumentally, such as professional decisions in real clinical situations, it is impossible to obtain decision-makers' cognitive process concurrently in the given situations. In terms of the detailed investigation of complicated tasks and in terms of

the practicability of the investigation, the present study uses a verbal protocol technique: retrospective Think Aloud Protocols.

Last, the research functions of process tracing approaches are in line with the aimed functions of the present study and future study plans. Svenson (1996) stated that process approaches lead to the occurrence or development of hypotheses or theories regarding decision-making and the hypotheses or theories can be tested through another process tracing research or structural approach (Svenson, 1996, p. 252). In this sense, the data collected through tracking the research participants' mental processing in the study would yield some theoretical bases regarding music therapy professionals' musical decision-making and would examine the research assumptions, namely the relations between music therapists' listening and subsequent musical decisions. Following the general path of developing knowledge, as in Svenson (1996), the results of the study may be further explored in more structured or quantitative research-oriented research methods, for example process tracing using information boards or quantitative experiments.

Summary

To help readers understand the research topic, the decision-making of music therapists, this section provided general concepts of decision making, types of decisions, and types of decision-making strategies. Additionally, major research approaches (e.g., normative and descriptive approaches) to investigate decision making were briefly presented referring to literature regarding decision research methodology in other fields. In particular, a type of descriptive research approach, process tracing research, was discussed with respect to its

suitability to this research in terms of the focus on the process of decision-making, research methodology, and research function.

Musical decision-making in music therapy

There has been little research directly investigating music therapists' clinical decision-making, and needless to say, almost none about music therapists' musical decision-making process. What little literature there is includes information regarding guidelines for the use of musical interventions in specific approaches and some authors' remarks regarding therapists' awareness of their own musical decision-making. Although the *foci* of the literature were not decision-making processes and although deciding musical interventions is not the only situation that requires therapists' musical decision-making, the relevant ideas from the literature are discussed in this section.

In her qualitative study, Amir (1999) investigated six experienced music therapists' perceptions about musical and verbal interventions and the use of these interventions. From her research findings, the definition of musical intervention based on the therapists' descriptions is:

> Musical intervention is an action by me, the therapist, coming out in a musical expression for the purpose of making a change in my client's inner being through changes in the music (the focus and direction of the music, the dynamic between the two players). Changes in my client's music are made either dynamically, harmonically, tonally, or rhythmically. I choose the musical intervention in a moment to moment flow of the session. It comes out intuitively and spontaneously from my inner music. It has intention and purpose, but it is not always known beforehand. The interventions come mainly in the form of song writing, improvisation, and the use of recorded music (Amir, 1999, p. 153).

Through looking into this definition, we can get some clues about therapists' musical decision-making. The definition indicates that these therapists are well aware that deciding and

implementing musical interventions are their own action directed by their internal thinking process. As possible influences on their musical decision-making, the therapists seem to consider their awareness of clinical purposes and their spontaneous and intuitive action at the moment.

In particular, Amir's research partially investigating the factors that affect music therapists' decision-making concerning musical intervention is invaluable literature in terms of its relevance to the topic of the present research. Although contributing factors to the therapists' decisions regarding musical and verbal intervention are combined, the findings of Amir's research are presented below as they appeared in her research.

1. Therapist's theoretical orientations, perceptions, and meanings attached to music and words
    - Music can be interpreted
    - Music cannot be interpreted
2. Therapist's own experiences with words and music
    - In life
    - In her own therapy
    - As a professional
3. Therapist's knowledge of client
    - Client's age
    - Client's population
    - Client's needs
    - Client's responses to specific interventions
    - Therapist's and client's goals
4. Therapist's professional knowledge of therapeutic process

- Level, depth of treatment
- Stage of therapy
- Kind of therapy (individual or group MT, GIM)

5. Therapist's counter-transference issues
    - Interventions that are influenced by therapist's own issues
    - Interventions that are influenced by client's issues
6. Therapist's belief in music and its therapeutic power
7. Therapist's belief that it is her role to use music
8. Therapist' musical ability
9. Therapist's training in verbal psychotherapy

(Amir, 1999, p. 168)

The factors for therapists' decision-making regarding musical intervention from the list are only discussed here within the three categories of philosophical/theoretical, musical, and clinical/client-focused areas. First of all, a therapist's philosophical/theoretical foundations appear to be critical factors that influence their musical decision-making. A therapist's theoretical orientations, perceptions, and meanings attached to music on the list may be used as his/her theoretical lens through which he/she considers or employs music in clinical situations. A therapist's professional knowledge of the levels of treatment, therapeutic stages, and differences among therapeutic approaches, which might have been gained through his/her professional experience, may bring out his/her insightful, intuitive musical decisions in given clinical situations as the therapists mentioned in the definition above. Furthermore, a therapist's belief in music and its therapeutic power, a therapist's belief about his/her role in using music, and a therapist's own music therapy experience could be strong influences on the therapist's musical

experiences and actions in his/her music therapy practice, and specifically on his/her decision-making concerning musical interventions.

Second, in the musical area, a therapist's experiences with music in his/her life and a therapist's musical ability appear to influence his/her musical decisions. For example, decisions concerning what music activity to use, what musical instrument to use, and what level of musical complexity to employ necessitate a therapist's practical considerations of his/her own previous experiences and musical abilities such as aural skills and performing abilities on specific musical instruments.

Last, a therapist's knowledge of a client and a therapist's counter-transfer issues are discussed in the clinical or client-focused area. Along with knowing a client's background information including his/her therapeutic needs, a therapist's awareness of a client's response to specific interventions—in this case, musical interventions—and a therapist' consideration of clinical goals for the client also affect the therapist's decisions concerning musical intervention, which is the primary therapeutic tool in music therapy. It is notable that the therapists in Amir's research conceive of their counter-transfer issues as an influence on their decisions regarding therapeutic interventions, including musical interventions—some therapists who do not adopt psychodynamics in their music therapy practice may give less credit to the counter-transfer issues.

In that Amir (1999) directly asked music therapists to share their perceptions of possible factors for their clinical decision-making, her research is conceptually quite close to multi-attribute decision research—although her research is not typical multi-attribute decision research. In that a sort of musical decision was dealt with, specifically deciding whether to use musical interventions at a given point, Amir's research provides invaluable, relevant information for the

present research although her research focus was not only on musical interventions but also on verbal interventions. Moreover, in that she developed global themes over the perceptions of six therapists who use different therapeutic approaches—Nordoff-Robbins Music Therapy, Analytic Music Therapy, Creative Music Therapy, and Guided Imagery and Music—her research also shares commonalities with this study.

A model of music therapists' clinical music listening

Bae (2010a) made an argument for the necessity of philosophical deliberation and theory development about music therapists' music listening in music therapy practice, based on which they may make related clinical decisions, while also proposing an analytic model of music therapist's clinical music listening. Her model-development started from the following question: despite individual music therapists' different perceptions and appraisal of music in their music therapy practice, is there a general mode in which they listen to music and a common protocol through which they make judgments or decisions about the music? In particular, she intended to discuss the link between music therapists' music listening for clinical purposes and their judgment or decision about what they listened to. The model was also intended to comprehensively explain the phenomenon across various music therapy approaches.

As the diagram demonstrates (Figure 1), music therapists' clinical music listening is a dynamic process of blending many plausible events and mental properties regarding music listening and of distilling the most proper musical decisions. The model consists of two major parts: (1) music therapists' listening experiences and (2) music therapists' decision-making based on their listening experiences. Using the EAR listening framework (Bae, 2009), she classified therapists' music listening experiences into (1) existential, (2) auditory, and (3) reflective listening, which

are located at the upper part of the model. To brief the components of each type of a therapist's music listening experience, existential listening contains (1) physiological and other bodily responses to music, (2) personal impressions of music including emotional feeling as well as related memory and thought, and (3) non-ordinary and intuitive listening experiences. Auditory listening includes (1) a therapist's aural recognition of physical properties of music at the micro level and (2) collative properties of music at the macro level. Lastly, reflective listening encompasses (1) a therapist's empathetic music listening, (2) awareness of specific listening purposes, and (3) critical and interpretive music listening. (See the section on various music listening experiences on page 16 for details).

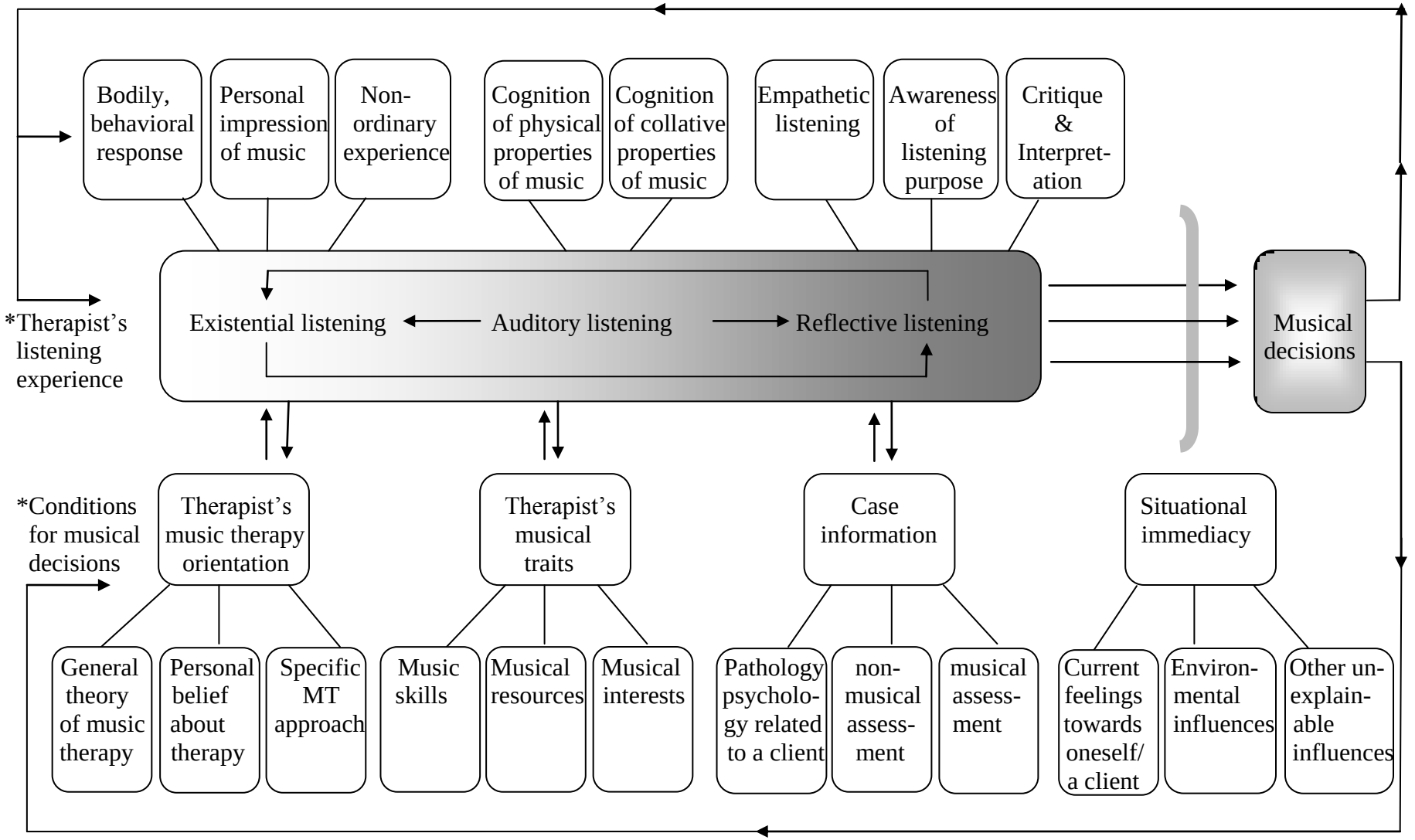

Figure 1. Music Therapists' Clinical Music Listening (Bae, 2010a)

At the bottom of the diagram are located four contributing factors for a therapist's decision-making: (1) a therapist's theoretical orientation, (2) a therapist's musical traits, (3) information about the clinical case, and (4) situational immediacy. First, a therapist's theoretical orientation encompasses (1) his/her knowledge of general theory in music therapy, (2) personal belief about therapy and music therapy that might have been established through his/her own therapy or learning experience, (3) and the specific music therapy approach and method they have learned or used. Second, (1) a therapist's musical ability such as aural and music performing skills, (2) musical resources, which he/she has used and piled up, for example, song repertoire, activity plans and music recordings, and (3) musical interests, for example in types of musical instruments, genres, and structures constitute a therapist's musical traits. Third, information about the clinical case means (1) the pathology and psychology related to a client, (2) a client's non-musical characteristics, for instance a personality and communication style, and (3) a client's musical ability and preference. Last, situational immediacy is the one that may elucidate the parts that are not able to be explained by other conditions. It consists of (1) a therapist's feelings towards oneself/a client, which may be identified as counter-transference, (2) environmental influences, for example, the presence of another person, noise level outside of a clinic room, availability and quality of musical instruments, and (3) other unexplainable influences, which may be understood as the therapist's intuition, unconscious, or spirituality.

These two parts of the model, therapists' listening experiences and contributors for decision-making, are inter-related. The mutual arrows between each condition for musical decisions and each type of music listening represent that a therapist's music therapy orientation, musical traits, and case information influence the therapist's listening experiences in existential, auditory, and reflective areas; conversely, a therapist's experience in the three music listening

areas contribute to forming the therapist's music therapy orientation, musical traits, and case information. These components of music listening and conditions for musical decisions all work together and proceed towards the right side of the diagram. Then, a music therapist's decision-making passes through situational immediacy, which is like a filter, to make the best decision in the moment, and ends up reaching a musical decision. Furthermore, the arrows from the final musical decision go back to a therapist's listening experience and conditions for musical decisions on the left-most side. In other words, a musical decision, which was made in a clinical situation, affects the therapist's next music listening experience and the following musical decisions, circulating continuously throughout the therapist's music therapy practice

The philosophical discussion and developed model of music therapists' clinical music listening have established the theoretical assumptions of the present research. On the assumption that there would be a linkage between therapists' listening and musical decision-making, the present research investigates how the linkage is established in each therapist. The components of the model and other details in the model also play the role of preliminary information to make the investigation process clearer and of food for thought to draw in richer information throughout the process.

Summary

Because research regarding music therapists' musical decision making is lacking, Amir's qualitative study provides valuable information about what the experienced music therapists consider as contributors to their use of musical interventions—although the research investigated their perceptions of both verbal and musical interventions (Amir, 1999). My philosophical study

proposing the model of music therapists' clinical music listening (Bae, 2010a) is used as the theoretical framework of this research as well as a practical guideline.

CHAPTER III

METHOD

Research Design

Natural inquiry and qualitative research

For this research project investigating music therapists' music listening and musical decision making, qualitative research methods were employed from the perspective of naturalistic inquiry. Utilizing Creswell's categories of the philosophical assumptions of naturalistic inquiries—ontology, epistemology, axiology, rhetoric, and methodology (Creswell, 2007)—I will discuss the rationale for using a qualitative approach for this study.

First, in terms of ontology, this study explores a music therapy phenomenon, in which there exists a fullness of intricate events, and I observe actual music therapy sessions in order to more fully understand the complexity of these events. Indeed, the research assumption lies in my awareness that the musical phenomenon is not a clear-cut matter, the mechanism or causality of the phenomenon cannot be easily clarified, and that the reality I would find through this research activity would be one of the possible multiple realities (Creswell, 2007). Following Guba's statement (1981, p. 77), my qualitative inquiry intends to develop "idiographic knowledge" concentrating on similarities and differences among music therapists. Thus, I neither conduct the research with the positivistic idea of confirming or rejecting a preset hypothesis nor attempt to draw statistical significance to support my research efforts.

Second, regarding epistemology, the way I explore and understand the phenomenon is to involve myself actively in the phenomenon by direct interactions with music therapists in their music therapy practice, not to conduct the research from a distant, omniscient perspective. I understand that the researcher is strongly interrelated with the collected data and research outcomes, and also that an optimal distance between the researcher and the phenomenon being studied is necessary, along with an awareness of the influence of the relationship, which exists despite his/her effort to keep the optimal distance (Guba, 1981). Regarding the epistemological soundness of the study, I shall discuss my stance in the research and employed research techniques in relation to this matter in the later section on trustworthiness.

Third, in terms of axiology, which is related to value judgment, the researcher who implements qualitative research should understand that his/her values are instilled in the research (Creswell, 2007). From setting a research topic through writing a research report and maintaining an appropriate position even after completing the research, the researcher's professional efforts to be ethical and to use relevant qualitative research techniques are essential. In this regard, I acknowledge the "value-laden nature" of my study (Creswell, 2007), and I attentively tried to evaluate possible biases throughout the research. Specific strategies are stated in the ethical considerations section.

Fourth, the language of qualitative research is enormously important in that a researcher's language is a manifestation of his/her research skills, understanding of the collected data, writing abilities, and stance towards the investigated phenomenon and research participants. Actively involving myself in the research process, I use the first-person point of view, and I include research participants' language in the research report without judgmental filtering as an effort to maintain their voices intact (as recommended by Patton, 2002). The analyzed data from various

perspectives are recounted through my language in the use of quotation or metaphor throughout the research process. Additionally, this study calls for the use of the vocabularies that are more agreeably used in qualitative research, for example, Lincoln and Guba's use of "credibility," "transferability," "dependability," and "confirmability," instead of corresponding quantitative terms such as reliability, validity, and so on (Creswell, 2007, pp. 18).

Last, in terms of methodology, the process of inductive reasoning is the scaffold of the qualitative research process. That is, from a researcher's immersion in the specifics and details, he/she finds patterns, themes, and relationships, and then appraises and confirms the findings (Patton, 2002). Following this logic, research is guided by emerging research designs until the researcher recognizes that the investigation is completed in terms of time, resources and logistics (Guba, 1981, p. 79). In this sense, I assume that the design and process of my research have changed over time in response to conceptual and procedural needs.

For a discussion of the suitability of qualitative inquiry for my research, I refer to the conditions that Creswell (2007) suggested under which qualitative research would probably be used. According to him, qualitative inquiry is used: (1) when an issue or problem that is critical needs to be explored, (2) when an in-depth and detailed understanding of an issue is necessary, (3) when a researcher wants to deconstruct power relationships, (4) when a researcher's writing should be more literary and flexible to present data and findings genuinely and aesthetically, (5) when an understanding of participants' context or setting is important, (6) when a researcher wants to verify the mechanisms or linkages in theories or models, following a quantitative study, (7) when a researcher develops theories based on partial or preliminary models, or, (8) when quantitative approach and statistical techniques do not address the investigated issue (Creswell, 2007, pp. 39-41).

The present study fits Creswell's (2007) conception of qualitative research. First of all, the research investigates a critical but unexplored topic, namely music therapists' musical decision-making. Second, music therapists' music listening and related internal thinking processes cannot be understood at a superficial level but necessitate a profound understanding gained by directly listening to their real experiences and thoughts. Third, although it may be slightly different from the power relationship Creswell might intend, studying this music therapy phenomenon may bring about a break from the determined, typical conception of the ways of making clinical decisions in each music therapy approach examined. Through looking into their own decision-making processes, music therapists may be able to have a sound skepticism about existing notions, and take on a more active, creative role in making clinical decisions in their music therapy practices.

Fourth, as a reporter of the research I believe that the investigated musical phenomenon in lived clinical situations should be illustrated in an idiosyncratic, literary language that is adventurous and non-technical. Fifth, without a close investigation and adequate understanding of greatly diverse clinical contexts, we are not able to simply explain how musical decisions in practice are made. Sixth, the research has a possibility for theory development since it is conducted based on pre-developed theoretical assumptions, and the research findings are anticipated to add more information to them. Lastly and straightforwardly, the research topic does not fit into the quantitative research paradigm and research techniques. To reject a null hypothesis on whether therapists use the same decision-making strategies, or to calculate numbers of responses to preset questions on the decision-making process, for example, would not be able to show a holistic, comprehensive picture of the phenomenon.

From a perspective inside the music therapy profession, the appropriateness of the philosophical framework of naturalistic inquiries for illustrating and elucidating music therapy and the value of employing qualitative research approaches were discussed by previous researchers (Amir, 1993; Aigen, 1993, 1996; Bruscia, 1995; Smeijsters, 1996; Stige, 2002). The awareness of qualitative inquiry seems to be rising in the music therapy discourse, and an increasing amount of published qualitative research is extant (Aigen, 2008). Regarding qualitative clinical research, one's dual position as both a researcher and clinician has been considered as an advantage, in that the music therapist can see his/her client's music therapy process intuitively. Furthermore, through the research process of probing clients' and others' perceptions, the therapist could find what he/she might have missed and, thusly, would have a better comprehension of music therapy (Amir, 1993; Bruscia, 1995).

To emphasize the value of pluralistic paradigms in music therapy approaches, Aldridge argued for case study research through which music therapists can maintain their clinical practices, namely including a reality of music therapy in the form of each clinical case's story—although his thesis included quantitative case study research as well (Aldridge, 2005, p. 20). Unlike such a general focus on *clients'* experiences, more recently qualitative research has investigated *music therapists'* experiences, although the number of studies is still very small (e.g., Amir, 1999; Grocke, 1999 ; Muller, 2008). Above has been the grounds for the present research in terms of the research topic. Taking all the discussions of the qualitative research rationales and the environment of music therapy qualitative research into account, I believe that naturalistic inquiry paradigms and qualitative research methods are suitable for researching music therapists' listening and their subsequent decision-making processes.

Multiple case-study research design

The present research uses a case study design, particularly multiple case-study design. Yin (2003, 2009) suggested three conditions for the use of case-study research: "types of research questions," "extent of control over behavioral events," and "the degree of focus on contemporary events" (Yin, 2003, pp. 5-9). First, the research questions of the present research include "how" questions, designed to scrutinize the relationship between therapists' listening experiences in music therapy practice and related decision-making. As Yin stated, "how" questions necessitate a probe of operational linkages over time (p. 6) and thus, can be dealt with in the form of a case study or a field experiment (p. 7). Second, as a researcher, I can neither control the phenomena of music therapy practice nor manipulate therapists' listening and decision-making processes. Likewise, when there is little or no possibility of controlling the research situation, a case study is an appropriate approach to inquiry (p. 7). Last, I intend to look closely into a contemporary phenomenon—therapists' musical decision-making—by visiting real clinical situations and listening to the therapists' voices in person. In this respect, my research meets Yin's three criteria for potential case studies.

In his definition of "case," Creswell (2007) stated that a case study is an exploration of "a bounded system" and that a case is bounded by settings or contexts (Creswell, 2007, p. 73). The cases for the present research are multiply bounded by different music therapy orientations, by the therapists' whereabouts, and by the various data collection times. Regarding multiple case-study design, Yin (2003) discussed the possible advantages of doing multiple case-study research, including the collection of convincing evidence and a robust research outcome. He articulated that a multiple case-study is a set of replication studies whose research population, procedures, or analysis can be changed; it is not a sampling logic of adding another case sampled from the

population (Yin, 2003, p. 5). Therefore, as a researcher, I need to understand the rationale and logistics of multiple case-study research clearly and be able to deal with the likely massive amount of data, which were collected from the three independent cases.

The researcher's role

As a human research instrument for a qualitative inquiry (Guba, 1981), I have been aware of the importance of my having a sound stance in the research process (philosophically, theoretically, methodologically, and ethically) and also of having addressed my feelings about my responsibilities for the trustworthiness and quality of the research. Since qualitative research is basically a form of interpretative inquiry, a researcher's theoretical, procedural, and personal lenses are significant influences on the research process and outcomes. In this section, I discuss my diverse roles in the multiple case-study using Stake's categories (1995). Then, in order to project my stance and evaluate possible biases, I take Moustakas's tactic of bracketing out a researcher's own experience or knowledge and presumptions (1994), which is a research technique often highlighted in phenomenological research.

Stake (1995) listed possible roles of case-study researchers: teacher, participant observer, interviewer, reader, storyteller, advocate, artist, counselor, evaluator, consultant, and others. Throughout the research process, the required roles might be different, and it is a researcher's job to decide upon how much emphasis to give each role in the given procedure (p. 91). Through this research, I am eager to inform readers about an essential but ignored issue—music therapists' musical decision-making—and thus, my roles might be deemed as an advocate and teacher. According to Stake, the role of teacher does not mean directly giving a lecture through a study,

but providing readers with learning opportunities to access valuable information (Stake, 1995, p. 92).

In research logistics, I would be an observer, interviewer, and reader. I will observe music therapists' music therapy sessions, communicate verbally with the therapists about their perceptions of the phenomena, and scrutinize their previously published writings, which may give me related information. Furthermore, as the research proceeds and my grasp of the phenomena improves, I will examine the therapists' decision-making process demonstrated in the collected data and present readers with the essence and mechanism of their musical decision-making. This is the role of evaluator and consultant that Stake mentioned (1995).

With respect to the impact of a researcher's role, Moustakas (1994) stated that through laying aside a researcher's own experience with the examined phenomenon and through acknowledging possible biases, the researcher may be able to suspend his/her personal judgment and to perceive the phenomenon freshly (pp. 85-87). In this respect, I reflect on three points: my interests and experiences in music listening in music therapy, the emotional burden of working on all three major therapeutic approaches, and my linguistic limits.

First, musical phenomena in music therapy have been my main interest in my clinical work and research: specifically, music listening. As a certified clinician of the Bonny Method of Guided Imagery and Music, which is a receptive music therapy, I have been intensely exposed to music listening situations through my BMGIM training and professional clinical practice. Indeed, I have been enthusiastic about developing systematic music listening training or a music analysis method: for example, EAR listening training for music therapy students (Bae, 2009) and a GIM music analysis method (Bae, 2010b). Such engagement in music listening has led me to the present research, while establishing theoretical grounds and experiential guides for the research.

However, to think in reverse, due to my devotion to music listening, I might have developed an assumption that music therapists should attend to their music listening for their successful practice and that what they listen to in practice would be very influential on their following musical decisions.

Second, in an extension of the first possible bias, I expect that I may undergo difficulties in elucidating the investigated phenomenon over the three music therapy approaches with equal profundity. To disclose my personal music therapy orientations, I have had a variety of educational and professional backgrounds and have transferred them into my music therapy practice and research, being eclectic in employing the three approaches: improvisational, receptive, and cognitive behavioral music therapy. First of all, since I was a piano performance major in my bachelor's degree, I have felt a strong bond with piano and have often improvised on piano with my music therapy clients, although I have not been trained in a standard protocol of clinical improvisation, such as Creative Music Therapy or Analytical Music Therapy. Regarding receptive music therapy, I have been a BMGIM practitioner as mentioned above. In terms of cognitive behavioral music therapy, I was trained with a strong emphasis on cognitive behavioral music therapy in my master's program. Additionally, due to my serious curiosity about clinical neurology/cognitive science, I took Neurologic Music Therapy (NMT) training. Notwithstanding that I have tried to widen the scope of my music therapy practice and research, it would be certainly abstruse and demanding to fairly depict and explain the phenomenon in all three approaches: improvisational, receptive, and cognitive behavioral music therapy. Such concern about my responsibility as a researcher seems to be shared by Aigen (1993, p. 22). His concern is the common, personal burden, which he says qualitative researchers should overcome. Another philosophical support, which might justify my concern, is Glasser's distinction between

traditional notions of scholarship and qualitative data analysis in a grounded theory research context (Glasser, 1978, pp. 11-12). Unlike a typical scholarly argument that may intend to accept, correct, or reject ideas in a finite, doctrinaire tradition, a qualitative analyst's work is to generate ideas while approaching the ideas from various, open perspectives. Glasser stated "the most parsimonious theory of greatest scope" may begin with "gaps, omissions, misses or holes," and as a researcher works the emergent problems continuously, he/she becomes matured (p. 10). Thus, rather than being apologetic about what he/she may not cover, a researcher should be vigilant to be theoretically sensitive by having few predetermined ideas, scrutinizing literature in-depth, and logically transcending the collected data to a body of theory he/she develops (pp. 2-3).

Third, there might be a complication in processing the research due to my language. I am a non-native English speaker who has spoken English for over three years since I moved to the U.S. for my Ph.D. studies. Throughout my stay in my doctoral program, I have honed my formal language to be acceptable in scholarly venues as well as tried to get a sense for people's informal language in lived clinical situations by observing and supervising music therapy practica. Stern (2010) wrote—in a grounded theory research context—that "researchers need to focus on the accuracy of their discovered truth, rather than the less important what-did-they-say-exactly" based on his experience in working with Thai students with limited English skills (Stern, 2010, p. 119).

As desired skills for a good case-study researcher, Yin (2009) suggested good knowledge about the phenomenon, being sensitive to unexpected issues, having good research questions, being a good listener, and being adaptable and flexible throughout the research process. None of the above can be assured at the time that I embark on a qualitative inquiry. However, just as

Moustakas stated (1994), as far as I am aware of the merit and demerit of my relationships with the investigated phenomenon and my research and as far as I try to improve the required research skills and abilities, I believe that my research will evolve throughout the process toward a better understanding of music therapists' listening and musical decision-making.

Participants

The research participants in the study were three accomplished music therapists. As master clinicians, they provided rich information about therapists' perception on their musical decision-making process and demonstrated a highly sophisticated level of thinking that might not have been present in inexperienced therapists. For this reason, I purposefully recruited three therapists who had extensive clinical experience and had built strong reputations in terms of their clinical work. This sampling strategy employs critical case sampling in that the three different cases are especially important in the scheme of researching the phenomenon (Patton, 2002, p. 236) and have potential for maximum application of the collected information to other cases (Creswell, 2007, p. 127).

In particular, having three experts from the three major approaches (improvisational, receptive, and cognitive behavioral music therapy) is based on the theoretical assumptions of my research, which is a multiple case-study. Along with the possibility of compatibility across the cases, it was assumed that each case might demonstrate a distinct approach to musical decision-making according to the therapist's methodological background and beliefs. This assumption allowed the investigation to develop a body of substantial knowledge, and this theoretical sampling was anticipated to contribute to possible theory development (Strauss & Corbin, 1990). At the beginning stage of research when I recruited the participants, it had not been decided

which aspects of the data would be selected and how in-depth information would be used for developing codes and theories (See the theoretical sampling of Glasser and Strauss, 1967). However, this theoretical sampling strategy for participant recruitment was a fundamental theoretical ground for further data analysis and theory generation.

For participant recruitment, I consulted with professional music therapists and university faculty in order to find candidates who would be suitable for my research. Based on this consultation and my experience of the candidates' conference presentations and published writings, I contacted the three participants via email and met in person with them to solicit their participation. In the process, I needed to clarify whether the three music therapists identified their major music therapy approach as improvisational, receptive, or cognitive behavioral music therapy, or at least whether they acknowledged the strong influence of one of these approaches on their clinical practice.

The research consent process was adjusted for each case as the research participants worked for different institutions and had slightly different contracts with clients regarding the release of video/audio. The research approval I obtained from the Institutional Review Board of Michigan State University and the consent form I developed were used as a common protocol for interviewing all three therapists. In observing their music therapy sessions or their videotaped sessions, I did not need additional institutional approval for receptive and improvisational music therapy cases. However, for the cognitive behavioral approach, I went through the process of obtaining additional institutional permission from the participating therapist's school district to observe her work with the students.

Following are brief profiles of the participating music therapists. The improvisational music therapist possesses a professional credential of Nordoff-Robbins Music Therapy (NRMT),

which is one of the representative improvisational music therapies. She holds a master's degree in music therapy and clearly identified NRMT as her major music therapy approach. Her clinical experience in music therapy is about 30 years, and she has served as a certified NRMT for over 20 years. She currently works at a music therapy center, which is located in the northeastern part of the United States, as a full-time music therapist, music therapy supervisor, and clinical training coordinator. She also has been a prolific researcher who has published studies and written music related to Nordoff-Robbins Music Therapy.

For the receptive music therapy approach in the research, I recruited a certified Guided Imagery and Music (GIM) therapist, namely a Fellow of the Association for Music and Imagery (FAMI). The participant for receptive music therapy also holds her master's degree in music therapy and has over 30 years of clinical experience in music therapy. With over 20 years of clinical experience in GIM, she has used her expertise in GIM for educating GIM trainees, general music therapy students, and other therapeutic professionals. Currently, she teaches and supervises music therapy students at a university in the Great Lakes region while continuing her clinical practice as a therapist. As has she worked in diverse music therapy settings where she may need other approaches like active music making and she claims that her music therapy approach is eclectic rather than identifying GIM as her major approach, the data collection focused more on her musical decision making in her Guided Imagery and Music practice.

In the case of cognitive behavioral music therapy, a specific professional credential was not required for the research. Instead, the participant for the approach was expected to have a strong background, training, and experience in cognitive behavioral music therapy. The music therapist who was recruited agreed with the statement that her major therapeutic approach was cognitive behavioral. She has a master's degree in music therapy as well and has about 27 years

of clinical experience in music therapy. She has worked with children and young adults with special needs as a full time music therapist at a school district in the Great Lakes region for about 25 years. Her expertise includes music therapy assessment and special education laws, and she has published related writings.

Research procedure

Data collection schedules were set up with each music therapist who agreed to participate in the study. Written consent of therapists' research participation and my observation of their clinical practice were obtained prior to data collection. The research protocol described below was implemented independently for each case. The length of sessions differed depending on each therapist's contract with each client. In the first meeting for data collection, I interviewed each therapist with an interview guide (See Appendix B), which is a list of key questions regarding how he/she generally goes about his/her musical decision-making. The interviews were audio-taped using a Samsung MP 3 voice-recorder (YP-U2), and after the meeting, I transcribed them while listening to the recording.

Then, I observed a music therapy session of each therapist with the written permission of either the client or his/her guardian. The music therapy sessions were video-taped using a video camera (Sony Digital Camcorder DCRSX44). I was not in the room with the client and therapist but in an observation room, taking field notes (see Appendix C) while watching the on-going session. In the cases of two participants, I agreed to use their videotaped sessions instead of watching their session at the site. When working with these research participants, my session observations were made by watching DVDs or video files stored on a thumb drive that they gave me so I could watch the videos at my convenience.

After the session observation, I conducted a review session using Think-Aloud Protocol, which is a verbal reporting of one's thinking process after doing specific tasks (Ericsson & Simon, 1993). While watching his/her video-taped music therapy session, I asked each therapist about how and why she had made such musical decisions in the given clinical situations. These think-aloud sessions were audio-taped. Following the same procedure, another music therapy session of each therapist was observed, which was followed by another Think-Aloud Protocol.

The last piece of data collected was a final interview with each therapist, which was anticipated to be a more in-depth conversation with various *foci*. In the last interview meeting, each therapist and I talked about his/her music listening and musical decision-making again by reviewing the previous interview, music therapy sessions, Think Aloud Protocols, and his/her previously documented writings.

For data analysis, I organized, classified, and edited the collected raw data to a manageable amount and accessible form. First, the audio-taped interviews and video-taped music therapy sessions were transferred to the qualitative analysis software HyperRESEARCH ™. Using the computer program, I transcribed all narratives and proceed with coding and theme development processes.

I also wrote self-reflective and analytic memos throughout the research—namely "memoing," which is a research technique often used in grounded theory research (Strauss & Corbin, 1990). Through a data triangulation process using various theoretical and practical standpoints and using the research techniques mentioned above, I analyzed the collected data and constructed research findings.

Data Collection

Three types of data were collected: transcribed data (verbatim transcriptions of individual interviews, music therapy sessions, and Think Aloud Protocols), researcher-generated data (researcher's memos and thick descriptions), and multi-media data (video files of music therapy sessions and audio files of participants' narratives).

Transcribed data

The main data for the research were the three music therapists' narratives, which were collected through two individual interviews with each therapist, two music therapy sessions of each therapist, and two Think Aloud Protocols with each therapist. First, for the initial interview, I had an interview guide, which was developed from the research questions and consisted of specific, subdivided items (see Appendix B). Although all items in the interview guide were dealt with in the interview, the items that a therapist wanted to emphasize or the items I thought of as important took more time than others.

Second, the use of the Think-Aloud Protocol (TAP) in the review sessions helped music therapists to verbalize their mental processes such as perception, cognitive thinking, feeling and opinion related to their musical decision-making in clinical situations. TAP has been used in psychology, education, linguistics, and industry, as a valid resource for revealing participants' internal cognitive processes (Ericsson & Simon, 1993). Particularly, the protocol I used in the research is Retrospective Think-Aloud, which is often used when testing the usability of technology, and in which participants are asked about their performance after completing their tasks (Van Den Haak, De Jong & Schellens, 2003). Furthermore, therapists' TAPs in the study were facilitated by visual stimuli, their videotaped music therapy sessions, along with my

specific questions about their perception, cognitive thinking, feeling, and reflection. The TAP questions for each therapist were set up based upon my observations of the therapist's musical decisions and each therapist's own concerns or opinions on his/her musical decision-making process.

Final interviews with each therapist basically were basically an extension of the initial interviews; however, as the research evolved, the dialogues in the final interviews were richer and more in-depth than the initial interviews. By bringing to the last interview the specific information that was gathered from the initial interview, therapy sessions, and Think Aloud Protocols, I facilitated focused discussions about the logical link between what they listened to and their immediate decision-making. This differed from the initial interviews, which aimed to discover therapists' overall perception of their clinical music listening and their musical decision-making. Furthermore, I encouraged them to discuss the interview topic more comprehensively and conclusively at a personal level and field-wide level while sharing my theoretical model of music therapists' musical decision making, which has been the theoretical assumption of the research.

Researcher-generated data

The second data sources were researcher-generated and included researcher's memos and thick descriptions. My memos, which were taken throughout the research process, included my self-reflections on each therapist's musical decisions observed in clinical situations and on their narratives from interviews and Think Aloud Protocols (see Appendix E). They also included my analytic notes on each step of the research process from designing the research to writing

research findings, and this has contributed to developing an audit trail, which is a record of the sequential research process of a study. The memos were in the form of Microsoft Word files.

Another sort of researcher-generated data, thick description, was a rhetorical tool to produce verisimilitude of an observed scene, which is a qualitative inquiry method (Creswell, 2007, p. 194). Depending on a writer's intent, thick description may be a pure description of scenes with as little interpretation as possible or may have a certain focus, which may be somewhat interpretive. I described some clinical situations in which therapists appeared to make musical decisions and carry out the consequential interventions; such descriptions produced more data, and they contained my analysis of the videotaped sessions to some degree.

Multi-media data

The third data sources were multi-media data and included video files of each therapist's music therapy session and audio files of verbal interactions between research participants and me as a researcher. In particular, although they were turned into verbatim transcriptions, video files of therapists' music therapy sessions, which captured the therapists' decision-making contexts and the resultant actions, made for raw data that should be maintained, as well as still leaving me as a researcher some space for analysis and interpretation. The equipment for videotaping and audio-recording was a Sony Digital Camcorder (DCRSX44) and a Samsung MP 3 voice-recorder (YP-U2), respectively. The multi-media data were loaded in my laptop and external hard drive, which were password-protected.

Data analysis

Following a common approach to qualitative data analysis, the constant comparative method, which stems from grounded theory research (Glasser & Strauss, 1967), I identified events and incidents from the raw data and continuously compared them until themes or categories emerge. In order to do so, first of all, I transcribed all narratives from interviews, music therapy sessions and Think Aloud Protocols by using the computer software, HyperRESEARCH™. From the transcripts, I found patterned instances and critical single instances in each case. Then, I assigned these to the suitable code from the *a priori* model (e.g., physiological/bodily experience, affective experience, and non-ordinary/peak experience) and kept examining whether the instances fit with the assigned codes.

While proceeding with the data analysis, I took memos on the process and the winnowed data for each procedure. The evolving form of data from the initial raw data to a final set of themes was preserved in the forms of Microsoft Word files, establishing a chain of evidence (Yin, 2009).

Ethical considerations

This research process involves in-depth investigations of the research participants' thinking processes, which perhaps encompass their philosophies, knowledge, experiences, backgrounds, and individual characteristics as professional clinicians and individual persons. I have been well aware of the necessity of my neutrality or balance as a researcher. In the research, I neither intend to make judgments about their clinical practice or clinical decision making, nor discuss their merits or weaknesses. On the other hand, I try not to compliment their work just because they are accomplished, outstanding clinicians in the field or because I am more familiar

with or in favor of specific music therapy approaches or specific therapists. Throughout the whole research process, I made a conscious effort to be neutral and balanced, and I sometimes consulted with my professors about how my positions are demonstrated in this research report.

I also did not ignore, as I observed the music therapists' sessions with their clients, the clients' personal information and experiences in the sessions were exposed to me. Although the purpose of my observation was only to obtain lived information about the therapists' musical decisions in order to facilitate further discussions with them, the clients observed might feel that their music therapy experiences were going to be publicized or infringed upon by my presence. During my observations, I tried to minimize the possible interference, and when watching the videotaped sessions for data analysis, I also tried to be careful so that the sessions were kept confidential. As a procedural tactic, the clients were informed via written consent forms that their personal information from the sessions would not be seen by anyone, and after the data collection, I changed the clients' name to pseudonyms on the verbal data transcripts. This research report does not include any information that may identify the clients.

Strategies to ensure trustworthiness

Trustworthiness of qualitative research concerns the epistemological soundness of the research, in which a researcher and the research process and outcomes are naturally interrelated (see page 56). To put this another way, trustworthiness is a matter of the extent to which research findings can be trusted, and thus the extent to which an investigator or evaluator gives credit to the research (Patton, 2002) in terms of the accuracy and convincing power of the research.

In terms of the qualitative research logistics, trustworthiness could be related to a researcher's perceived methodological rigor in research procedures (Lincoln & Guba, 1986;

Patton, 2002), and I agree with this emphasis on methodological rigorousness. Regarding specific methodological tactics, first of all, Guba and Lincoln (1982) suggested research techniques to address the aforementioned four components of trustworthiness: (1) a researcher's prolonged engagement at an investigation site, persistent observation, peer debriefing, and data triangulation for credibility, (2) theoretical or purposive sampling, member checks, and thick description for transferability, (3) overlapped methods, research replication, and audit trail for dependability, and (4) data triangulation and confirmability audit for confirmability (Guba & Lincoln, 1982).

Second, in terms of their frequent, general use, Creswell (2007) categorized research techniques to ensure validation or trustworthiness into eight categories. They were (1) prolonged engagement and persistent observation, (2) the use of multiple and different sources, methods, investigators and theories in triangulation, (3) peer review or debriefing, (4) negative case analysis, (5) examining researcher bias, (6) member checking, (7) thick description, and (8) external audits (Creswell, 2007, p. 209). Last, regarding the research processes in which each technique is used, Whittemore, Chase, and Mandle (2001) sorted 29 research techniques into four research processes: design, data generating, analysis, and presentation (p. 533).

Regarding the research techniques that deal with each component of trustworthiness (Guba & Lincoln, 1982) and that are frequently used (Creswell, 2007) in research procedures (Whittemore, Chase, & Mandle, 2001), I discuss my strategies to establish the trustworthiness of the study. I have made deliberate efforts to achieve each component of trustworthiness (Guba & Lincoln, 1982). First of all, for credibility, I conducted data triangulation and peer debriefing, and I also attempted a prolonged engagement and persistent observation. As credibility is related to the truth value of research, in other words, a verisimilitude between the collected data and the

investigated phenomenon, I collected data from different music therapists at various clinical situations throughout different temporal phases in the research for the purpose of having credible data—this is data triangulation.

For transferability, which is related to the possible applicability of the research to different times and contexts (Guba, 1981), I clarified my purposive sampling strategies and wrote thick descriptions. Specifically, the critical case sampling based on which I recruited three experienced music therapy clinicians rests on an assumption that if a musical decision-making process exists in these experts, it will exist in other therapists, and conversely if it does not exist in the experts, it will not exist in other therapists either (see Patton, 2002, p. 236). Furthermore, choosing subsets of data that I need for coding and extracting themes from the larger data set relied on theoretical sampling (Glaser & Strauss, 1967) that is based on my previously developed model and the research assumptions that were drawn from the model. In short, the sampling strategies I identified play roles in delineating the extent of my research contexts. Additionally, through thick description (Geertz, 1973), I attempted to fully describe the observed phenomenon, music therapists' musical decision-making, with great detail.

Dependability is a matter of the consistency of research, and Guba (1981) relates dependability to "trackable variances" due to the evolving research process and changes in human resources (Guba, 1981, p. 81). In order to examine the dependability of this research, I developed an audit trail. To make this possible, throughout the research, I wrote researcher's memos, which outlined the methodological procedures that have been done and the decision points where I captured essential specifics and move to the next step towards bigger, more general concepts within, across, and beyond the cases. As data analysis proceeded, I preserved

the evolving forms of data— for example, initial raw data, coding categories, and findings within cases, and findings among cases.

Last, to establish the confirmability of analysis, which is related to the neutrality of research data, I used data triangulation and an external audit. Unlike my self-examination of the research process for ensuring dependability, I had an external consultant who traced back the research steps to examine whether I achieved meaningful findings from appropriate data through reasonable ways of analysis.

I have discussed my strategies to ensure trustworthiness in the research from the standpoints of the attributes of trustworthiness, the frequently used research techniques, and the research techniques related to research process. Through this probe into my research strategies, I intended to check my epistemological soundness in getting to know the investigating phenomenon and to compel myself to refine my methodological techniques as an effort to establish trustworthiness.

CHAPTER IV

CASE I: RECEPTIVE MUSIC THERAPIST

Mrs. Snow

MT-BC (Music Therapist-Board Certified),

FAMI (Fellow of Association for Music and Imagery)

Vignette

"So glad I can be here. It's like an ocean of life." Janet's low and almost inaudible voice whispers over a vocal rendition of Barber's Adagio for Strings that warmly fills the dim clinic room. "Um-hmm," Mrs. Snow says, immediately giving her short and animated support while picking up her silver iPod. Then, she scrolls up and down the device quickly with it held close to her eyes. As the Barber reaches its conclusion, Janet exhales a long sigh, and as the last note of the music gradually disappears into the air, the clinic room is left in silence.

Mrs. Snow's busy fingers looking for the next piece get quicker and then take pause. After a short stare at the small screen, she nods once decisively. She seems to have listened to the piece in her head and seems to have decided to go with it. Vigilantly attending to the subtle changes in Janet's voice, breath, and physical movement, Mrs. Snow unplugs the iPod jack, which played Barber, from the speakers making a little noise. Then, she quickly hooks up the other iPod on which she loaded the next piece for Janet.

A few seconds later, gently breaking the long silence, the limpid harp of Elgar rings. It is Elgar's Sospiri, the English word for which is 'sigh.' Huh! The last notes of Barber, the silence like a multi-measure rest, and the harp opening of Elgar flow smoothly as though the music has not stopped. Then, a voice-like violin in the Elgar joins the harp. About twenty seconds pass, and Janet continues to talk naturally. "Now, I see myself swimming in the ocean. […] It's very open. I wonder what's out there." "Aha," says Mrs. Snow in a tone that seems this time to say, "There you are."

Process

The first interview

My first interview with Mrs. Snow occurred at the music therapy center at the university where she teaches. After a short greeting, I went straight to the interview questions. Her enthusiastic, ample answers kept pouring out for about one and a half hours without break. Mrs. Snow, who has over 30 years of clinical experience in music therapy, including her Guided Imagery and Music (GIM) practice, seemed assured and seasoned. She was also willing to self-disclose. She shared her process of maturation throughout her professional life and was not shy about acknowledging her possible weaknesses. When talking about her own experiences in music or with her clients, she glowed with excitement and enthusiasm, just like a young music therapist who had finished her first successful music therapy session with a client. Our conversation in the first meeting was not very focused on her GIM practice. As she claimed that her music therapy approach was eclectic, we had a quite broad conversation about how she would usually go about her musical decision-making, touching on her work in the use of other music therapy approaches.

The first session observation

On another day, I observed her Guided Imagery and Music session with a female client who was Mrs. Snow's GIM trainee. The session took place in a music therapy room, which was located in another building at her university. After being introduced to the client, I went into the observation room next to the session room. As observing and recording GIM sessions is not very common, my presence in the next room might have interfered with her freely "traveling" in music and expressing herself. With those thoughts, my nerves were on edge not to give the client

any reminder of the fact that I was watching her by making noise, even though I had gotten her permission for my observation. The session had the usual format of individual GIM: preliminary conversation, relaxation/induction, guided music-imaging experience, return, and postlude discussion (Ventre, 2002).

As Mrs. Snow turned off most of the lights in the session room for the induction to help the client focus more on her experience, it was difficult to catch details of what was happening in the room. Following the induction, five pieces of music were played: Enigma Variation # 8 (Elgar), Enigma Variation #9 (Elgar), the Adagio of Piano concerto # 5 (Beethoven), Adagio for Strings (Barber), and Sospiri (Elgar). All of these pieces are commonly used in GIM practice by practitioners. However, the sequence of the music was not a preprogrammed one but came from Mrs. Snow's spontaneous choices in the session. Some parts of their conversation during the music were not audible and did not make sense to me at the time. However, the whole session was preserved in the form of audio files. After their one and a half hour-session was over, I thanked the client for the opportunity to observe her session, and she told me that she was so focused on her experience that, at some points, she forgot that I was in the next room.

The first Think Aloud Protocol

After the client left the clinic, as a Think Aloud Protocol, I asked Mrs. Snow to tell me the possible reasons for choosing those pieces of music, her intentions with her musical interventions, and her client's responses to her musical decisions. She shared the conditions she considered when making decisions, the alternatives she had in her mind, and other possible influences on her. Although it was just after her long session, she was still passionate in introducing her music resources to me by showing me her music program notes and her two

iPods which contain single pieces and music programs—this was very impressive to me, because many GIM practitioners, including myself, still use Music CDs in clinical sessions. We finished the Think Aloud Protocol session in about 25 minutes.

The second session observation

Mrs. Snow's second session, which we scheduled for another day, was with another female client who was her former student and took GIM sessions from her about two years ago. In the same clinic room as the first session, the second one was also done in the same format of individual GIM: preliminary conversation, relaxation/induction, guided music-imaging experience, return, and postlude discussion (Ventre, 2002). Most of the pieces used were from the GIM music program "Solace," sequenced by Bruscia (Bruscia & Grocke, 2002). However, in the session, Mrs. Snow spontaneously modified the program by beginning with the third piece, Haydn, without using the first and second pieces and by adding two additional pieces. The sequence of music was: Cello Concerto in B flat, Adagio (Boccherini), O The Steppes (Russian folk song), The Joy of Those Who Mourn (Russian chant for vespers), Piano Concerto #2, Andantino (Shostakovich), Serenade in E, Larghetto (Dvorak), and Cradle Song (Grieg). The physical environment for my observation and audiotaping was also identical to the previous one. Mrs. Snow and her client, who had a background as a musician, spent quite a long time talking about music and the pieces used during the session in their postlude discussion. The entire session took about one hour and 40 minutes.

The second Think Aloud Protocol

Right after the second GIM session, we had a 20-minute meeting to check through the musical decisions made and to talk about the considerations and alternatives Mrs. Snow might have had in mind. She seemed a little tired in this specific meeting but was still active in sharing information related to her decision-making process with me. Utilizing her music program notes, I-Pods, and session notes, she tried to retrieve ideas that were in her mind even for a short time but were not used in her decisions. I asked her if she would be willing to show me her session notes on which she had jotted down key phrases spoken by her client during the session. Later, she sent me her typed session notes for the two sessions via email.

The last interview

For the last interview, I met Mrs. Snow again in the same clinic room. In the last interview, I asked her to tell me more specifically about her musical decision-making in her GIM practice, as our first interview had a slightly wider focus. In order to use it as an interview guide or agenda, I brought a hard copy of the model of music therapists' clinical music listening I developed previously (Bae, 2010a). I did not use it in the previous meetings because of the possibility that the visual representation of my theoretical assumption might pressure or restrict her from freely expressing herself in any way. Checking each component of the *a priori* model from which all my interview questions came, we went through the same questions as we had before. Keeping the focus on her GIM practice, she confirmed some of what she told me previously and added more thoughts from her lived clinical experience. As a GIM practitioner, I was thrilled, especially when talking about the uniqueness or idiosyncrasy of music listening in GIM, and found common ground with her experience. In terms of her music therapy orientation

or her general music therapy approach, however, she articulated that she was "integrative." My last meeting with Mrs. Snow lasted for about 55 minutes.

Findings

Music listening experiences

My interview questions, which relied on my theoretical propositions in the *a priori* model, were geared towards two topics: a music therapist's own experiences when listening to music for clinical purpose and the considerations she might have when making a clinical judgment about the music. For Mrs. Snow, her own listening experiences and her awareness of them seemed to be as strong a contribution as any other aspect of her musical decision-making in her Guided Imagery and Music (GIM) practice. However, her keen awareness of her own listening experience does not mean that she relies on her personal preference in music or her incidental impressions without meticulous, clinical assessment of the music. Rather, Mrs. Snow seems to use her thoughts and beliefs as a systematic medium to assess and evaluate music for its use in GIM situations. When a GIM practitioner assesses whether a single piece or a set of music possesses appropriate attributes and therapeutic potentials for its clinical use, her heuristic analysis based on the internal information derived from her own listening experience from various perspectives has been labeled in an empirical and also systematic way of doing so following the systems of Kaysaka (1991) and Grocke, (1999, 2007). Furthermore, if a practitioner wishes to be attuned to her client's listening experience during a session, the practitioner's attentive listening and keen awareness of what she is listening to are indispensible (Bruscia et al., 2005). Using Mrs. Snow's own language from our conversations as data, I will

present the critical information for her decision-making from her listening experiences, in terms of existential listening, auditory listening, and reflective listening (Bae, 2010a).

Mrs. Snow's existential listening experience

"Body listening" would be a fair term to describe Mrs. Snow's accounts of her personal (existential) experience while listening to music for the purposes of her GIM practice. First of all, regarding each type of listening experience in this realm—(1) her physiological/bodily experience, (2) her affective/emotional experience, and (3) non-ordinary/transpersonal experience—she demonstrated that she certainly had had experiences related to all of them and also provided lived, colorful examples for each type. Through her expressions in our conversations, it was obvious that her physiological/bodily, affective/emotional, and non-ordinary/transpersonal experiences had been interrelated, falling into the theme of body listening experiences.

> *So, if I'm listening to music to choose it for GIM, which we do, I'm really often very aware of my physiological responses. And what I'm really trying to focus on is my own level of relaxation or if there is an emotional connection—if there's a sense of emotionality about the music or it brings out emotions for me while I'm listening to it. But a lot of the time, I'm really focusing on the sense of tranquility or peace or relaxation. Even a deeper sense of relaxation when I listen to music to choose it for GIM* (From the initial interview).

Her account above, which was her first response to my first question about her physiological/bodily experience, spontaneously puts her various listening experiences together, adumbrating the great value of her physiological/bodily listening experience. She also said, in the last interview, that her physiological/bodily experience is "a combination of things" while depicting one of her non-ordinary/transpersonal experiences that was revealed to her through her bodily sensation. In terms of types of her bodily response, along with her physical reactions such

as nodding in her general music listening, she seems to have a variety of in-depth bodily experiences when listening to music for GIM purposes. The following are two examples of her related experiences, which came to her when listening to music for future use and in her session respectively.

> *Sometimes, it's just that sense of uplifting. But I feel it. It's not just I'm thinking it. I* feel *it's uplifting. Or, I feel it's allowing yourself to sink down. So I'm aware of those sensations or physiologic responses in my own body when I'm listening to the music* (From the first interview).

> *Another one that I experience in session sometimes is I will experience physiological responses of awe. Like a deep sense of... like a twinkling or a sensation going through my body that it's like, "Oh my gosh! Look what's happening. Whoa!" You know, that kind of big awe inspiring sensation* (From the last interview).

Her affective/emotional experience also seems to be strongly bonded with her bodily experience. "I connect affective experiences to physiologic experiences many times," said Mrs. Snow. Physically experiencing emotions that the music may bring for her, she seeks "a sense of emotionality" or "emotional connection" in the music for clinical use. However, what she clarified in terms of affective/emotional listening experience is that neither her emotional involvement in music nor an inquiry into her own emotional feelings is her focus in clinical music listening.

> *I would not say that I respond strongly emotionally with emotions. However that's different than thinking about the music in emotional context. And I don't know that I think about the music emotionally either unless I'm dealing with something like, you know, somebody's dealing with sadness or something like that. But other than that I wouldn't say that I think a lot about it on an emotional level, but more on an energy level. So I will think about it in the context of sadness or even energy for anger* (From the first interview).

To my question about non-ordinary/imagery experience that might occur in altered states of consciousness while listening to music, she gave me an assurance that she had had related in-depth experiences. According to her shared experiences, she appeared to be both a strong

kinesthetic and intuitive imager in music listening. Music imagery experiences are often categorized into visual, kinesthetic, and intuitive types (Mid-Atlantic Training Institute, 2008). In terms of the ordinariness/non-ordinariness of the listening experience, she claimed that a fleeting visual image one might have at a sensory level, for example, was not a non-ordinary experience for her because it occurs so often. She told me, however, that she has sometimes experienced transpersonal or spiritual events, such as sensing the presence of something greater than herself or energy coursing through her body. She added that those experiences happened in both her GIM practice with clients and her own GIM sessions, highlighting that they were non-ordinary experiences for her.

> *It's when they have that sense of being in the presence of something greater than yourself or this sense of energy flowing through you. It's that when you're on a deeper level. […]the visual to me is kind of up here at the cognitive level. Close. And then when we start moving down into the kinesthetic and the deeper non-tangible, intuitive kind of level—that's when those types of what I call non-ordinary experience [happen]* (From the last interview).

> *Well, there are times in my own sessions too, when I've had my own sessions, when clearly the connection with music brings about this real transpersonal experience. This sense of being beyond yourself, connected with things bigger than yourself. Out of your body, kind of, you know, strange things that happen. Or, things that happen that are not typically ordinary in our everyday life* (From the last interview).

With her acknowledgment of the existence of her physiological/bodily, affective/emotional, and non-ordinary/imagery experiences, Mrs. Snow's existential listening experiences can be summed up with the words "body listening." This is based on her frequent, direct use of related words, such as "through body," and "in my body," and based on her emphasis on her related experience. "Body listening" is also a term from the music listening approach for reviewing GIM music programs, which the founder of GIM, Helen Bonny,

proposed (Bonny, 1993). As an individual therapist, Mrs. Snow seems to collect experiential information through her bodily experiences while listening to and listening for music.

Mrs. Snow's auditory listening experience

Regarding musical attributes to which she attends when listening to music in her GIM practice, Mrs. Snow asserted that she does not analyze music purposefully in terms of music theory analysis. Rather, she focuses more on the overall musical characteristics that might be related to the "energy levels" of music. According to her accounts, "energy levels" are not musical properties as such but are significant qualities in music that should be matched with a listener's energy level. This was evident in her account in the first interview: "[What is] the level of energy of the music and do I feel a level of energy within myself?" In particular, she said that "energy levels" are related to the "amount of stimulation" in music.

> *I think I would just call it an amount of stimulation that I'm really just constantly aware of in sessions. And that's true in GIM too. I mean, we're always aware of the music that we're choosing. Is it too loud? Do I need to bring it down a little bit? Maybe that music was just too complex. Maybe something else, something a little simpler.* (From the first interview)

More specifically, the Think Aloud Protocols we had after her GIM sessions revealed the musical properties that she actually recognized and to which she attended. Although Mrs. Snow said that she does not do musicological analysis, her accounts in the Think Aloud Protocols showed that she had a good understanding of the musical properties of the music she used. She also dealt with a wide range of musical attributes including single musical elements and structural aspects of music.

> *So, it's [Elgar's Enigma variation number] 8 and 9. And number 9 has got... you know, the first one [i.e., number 8] is kind of la, la, la, la, la, la [singing the melody]. There's all kinds of interplay going on, so there's lots of ambiguity. The*

> *second one's much quieter. Not quieter, but much more consistent. But it's stronger. So it gets really strong, and there's a lot of tension in the music* (From the first Think Aloud Protocol)
>
> *I needed music that was fairly steady, but with enough ambiguity and enough complexity to allow her to explore. [...] I didn't want to use Baroque music. I didn't want Classical music either because that's just too metered. I want something that was a little more fluid and a little less rhythmically. [...] Not 'choppy' but you know, [but still] strongly rhythmed. So, that's why I chose the pieces that I chose. They're more flowing, more consistent. Even though it changed timbres from orchestral to piano, to voice, back to orchestral, and back to piano* (From the first Think Aloud Protocol).

In all, Mrs. Snow's auditory listening experience does not concentrate on pure musical properties like musical elements and structures in musical syntax. While listening to music, she immediately and spontaneously looks for the relations between the musical attributes, which she picks up through her auditory experience, and the semantics of the music, which are built through her own experience and/or her client's lived response to the music, depending on the clinical situation. This is a method commonly used by practitioners to analyze GIM music programs. In this regard, borrowing Abrams' categories, her listening approaches in her GIM practice are "heuristic" as well as "phenomenological" rather than "musical" (see Abrams, 2002, pp. 322-332). To reiterate, despite her proficient aural ability, which I observed, Mrs. Snow's auditory listening experience seems to be centered around matching "energy levels" of music to listeners and the substantial effects of the music on listeners.

Mrs. Snow's reflective listening experience

Mrs. Snow listens to music attentively from her client's perspective and listens to music analytically with a clinical intention. In other words, her music listening is client-centered as well as clinically focused. To my question about whether she would be empathetic with her client

while listening to music for/in her GIM practice and what she would consider when doing so, she said that she certainly makes efforts to be in her client's shoes and attempts to understand what the client would experience during music listening.

> *I'll try to be listening from their perspective as well as from a therapist's perspective and get a sense of what is this validating or expressing for that person? What is it that they're trying to ... what's underneath that choice of music for them?* (From the first interview).

In GIM, which is a type of music-psychotherapy, a therapist's presence with her client and the maintenance of her presence through mutual music experiences are key factors for successful therapeutic processes (Muller, 2008). Mrs. Snow's lived experience of being with her client's moment-to-moment response to music is shown vividly in her account.

> *I don't know if I feel exactly their feelings [when they listened to music in sessions] because we can never know that. But, I do know that there are times…well, for example, if they're struggling with something. And I will feel myself starting to tense up. So, I get that empathic response. […] Or, if they're really sad, I don't usually connect with that. On occasion I have. But more when something really powerful is happening. I guess it's more that when I... not necessarily what they're feeling, but more that I know how this could be helping them. That's more the affective response that I get. But I do tense up when other people tense up. I don't usually get teary when they get teary for sad reasons. Although occasionally. I do, if there's something that's amusing or funny I do experience that pleasure, that joy, and that sense of laughter* (From the first interview).

As the quote above indicates, Mrs. Snow's empathetic listening in her GIM practice does not mean that she gets emotional or sympathetic in response to her client. The word "empathy" means, in general, one's act of intuiting what someone else's feeling is like from the person's perspective while gaining a rational understanding of the feeling. To apply this to a music therapy situation, Mrs. Snow seems to listen to music while being in tune with her client's listening experience; however, she is not swept away with her client's feelings or her own feelings elicited by the client. Rather, she assesses and evaluates the music she is listening to

based on her rational understanding of her client's listening response and musical needs, i.e., what musical environment or musical stimulation the client needs in the moment.

> *So, the empathic listening would be, in the session, listening with the sense of what's occurring with the client with the situational immediacy. Before the session, it's sort of a preplanning of what kind of music do I think the client, this person, might need. Do they need holding music? Do they need energizing music? What kind of music do I think they need?* (From the last interview).

Mrs. Snow's intention for clinical analysis of music is apparent in her account. This analytic approach, moreover, seems to call forth simultaneous, complex thinking processes in her to collect related information to analyze the music. As she said, when she is in a session, she analyzes the music with a strong reference to her client's listening responses, which she is observing, and with her interpretative understanding of them. When she prepares for her coming session, she assesses possible music selections based on her intuition of how the music will affect that particular client.

In sum, Mrs. Snow's experience in the reflective listening realm could be described as not only empathetic to her client's listening experience but clinically analytical with her own listening. Moving to different kinds of research questions, I present what information she intuits and collects when listening to music in her GIM practice and what influences her decisions regarding the music.

Influences on musical decision making

The second set of research questions is designed to investigate how a music therapist's listening experience affects her musical decision making. In particular, I aim to reveal what is involved in a therapist's musical decision-making process and how her initial listening experience influences her ultimate judgment/decision regarding the music. In order to facilitate a

specific discussion about the influence of her existential, auditory, and reflective listening on her musical judgment/decision, I brought the ideas of "conditions for musical decision making" from the pre-developed model to our dialogue: therapist's music therapy orientation, therapist's musical traits, case information, and situational immediacy.

Mrs. Snow's music therapy orientation

Mrs. Snow's music therapy orientation is interrelated with her existential listening experiences and, furthermore, is a strong contributor to her musical judgment/decision making in her GIM practice. First, regarding her music therapy orientation, she expressed her firm and wholehearted belief in the therapeutic power of music for her clients, referring to her clinical cases in which she witnessed her clients' successful music experiences. Such faith seems to influence both her listening experience and her related musical decision-making, which also have an effect on one another. When listening to music in practice, she is touched emotionally by her client's experiences in music and by her knowing of the profound effect of music. In other words, her knowledge of music therapy seems to affect her listening experience in practice, and conversely, such listening experience seems to have built her experiential knowledge in music therapy.

> *Lately, on occasion, I feel the emotions that they're experiencing. I feel that within myself. So usually, again, it's back to "I know the music" [my knowledge of music] and how it is affecting them. "I know what the music is bringing them" [the effect of music]. And usually it's not about sadness. It's usually something about when I see I know that this music is bringing this person a sense of strength. And you can see it and feel it starting to build. And that's so moving for me that I'll start to get a little teary and I'll have to take deep breaths and not be teary when I'm guiding them* (From the first interview).

Regarding the relation between her therapeutic approach and her musical decision-making, there were her straightforward expressions. Mrs. Snow articulated that her approach

would be "eclectic" and "integrative" in employing approaches to her music therapy practice and would be philosophically "humanistic." To my question whether or not such a "humanistic" approach affects what she listens for and what decisions she makes in her GIM practice, she affirmed that it does:

> *I think so because, in GIM, my goal is to find the music that's going to help you find your answer, which is the humanistic approach, right? […]Or, access your own inner wisdom. So, that is kind of the point of finding, trying to find what's the best fit of the music to help you today go where you need to go. That's pretty abstract, isn't it? But I think that does affect [my choice of music]. Yeah, I do believe that. Because if I were doing it non-humanistically or psychoanalytically, let's say, it would be what I think you need. So I think you need to go fight the dragon. That would be a psychoanalytic approach. Whereas a humanistic approach is, alright, what do you need to do and how am I going to find the music that helps you figure out what you need to do? Even if in my brain I still think you need to go fight the dragon, that may not be what you really need to do today. So the humanistic approach I think really does affect my choice of music and my listening* (From the last interview).

My observations of her GIM sessions and her accounts in the review sessions attest to the influence of Mrs. Snow's music therapy orientation on her actual musical decisions in her GIM practice. In the sessions, Mrs. Snow was supportive and encouraging to her clients' experienced images and gained insights while listening to music. Even when her client seemed to be stuck in a certain image or seemed not to be sure about her own feelings, Mrs. Snow did not offer directive, suggestive musical interventions to her client that might lead to certain experiences she anticipated. Rather, Mrs. Snow patiently let the client find the meaning of her experience for herself while giving support to the client with feedback like, "Just stay there with the music, " "Um hm," and so on (From the first review session). Relying on her client's listening experiences, Mrs. Snow was flexible in the use of music. She did not stick with preprogrammed music programs by other GIM therapists or herself but spontaneously incorporated different

music pieces, considering where the client was in her listening experience and where the client's experience was heading.

> *That's why I chose that [Elgar's Sospiri]. Sometimes that's a good place to end. But it wasn't for her. So, then I went back to my original [idea for] what I was going to do after. The Barber* (From the first review session).

> *I do want something with moving. […]I actually ended up going with the first one that I was going to use, which is the Boccherini because it had for her enough movement. She's not one of those people that have all these bouncing images all over the place. She's very much, much slower. So, [I replaced Swan of Tuonela with] the Boccherini, like I said, I didn't want to use the Swan of Tuonela, which in the Solace program is the first piece* (From the second review session).

More specifically, I asked Mrs. Snow whether her devotion to a specific music therapy method, which would be GIM in her case, influences her music listening experience and subsequent clinical decisions. She condensed her answer into a few words: "Absolutely! I would say it absolutely did." To my request for her to elaborate on that, she added that GIM effects all her practice in multiple ways, such as her listening attitude, choice of music, and analysis of music. This is not only the case for her GIM practice, but also for her general music therapy practice in which she does not use traditional GIM.

> *I used it [GIM] as a way of accessing the music, as a way of accessing and teaching people about reaching their internal strengths. I would never have done that without the GIM training. I would have been pretty much cognitive/behavioral, I would say. Maybe doing some movement kinds of things, which I did before I did GIM training. But, it also taught me to listen carefully to what the client's responses were, or the client's reactions. And it taught me to accept whatever reactions there were* (From the first interview).

In all, her belief in music therapy, her knowledge of music therapy, and her specific method of GIM, influence her listening experiences and her musical decisions in her clinical practice. However, this does not seem to be a lineal or causal relationship such that her music therapy orientation directs her listening experience and subsequent decision. Her existential listening experience and the musical decisions she has made in practice might have contributed

to building her music therapy orientation. In sum, being interrelated to them, Mrs. Snow's music therapy orientation is a strong contributor to her decisions about the music she listens to in her clinical practice.

Mrs. Snow's musical traits in listening

Throughout the interviews, Mrs. Snow expressed that her musical traits, such as musical ability and music preference/interest, hardly influence her clinical listening and related decision-making in her GIM practice. However, the music resources that she has compiled throughout her clinical practice seem to be a strong contributor to her actual decisions in her GIM sessions. To begin with, she was candid in talking with me about her musical ability, her musical preference/interest, and her music resources. She claimed that her aural skills had little effect on her decisions in her GIM practice. Furthermore, she mentioned distinctly how her own musical traits had less influence on her GIM practice than on her other types of practice, saying "probably not as much as some other things" (From the first interview). She denied the direct influence of her musical preference/interest on her actual musical decision-making as well.

Although active music therapy approaches are not the main concern in this single case study, it should be noted that she took different positions for active music therapy and receptive music therapy, i.e., GIM in this context. "I would say, sometimes, my decision-making is, 'I can't do that immediately,'" Mrs. Snow said (From the first interview). For example, if she is not able to play the piece by ear that she just listened to, she may decide not to play it immediately in the session and may try to find alternative options. She also insinuated that her music preference indirectly affects her musical decisions in her active music therapy practice. Using the example of rap (a genre of which she is not particularly fond) she said that her music preference in

listening affects her aural and performing skills. She mentioned before that her musical decision-making is affected by her music skills. Thus, her preference for and familiarity with certain music might affect her ultimate musical decision indirectly.

Slightly different from her perception of her aural listening skills, my observations of her sessions tell me that her aural listening ability affects her subsequent musical interventions to some degree. For example, while her client listened to the music being played, Mrs. Snow quickly checked some spots in other pieces by listening to them in the other I-pod with ear buds. In immediately choosing the most appropriate piece among options, her ability to listen for the essential musical qualities she needs seems to help her work. Another example that shows the influence of her aural perception of music is her immediate adjustment of the volume of the music in her sessions:

> *Yeah. I was adjusting the volume sometimes. Sometimes it just got too... I couldn't hear her. Because she was really quiet. So I adjusted the volume a little bit. And sometimes it felt to me like it was too overbearing. So then I make it a little quieter. I didn't have to do a lot of it because the music didn't change a lot. Except in Elgar.* (From the first Think Aloud Protocol).

> *Usually, it was in response to my ears. She's [my client] laying there. Sometimes laying there you can take louder music. It was like, "Wow, this just feels like overwhelming music." There was too much of a sharp edge to it for my ears. So it was kind of like, it just needs to be a little softer* (From the second Think Aloud Protocol).

Both Mrs. Snow and I agreed that one obvious influence on her musical decision-making was her music resources, in other words, her GIM music programs and other pieces she has compiled for clinical use. In the Think Aloud Protocols, she demonstrated her acquaintance with the contents and clinical uses of the existing GIM music programs, for example, Bruscia's "Solace." She was well versed in changing existing pieces in a program spontaneously and creating various combinations of pieces, and throughout the interview, I heard about her many

experiences of doing so. Along with such internal music resources in her memory, she actually had the I-pods on which her music is stored—such clinical use of I-pods as a reservoir of music programs is a cutting edge technique in GIM. She also used the hard copies of the music indices, which looked tattered, used and old, when selecting music in her sessions.

> *I have the book that Marilyn Clark did, or the piece of paper that came with the Brucia's CDs. And I'll often just sort of flip through that while I'm talking to people [clients]. So I'll be looking at the titles. I'll end up going. "No, that's not it. Not that." Because when I see it, then I audiate a little bit of it, of like the beginning of it in my brain* (From the first interview).

Moreover, Mrs. Snow is open to music she does not know or with which she is not familiar, and she is enthusiastic about discovering and learning new music. She learns new GIM music programs, and, for future uses in her practice, she develops her music repertoire. For example, when a piece of music from the radio catches her ear, she finds it at the "iTunes" website and decides whether or not it will be clinically usable (From the last interview). After all, her music resources, which have developed like this, have an influence on her actual use of music in both her GIM and other types of practice.

> *I'll get ideas of "oh, there's some other music I could use. So, I could use this music too." […] I guess it does affect it in the sense that how it affects it is that I don't limit myself to music that I already know. For GIM, I explore other new music. So, I guess that's how it [my music resource] affects it [my musical decision]* (From the last interview).

Compared to other influences, she tends to put less emphasis on her musical traits as contributors to related decision-making. She was subtle in supporting the influence of her listening ability and music preference/interest on her musical decision; however, she acknowledged the influence of her developing music resources. Lastly, based on my perceptions of her sessions, her knowledge of and experience in music, as well as her perceptive aural skills, function as one critical factor in her musical decisions.

Mrs. Snow's information about her case

Case information turned out to be the first and foremost thing that Mrs. Snow considers when making musical decisions. Opening the discussion about the knowledge of psychology or pathology related to a particular client and information about a client's personal characteristics, she expressed her conviction about their strong influence on her decision-making as well as the importance of knowing them for a music therapist.

> *Absolutely! My knowledge of what symptoms they're having, what experience they're having, will absolutely, totally affect my decision-making for music choices* (From the first interview).

> *I believe strongly that the first thing we need to know to be good music therapists is we need to know our clients and we need to know what their issues and needs are and strengths and weaknesses* (From the first interview).

Mrs. Snow aggressively and aptly utilizes her understanding of individual clients' personal traits and current psychological states when making musical decisions. This is done based on her evaluation of where the client is in the course of the therapeutic process. For example, she may choose the music that matches with a client's current state, but when necessary, she may choose music that does not fit the state and rather stimulates the client to go beyond the present state. This is used intentionally as a psychotherapy technique.

> *Let's say if somebody has a lot of energy. And they're really upbeat and have a lot of energy. That would affect the kind of music that I probably would work with them. At least in the beginning of the session. Depending on if I'm going to be matching that or if I'm going to be confronting that energy. Normally, I don't walk in and confront it unless it's an adult and we're working on slowing things down, if they have the cognitive ability to do that. But if it's somebody else we'll probably match it and then gradually change the tempo* (From the first interview).

Furthermore, her client's mood or physical condition on that day and the client's direct requests also affect her music choices and related interventions. The following is the clinical example she made:

> *If they're really stressed or really anxious, sometimes people will just come in and they just feel fragile to me. I remember one person, very strong woman, very centered, organized person. And I was doing some sessions with her for her [GIM] training. And she came in she said, "You know, I just feel like I need to be centered today." I was like, well… I'll just use a program called centering then, which I actually did do* (From the last interview).

In addition to the information about clients' psychology and personal characteristics, Mrs. Snow considers her clients' musical traits, which include music preference, music experience, and response to music, as a critical factor to her musical decisions. One way she collects information about client's musical traits is to do an assessment at the beginning of the course of therapy. She said that she always asks her clients verbally about their musical backgrounds, musical taste, and the musical instruments/timbre they like or do not like. Her formal way of doing this inquiry is to play some "snippets" of music and to get a sense of "how was their traveling [in music]" as a sort of "a trial session" (From the last interview). Stephanie Merritt's music selections (1996) are the ones Mrs. Snow often uses in doing this. The following quote illustrates her perceptiveness of the relations between clients' music responses and their related psychological processes and shows the specific musical traits of individual clients that she pays attention to while doing music assessment.

> *I'm really interested in this whole instrumental versus vocal thing. Because some people really don't do well with vocal music. So, I'll do instrumental music then, I'll put in, like the humming chorus from Puccini which is so gentle. Or, I'll put in a Pie Jesu or something that's just a little gentle piece in there and gradually just build up their tolerance to listening to voices. To hearing vocal things and using that in a positive way and being connected with them. Because I really think it's important for people to be connected in vocal music as well.[…] I'm really aware of their musical responses, their likes. If they're musicians I can always ask them what period they like, if there's any they don't like, that kind of a thing* (From the last interview).

Her consideration about such musical traits of her clients affects her actual decision-making as evidenced by her accounts in the Think Aloud Protocols and my observations of her

sessions. In her first session, her client expressed her liking of Baroque music, and this affected Mrs. Snow's decision in music choice in a different way.

> *I didn't want to use Baroque music because that's something she's really familiar with. And I wanted something that would be a little more ambiguous in the very beginning to allow her to make the choices of being at a crossroads. If you're at a crossroads and you have really directive music it kind of says, "Go this way, go that way" Right? If it's kind of "well, I don't know, what do you think?" Then, it gives the person the option of looking around, which she chose not to do. […] So, that was my thinking process of going through the music for this* (From the first Think Aloud Protocol).

Her second GIM session was with a lady who has a musical background as a flute player and who has a Jewish cultural background. Mrs. Snow had information about what the client's music responses would be like based on her previous work with the client. In the session that I observed, a quite long conversation about the music used went on between Mrs. Snow and her client after the music listening. Through hearing from Mrs. Snow about her related thinking processes for her music choice, I knew that she took the client's music experience and knowledge and even the client's cultural background in music very seriously.

> *She's a flute player, so I'm careful about how much flute music I use and where it comes in the session* (From the second Think Aloud Protocol).
>
> *The cello's always a good choice for her anyway because she has a real strong connection with it. So then I put the Sospiri piece [which is cello music] after the Boccherini [cello concerto]* (From the second Think Aloud Protocol).
>
> *Whereas a lot of people hear the minor notes as sad, she does not necessarily because of her Jewish background. Many of the Jewish traditional songs are in what we consider minor modes. So, it's a less strong minor association. It's more of a family, heritage, cultural, comfort association for her than it is for other people. So that's why I felt it was okay to start with this. And there's a lot of the minor type modes in there* too (From the second Think Aloud Protocol).

In all, Mrs. Snow collects case information through both informal and formal modes of inquiry into a client's musical and non-musical traits, utilizing her knowledge of psychology/pathology

related to the client. As she emphasized, her information about her clinical case works as a strong, direct contributor to her decision-making regarding music in GIM practice.

Situational Immediacy

Mrs. Snow strongly stressed the importance and value of "situational immediacy" as a core component that might explain how a music therapist's musical decision-making process works. In the last interview, to which I brought a copy of the *a priori* model, she often referred to the component of "situational immediacy" from the model while talking about her listening experiences and other influences on her musical decisions. Throughout the data collection with her, I had found that she has given serious attention to the phenomenological aspects of GIM and that she has a comprehensive, delicate awareness of music-related events in clinical situations.

> *Barber's Adagio for Strings is a good example. Sometimes that feels so gentle. Same recording. So, gentle and soothing. Sometimes it feels really strident. And that has to do with the client, you know, with these other things, with the client in the session. And I'm always impressed how I hear it differently depending on the situation. So if the client is experiencing it as very strong, I also hear it that way. And other times, I will hear it, and it will not feel that way. And it really has, it's a very interesting thing that happens because it's exactly the same piece of music. It's the same performance, it's the same iPod. Why does it feel so different one time versus the next time?* (From the last interview).

As the quote above shows, she sees how she perceives music differently in different situations with different clients, and this is directly in line with the concept of music as "the language of immediacy" in GIM (Bonny, 1987). After all, Mrs. Snow listens to "the language of immediacy" in order to understand it and respond to it appropriately in the situation.

In terms of specific influences regarding situational immediacy, Mrs. Snow strongly agreed with the influence of the physical environment of GIM sessions. According to her, environmental influences might change her client's and her own perception of music, and she

might have to make immediate decisions for the sake of her client's safe and successful music experience. She told me her clinical examples such as how noise, temperature, light, and the size, location, and atmosphere of a room affected her GIM sessions with clients.

Mrs. Snow also gave much credit to "unexplainable influence," which has been rarely dealt with in music therapy research and practice, but its existence has been acknowledged among clinicians. In terms of this research, "unexplainable influence" covers factors that have not been identified with the other components in the model. It may encompass spiritual, peak experiences in music listening and the making of clinical decisions in the moment. Agreeing that it is difficult to talk about such ineffable things, she shared her thoughts and real experiences regarding spirituality, with exclamations and some pauses while talking.

> *Um, I really feel like there is a spiritual energy in the room that there's a definite connection with, depending on the person, it can be God.[…] You know. Yeah, that's pretty unexplainable. Or, my explanation most people don't want to hear. You know. We do transcend time [in GIM], right?* (From the last interview).

> *Oh, yeah. Once we're connected, you know, once we're out and connected with that non-verbal level, once we're connected with whatever you want to call that, yeah. All kinds of stuff happens. And I think it does affect our music decision-making, but I don't even know if we know how it does. It's that unexplainable thing* (From the last interview).

As another aspect of the unexplainable influence, Mrs. Snow does not always precisely know how she made such a decision and what strategy she used. According to her accounts, she makes decisions based on her knowledge about the representative uses of music in GIM, her memories regarding previous uses of the music, or her mental simulation to assess if the music will work for a specific client (See the decision-making strategies in Kellogg, 1995). Sometimes, she just intuitively feels what would work in the situation. While providing me with related examples, she seemed pretty clear about her mental processing in practice, but sometimes left my questions unanswered, for instance, by saying "we do not know how this works."

Such a position as hers, however, does not degrade her excellence in clinical work and her philosophical, theoretical acumen. This established clinician discloses her internal thinking process authentically and does not act as if she knows everything. Rather, with a keen awareness of the phenomena, she gives great value to "situational immediacy" as a scaffold on which she constructs her perceptions of live musical events and makes clinical decisions.

Summary

To most questions from the pre-formulated model, Mrs. Snow provided rich related contents demonstrating her expansive knowledge of and ample experiences in clinical music listening. However, she certainly emphasized specific listening phenomena. She has more in-depth experiences in and more concerns about her "existential listening" (i.e., physiological/bodily, affective, and non-ordinary/peak experience) and "reflective listening" (i.e., empathetic listening, awareness of listening purposes, and critique/interpretation of music) as compared to "auditory listening." The first two types of her listening experience seem to work as strong contributors to her musical decision making. Supporting the strong, natural relationship between existential/individual listening and her music therapy orientation and between her reflective/client-centered listening and her information about a client, she articulated that these components are strong influences on her musical decision making. Lastly, she also stressed "situational immediacy" as a part of the nature of music therapy and a decisive factor that affects her moment-to-moment decision-making.

In this chapter, through the lens of the *a priori* model, I have tried to describe Mrs. Snow's music listening and related decision-making within this single case. Further analysis and

interpretation will follow in chapter VII in order to see the case of this receptive music therapist through different theoretical lenses and all together with the other cases.

CHAPTER V

Case II: IMPROVISATIONAL MUSIC THERAPIST

Mrs. Collins

MT-BC (Music Therapist-Board Certified)

NRMT (Nordoff-Robbins Music Therapist)

Vignette

"Oo-oo-oo-oo" Picking up the "oo" of her client, Brain, Mrs. Collins sings a slow phrase along with her whole-tone arpeggio on the piano. Brian makes another "oo-oo," rocking a wooden xylymba beater in his hand, and then, he just leaves off from their singing.

"Bell. You found the bells!"Mrs. Collins' sing-song voice is directed towards Brian who fumbles with a bell on the table. Her piano makes up three short stimulating chords, which sound like his tinkling bell.

"How-a-bout-a-chair? How-a-bout-a-chair, to-day?" Immediately, Mrs. Collins sings to invite Brain to a green cubic chair for kids next to her piano bench. Her hands playing on the piano turn to the chair and tap on it with the rhythm of "How-a-bout-a-chair?" With hand-holding help of the co-therapist, Jinny, he sits on it momentarily.

"Oh, wait, Oh, no!" Mrs. Collins says looking at him spring out of the chair. She sounds like she wishes Brian would keep sitting for further music making. She improvises, reflecting his quick, short steps running around and then, moves to the song "Play your bell" (Ritholz, in Ritholz & Robbins, 1998?) in the tempo of his steps.

"Oo-oo-oo-oo" Now, Mrs. Collins quickly responds to Brian who has just returned to singing "oo-oo." He slowly approaches Mrs. Collins' right side and presses white keys, alternating his two hands. After a short attunement to Brain, Mrs. Collins starts improvising the blues, singing "oo." It seems to catch Brian's ears. He peeps at her. Then, he keeps playing the piano while rocking his body back and forth.

"Coo-coo-coo-coo." Mrs. Collins' assured voice sings, which is different from his "oo," drawing him in again. Stopping his piano, Brain stares at her with a sort of surprised look. They freeze for a few seconds with no music. They listen to each other in silence! As she goes back to "Coo-coo-coo-coo," he hangs a subtle smile on his face. Now, the 'musical trials'[1] Mrs. Collins has gone through seem to settle after about two minutes, which leads the two to further music making.

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[1] Musical trials is the word Mrs. Collins used in an interview during the data collection

Process

The first interview

My first encounter with Mrs. Collins occurred at her office in the music therapy center where she works, and it was right after my long and tiring trip from Lansing where I live. Mrs. Collins also just finished a music therapy session when I arrived. As our meeting was tightly scheduled between her back-to-back sessions, I hurried to get to the main subject after a short introduction about me and my research.

According Mrs. Collins, her music therapy life started when she was amazed by Nordoff-Robbins Music Therapy (NRMT) at a workshop about thirty years ago, and she clearly claimed NRMT as her main therapeutic approach. Additionally, she has a bachelor's degree in psychology.

While interviewing this expert in NRMT, in which I have not had direct, professional involvement, I found myself being a little nervous. However, the feeling did not last long as Mrs. Collins openly listened to me and asked me to teach her some of the concepts in my research. Using my interview guide, I asked questions about what her clinical listening experience is like and what she considers when making related decisions—all interviews throughout the data collection were audiotaped. Mrs. Collins answered forthrightly with a soft but assertive voice keeping the focus on NRMT. Consciously, I tried to listen to her with the ear of a new learner, because I wanted to hear a NRMT insider's genuine voice without filtering it through my knowledge of NRMT or my experience in other types of clinical improvisations.

As the one hour that we reserved for the interview ran out, we put off several remaining topics for our next meeting. In order for me to watch it before our first review session the next day, she gave me a DVD of her music therapy sessions.

The first session observation

My session observation was made on the same day by watching the DVD Mrs. Collins gave me. Before launching the data collection, Mrs. Collins and I agreed to use her videotaped sessions instead of watching her sessions at the site. She already had official permission from her clients' guardians for the use of the videotapes in research/education purposes. I had no direct contact with her clients.

The DVD she gave me included her 20-minute session with a little boy whose communication skills were still at an early stage and who was non-verbal. This client is one with whom she no longer works. The sessions included a hello song and good-bye song, and between them, there were various types of music playing. Mrs. Collins sang and played piano usually but sometimes ukulele. At her piano, she had the book "Themes for Therapy" (Ritholz & Robbins, 2008) and her memo sheets. She occasionally used these resources. There were rhythmic and melodic instruments in the room for her client such as tambourine, xylophone, and hand bell. She often improvised and sometimes played the NRMT songs I am familiar with through published music scores or films, for example, "Play your bell" (Ritholz & Robbins, 2008) and "Let's sing together" (Ritholz & Robbins, 2008). There was a female co-therapist who assisted the client in actually making music, but it was apparent that Mrs. Collins made more of the musical decisions as the primary therapist in the session. At the time when the sessions were recorded, Mrs. Collins, the co-therapist, and client had worked together for about a year.

The first review session

The next day of the first interview, I met Mrs. Collins again at the same office with a huge curiosity about her musical decisions that I saw on the DVD. For the reason that the

duration between the music therapy sessions and our review session might affect Mrs. Collins' perception and memory about her decision-making process, I preferred to call our meeting a review session rather than a Think Aloud Protocol.

Since we had to use her lunch time for the review session, she took bites of her lunch at times during the conversation. Using the video player in her office, I played some parts of the DVD for her and heard from her about the situations she just watched. By doing so, I intended to remind her of the situations and facilitate related discussions. As I was not familiar with the equipment in her office, I had difficulty in quickly finding the right spots in the video clips, and this caused some delays in our conversation.

Although some details did not come to her immediately, Mrs. Collins seemed to remember each situation with much clarity. She told me about what she was thinking then as well as her current reflections on the musical decisions she made in the sessions. We alternated between smiling and laughing with the video clips and seriously talking about her decision-making process in the situations.

We spent about one hour for the review session. When I left, I received another DVD from her for my second session observation and our following review session.

The second session observation

I watched the DVD of her music therapy session before I flew back to complete the remaining data collection. The session was about 30 minutes and was with a current client whose guardian had given consent for the videotaped session to be used for academic purposes. Her client in the sessions was a little girl who appeared to have a good intellectual ability and expressed herself verbally and non-verbally.

Mrs. Collins used the piano as the primary instrument in this session, too. She improvised and played pre-composed NRMT songs such as "Play your bell" (Ritholz & Robbins, 2008) and "It's time to say good bye" (Ritholz & Robbins, 2008) as well as children songs such as "Twinkle twinkle little star" and "The wheels on the bus." The musical instruments, which she had in the clinic room, were a wind-chime, conga, auto-harp, and resonator bells. Unlike the other case with the boy, these sessions did not have a hello song but began with her piano improvisation. As her client talked a lot and played with the toy bus she brought in, Mrs. Collins sometimes talked with her client without playing music. The client also actively suggested her own musical ideas, and Mrs. Collins accepted most of the client's suggestions. There was no co-therapist for the sessions.

The second review session

Two weeks after the first review session, I met Mrs. Collins again at her office for our second review session. Like the protocol of the first review session, I played certain parts of the video clips for her, which were usually the moments when she changed musical interventions, and she told me about the details of the situations and why and how she made the particular decisions.

As this was a client whom she was still seeing, Mrs. Collins' accounts were, sometimes, drawn from more recent sessions with the client. The contrast with the previous case of the boy, which was quite different in terms of client communication styles, musical interventions, interpersonal dynamics, and so on, was a good facilitator for our in-depth discussion about decision-making in various situations.

Our conversation was interrupted several times by her colleagues' short visits to the office, but we quickly returned to our conversation without losing focus. She did not have an immediate music therapy session after our meeting this time, and the review session was about ten minutes longer than the previous interview.

The last interview

For our last interview, I met Mrs. Collins at a different room in the music therapy center on the next day. I brought in a hard copy of the *a priori* model of clinical music listening (Bae, 2010a) to talk about her music listening and subsequent decision-making process again and to hear her comment on it. We went through the items of the model, from which the interview questions she previously answered were derived. This time, her accounts did not go into as much detail as in the first interview. However, they confirmed what she had said throughout the data collection, as well as suggested what she wanted to emphasize, making her position clearer to me. She also talked about how the model could work for Nordoff-Robbins Music Therapy through showing her curiosity about it, giving me some positive feedback, and asking me questions.

Due to the tight schedule at her work and my returning flight, she had had to give up several of her lunch times for our meetings. Conveying my deep appreciation for her time and interest in the research, I finished the last interview in about 50 minutes.

Findings

Music listening experiences

Before presenting my findings about Mrs. Collins' music listening and related decision-making in her Nordoff-Robbins Music Therapy (NRMT), it would be helpful to have a brief

picture about a therapist's music listening situation in NRMT. First of all, the object of Mrs. Collins' music listening is largely the live music she and her client make in sessions. In this active music making with a client, the music therapist's own music making is also a critical listening object, along with her client's music. "Listening to the client as the client is creating and then listening to ourselves as we're creating. What are we doing? How am I playing?" Mrs. Collins said (From the first interview). In terms of music therapy protocols, a therapist's music listening and related decision-making mostly occurred during music playing in sessions and post analysis after sessions.

Mrs. Collins stressed the importance of a therapist's attentive listening and the awareness of her own listening in clinical music making. From a Nordoff-Robbins Music Therapist's position, she articulated "we're trying to become more aware—as musicians, therapists, music therapists—of what we're doing and what we can offer and what is the client doing and listening to, on a very deep level and detailed level" (From the last interview). Referring to Verney's new book, which partially dealt with listening phenomena in NRMT (Verney, 2010), she demonstrated her interest in investigating multiple aspects of clinicians' music listening to improve their clinical practice. In addition to her stress on the necessity of improving one's self-listening, she also clarified the music listening areas in which she has more or less related experience and on which she puts more or less emphasis.

Using the three concepts in the model as an analytical tactic—existential, auditory, and reflective listening (Bae, 2010a)—I extracted the essential information from the data collected with Mrs. Collins. Relying on her own language, I present my findings regarding this improvisational music therapist's listening experience.

Mrs. Collins' existential listening experiences

Mrs. Collins shared her experience in the realm of existential listening, but such listening experience seems to her to be not as important as other types of listening experience (i.e., auditory listening and reflective listening) for her Nordoff-Robbins Music Therapy practice. That is, she is well aware of her own listening responses and related experiences, such as affective and bodily experiences, but does not consider them as a direct, conscious influence on her music making in sessions.

Specifically, in the realm of existential listening, the physiological/bodily listening experience is the one to which she may give least attention. "I think, truthfully, I'm not as in touch with that [physiological/bodily listening experience]. And maybe that's an area I can grow in," Mrs. Collins said. Despite the honest expression of her disinterest in this type of listening, her report on related musical events in her sessions is, however, so keen and detailed that it describes her bodily perception of music clearly and explains its clinical function lucidly.

> *I want to dance, I want to move. And so I think we put our whole selves into playing. I sometimes review a tape. I see my foot is tapping. I'm trying to sometimes take on—sometimes intentionally, sometimes unconsciously—the way my client plays into my body to find the music where we meet. So, maybe I do it more than I'm thinking of it. Differently. If the client is playing the drum, big movement, my body is moving on the piano probably in a way to incorporate that. So, I find the music to be with that client.[…] I may not be as aware of it, but I know that I'm responding that way. I'm reacting on that level* (From the first interview).

Talking about her affective listening experiences, Mrs. Collins was more enthusiastic. According to her, she experiences "the whole spectrum of affective response" to her client's music and related behaviors (From the first interview). From her actual clinical cases, she made some examples of when she was made joyful by her client's music and also when she was upset with her client's behavior. Again, she acknowledged that she perceives and feels music played in

her sessions on an affective/emotional level and furthermore insinuated that such experiences could be a material for her music making in the sessions. “I am having affective experiences as this is going. Or, I'm reacting on an emotional level to what the clients may be saying, or singing, or playing. It's touching me in a way,” Mrs. Collins said (From the first interview).

As another example of her affective listening experiences, she brought up a story about a person who came to mind while she was working with a client who reminded her of that person. Not losing the emphasis on a clinician’s control for her own emotions, she expressed that such affective associations in music listening/making could be a natural, invaluable, internal resource for a music therapists’ creative music making.

> *I would say in my work with the elderly with dementia, I would say more came up for me in terms of memory and relationships with my relatives. But I think it's amazing as improvising therapists or any therapist, we're with the person, we're listening, we're playing, we're creating, and at the same time we're having memory. And we're having associations and we're having feelings. I think it's amazing what we do. And we have to somehow manage it and have our focus on the client. So sure, things come up and I think we learn to kind of see it* (From the first interview).

Being perhaps at one end of the continuum of her affective listening experience, her non-ordinary/peak experiences largely focus on her special, rewarding experience of the “unfolding of something beautiful in someone.” Her descriptions of the peak experiences were the “Aha,” “Oh, wow,” or “That’s amazing” that she experiences at the moment when the music manifests the change, achievement, and growth of a client. She elaborated, “They’re given [musical ability] and, really, love through the music and attention can bring them joy. They can discover things they didn’t know that they could do” (From the first interview). This is a core philosophy of NRMT regarding a client’s self-actualization through music (See Nordoff, Robbins & Marcus 2007, pp. 3-4; Aigen, 1998, pp. 295-297).

Then, she asserted that her affective, peak experiences might be the ones that drew her to NRMT. She, furthermore, posed to me the question of how she can help her clients have those peak experiences if she does not have such experiences with her client (From the first interview).

To reiterate, existential listening is not an area to which Mrs. Collins has given conscious attention in her NRMT practice. However, she has rich related experiences particularly to affective, peak listening, and she was also astute in stating what her own listening experience (i.e., physiological/bodily and affective/peak experience) could mean within/to her clinical practice. Presumably, her clear concentration on her client during clinical music listening could minimize her attention to her own existential listening; nevertheless, her accounts provided some good related information that illustrates her existential music listening as an improvisational music therapist.

Mrs. Collins' auditory listening experience

Mrs. Collins' auditory perception of music is a seminal component of her music therapy process that automatically entails her clinical thinking. Her detailed, rich description of the music in her sessions supports her keen auditory perception of music from the Nordoff-Robbins Music Therapy perspective.

First of all, to my questions about what musical elements and structural aspects of music she attends to when listening to music, she responded that she tries to listen carefully to both of these aspects of music. As single musical elements (e.g., timbre, beat, tempo, pitch, and volume) and structural aspects of music (e.g., rhythmic, melodic pattern and musical form) are naturally interwoven within music, it is sometimes difficult that we discuss each aspect of music separately, since they intertwine. As she expressed, the musical attributes she perceives always

coincide with her related clinical thinking; her account of her auditory listening was often combined with her clinical analysis of what she listened to. However, throughout my session observations and following review sessions with her, it was apparent that she analyzes each musical attribute in detail, and I had access to her "lived" reports that show what musical aspects she pays attention to.

> *He's playing. Can we hear it acoustically? […] I probably thought either the size or the texture—like when he uses a soft mallet you can't get much sound. I want him to get the feedback (From the first review session).*
>
> *I'd say the listening for the timbre of each instrument. So, aside from all the other things we talked about, the timbre of those things, the attack, how long it sustains* (From the second review session).
>
> *I was playing in a mixolydian mode before. Now he's gone over to the xylymba. But, it's [the xylymba is] in pentatonic. So it's like the first three notes of a major scale, but, then the five and six. So, I changed to be able to play with those tones. To highlight those tones. And I also think that lightness and stimulation of that music is nice for him* (From the first interview).
>
> *I'm in E flat. Now he comes over and I think he started on the white keys. So, right away I'm adjusting. So I was going between white and black and keeping some things the same* (From the first review session).
>
> *The whole tone [I played] was about what's going to happen. Some suspense. Not a definite "I am in a key now and this is my tonic," because whole tone is so open. […] Then, I think it [later] sounded more pentatonic, sometimes majory, sometimes, pentatonic as a contrast* (From the second review session).

Her accounts above deal with diverse musical elements and structural attributes, such as music acoustics, specific rhythmic characteristics, mode/tonality, and so on. Aside from the presented musical attributes here, she touched on tempo, melodic contour, rhythmic pattern, repetition (shaping musical structure), meter, to name a few, despite the limited time we had for our interviews.

Another interesting thing she mentioned regarding her auditory listening was about her presentation of music in sessions. As mentioned previously, a music therapist's own music is

also a critical listening object along with her client's music in an active music making. In this regard, she gives great attention to the musical and therapeutic quality of her music performance in practice, in other words, the way of her music playing.

> *Let's say somebody is just playing a song for someone. So, I would say here we think of doing it with a composition or a song as well. How am I presenting this? Does it feel alive? Is it responsive? So not just, okay, I am doing my song now. The* how *of how am I doing it* (From the first interview).

During the review sessions, a couple of times, she said that she did not know why she played music in such ways or that the piano she was playing was a little un-tuned and did not sound good to her. Although I pre-planned to ask her about the clinical influence of her music recognition or performance (which will be discussed in the later part of this research), her straightforward discussion and disclosure about her auditory perception of her music performance was unexpected and novel information in the realm of auditory listening. It also makes my research findings in the realm of auditory listening stronger.

In all, Mrs. Collins attentively, meticulously listens for various aspects of music in her NRMT practice, encompassing single musical elements at a micro level as well as structural attributes of music at a macro level. Moreover, the quality of her music playing, that is, her way of performing music, is also one of her concerns in clinical music listening. Being strongly tied with her reflective listening, which will follow later in the research, her auditory listening is a preliminary, critical process of her clinical music listening.

Mrs. Collins' reflective listening experience

Mrs. Collins' reflective listening is the heart of her music listening practice, which will ultimately lead her to a certain clinical decision. As stated previously, her aural perception of music immediately calls forth her mental involvement in a clinical analysis of the music. That is,

she listens to music while thinking of its clinical relevance, and so, the music contains and yields its clinical, therapeutic meanings for her beyond its pure musical attributes.

First of all, Mrs. Collins approaches her clients and their music with empathy. To Mrs. Collins, her client's music, as such, seems to be a direct expression of the client's current state. In line with the core concept of NRMT, it seems to be an embodiment of her client's inner self, which is presented by the client's engagement in and organization of music (Aigen, 1998; Nordoff, Robbins & Marcus, 2007; Verney & Ansdell, 2010).

> *I'm thinking about them as people as I'm listening. I'm hearing that somebody who couldn't express themselves before is now singing. So, I feel something about them as a person opening up. So, I'm hearing their process, their personal process, with the therapeutic process* (From the first interview).

She feels and knows what her client might have experienced through picking up the expressed quality in her client's music, in terms of the client's emotional, cognitive, communicative status, and so on.

Throughout our conversation in the review sessions, I found her to be empathetic toward her client's music. For example, when her non-verbal client made a short, tantalizing sound with his voice in the videotaped session, she seemed impressed by his tentative but promising musical effort as well as seemed to sense where he is currently and where to go as a clinician. "I want to encourage it. I want to say, 'I'm here too.' I want to encourage him to do it again," Mrs. Collins said. When the client eventually vocalized more as she had hoped, she said "I really felt like he was listening the whole time" (From the first review session). She had been aware of the client's presence in their music.

Furthermore, Mrs. Collins analyzes and interprets music with a clinical intention. In specific, she aims to systematically construe clinical, therapeutic meanings from what she hears

in her client's music. She said, "I'm thinking about the way somebody's playing and what that means for them. I'm thinking on levels underneath the music as well" (From the first interview).

The aspects of music to which she pays attention for clinical analysis/interpretation were specifically described in her accounts. In terms of her client's music:

> *I'm listening for "Do they only play one way? Is it restricted? Is it only loud, impulsive playing?" [with] the idea that someone can inhabit the whole continuum of feelings and dynamics and be flexible musicers and as people. […] What is their dynamic and tempo flexibility? What is their ability to play with another person?* (From the first interview).

As her music playing is also a critical part of the mutual music she makes with her client, she closely listens to her own music as well, examining whether it works for the client in the given situation. Her descriptions and explanations of her music during the review sessions show that she closely inspects how the music she plays clinically functions in their mutual music making, and they also show what implication the inspection generates for her musical decisions.

> *I would say generally it's kind of a welcoming, opening atmosphere, in [my]music and see where she is going to go"* (From the second review session).
>
> *Probably, I'm thinking a contrast here. We want to move into something else. Before it was more sweet and now, "Come on. Let's get down to work. Can you do something purposeful with that?"*(From the first review session).
>
> *I'm trying to appeal to that and bring it back. Sometimes that works when we do that, sometimes it's absolutely not fitting. I go, "Oh, this was so significant last week, but today he's just in a completely different place*." (From the second review session).

Along with her moment-to-moment analysis while playing music with her client, such retrospective clinical interpretations are a routine, systematic protocol in Nordoff-Robbins Music Therapy. According to her, she and her co-therapist index the recordings of her music therapy sessions every week and, from time to time, communicate with clients' caretakers for clinical interpretations and goal setting. The use of the formal assessments developed by NRMTs was

also mentioned such as the Nordoff-Robbins Child Therapist Relationship Scale (See Nordoff, Robbins & Marcus, 2007, pp. 367-457). She added that all these processes are done together "to balance the spontaneity" of her music listening and making in sessions by expanding the scope of clinical reflection (From the first interview).

In all, reflective listening is a music listening area on which she places a high priority in her NRMT practice. While listening to music empathetically, she also rationally and critically analyzes and interprets the music for the sake of her client's therapeutic progress. To illustrate this, her statement will be a fair summary of the importance and influence of such reflective listening experience on her clinical work. "Reflective listening, yep, influences very much what I'm playing. […] Also, things unfold and then through reflective listening and assessment we decide 'is this the way I want to go?'" (From the last interview).

Influences on musical decision making

This section presents the findings regarding the influential factors for Mrs. Collins' music listening and related decision-making. In that such factors might be conditional circumstances, which have effects over all her listening experiences, as well as catalysts, which make her particular decisions happen in the listening situation, it would be advantageous to read this section in relation to the previous discussion of her listening experiences, picturing the whole situation in which she makes clinical judgments/decisions regarding what she listens to.

In the interviews with Mrs. Collins, I directly used the items in the pre-developed model (i.e., therapist's music therapy orientation, therapist's musical traits, therapist's information about a case, and situational immediacy) to ask about her perceptions of their influences on her

musical decisions. However, our conversations were open to her suggested new ideas or criticism of particular items in the model.

Mrs. Collins' music therapy orientation

Mrs. Collins' music therapy orientation is a strong influence on the way she listens to and understands music and on her following decisions. For an in-depth, broad discussion, we went into specifics about the influences of her knowledge of general music therapy, her major music therapy approach, and her belief in music therapy. As she is passionately devoted to Nordoff-Robbins Music Therapy, and just as our interviews had a clear focus on her NRMT practice, her perception regarding her music therapy knowledge appeared to be saturated in her intense expressions about her knowledge of NRMT. The influences of her personal belief in music therapy were also discussed largely in relation to her Nordoff-Robbins Music Therapy practice.

For the sake of the discussion about its contribution to her clinical decision-making, I would like to offer a quote from her that gives a glimpse of her overall music therapy orientation. "I believe strongly that the music of a person is [that person]. The music I'm hearing is the person" (From the first interview). As stated in the previous section, this is a philosophical, theoretical framework of NRMT, through which a therapist understands a client's music as a manifestation of the client and helps the client grow by actively expressing him/herself through music. Her account above suggests that Mrs. Collins' music listening and related decision making are certainly done in the NRMT paradigm. Decisively, to my direct question of whether her knowledge of and experience in NRMT would affect her musical decision making, she decisively answered yes (From the first interview).

To another question about her personal belief in music therapy, she also responded that it surely affects her listening and decision-making (From the first interview). Her confident and passionate tone during the conversations about her music therapy process indicates that she has a strong conviction in music therapy, particularly, NRMT. That her accounts frequently refer to NRMT also supports the direct influence of her major music therapy approach, NRMT.

> *Sometimes, it's the unfamiliar music—this is a Nordoff-Robbins value—the unfamiliar music that can spark a response* (From the first interview).

> *In my belief in [Nordoff-Robbins'] approach, I believe that what's important is forming a musical partnership with my client, listening closely, respecting what they're doing, finding a way in* (From the last interview).

Besides her commitment to NRMT, her other educational and professional knowledge and experience also influences her music listening and clinical decisions. Mrs. Collins has a psychology bachelor's degree along with her music therapy degrees, and her theoretical and experiential knowledge in psychotherapy seems to contribute to forming the way she derives clinical meanings from music, as well as the way she makes clinical decisions from a psychotherapy perspective.

> *In terms of my music therapy background here at […], and music as therapy, and music psychotherapy, and my own therapy experiences in learning about psychology, I'm thinking about the way somebody's playing and what that means for them. I'm thinking on levels underneath the music as well. […]I know about the relationship. They have a relationship with their mother. And they're treating me a certain way [projecting the mother-child relationship to me]. I'm thinking about those things, not just the music (From the first interview).*

> *It's like listening to a person in verbal psychotherapy. What are they saying? How are they saying it? What's the speed of it? What's the feel of it? And then I'm going to make some decisions based on that* (From the last interview).

Incorporating her knowledge of and experience in other areas, she seems to have formed her music therapy orientation, which is strongly NRMT-centered. Thus, her music therapy orientation turned out to be highly influential over all her music therapy sessions, from taking a

philosophical lens to understand music, to making specific choices of songs or musical ideas. Through my observations, I noticed that it affects her musical decisions in the sessions, and her accounts in the review sessions became testimony to my perception. From myriad evidential data, the following quote seems to illuminate how her music therapy orientation affects her actual musical decision-making process.

> *I think we can give the clients—if it feels right for them that day—a rich range of musical/ emotional environment. Okay, we just did two songs in major. What else is there? What about minor here? What about something more exotic or not just the same. Nordoff- Robbins wrote—music therapy and special education together—that many, many children's songs are in major and have three chords. Are children happy all the time? No. Is that the only emotion? At the very least, we can say that's a limited emotional musical vocabulary. […]So, I think with her playing on the white keys, singing in C major, it can get to be the same, which is why, maybe, the modulation or the transposition* (From the second review session).

It may be a matter of course that her knowledge of and experience in her major approach, NRMT, affects her musical decision-making in her NRMT practice. However, it is vital information that could explain the theoretical foundation upon which she makes clinical decisions in actual sessions. In sum, being epitomized by Nordoff-Robbins Music Therapy, Mrs. Collins' music therapy orientation is a very strong contributor to her music listening and related musical decision-making.

Mrs. Collins' musical traits

The interview questions regarding a therapist's musical traits were designed to probe specifically into the influences of Mrs. Collins' music skills and musical preference/interest and of her music resources on her musical decision-making. Throughout the data collection, Mrs. Collins highly stressed the importance of a music therapist's rich musical resources and her

clinical music skills. According to her, in Nordoff-Robbins Music Therapy discourse, the term, musical resource, is used to combine both a therapist's compiled music repertoire and his/her musical—usually pianistic—capability of playing various musical idioms: for example, various modes, intervals, rhythmic styles, and formal structures. In this regard, her accounts tend to deal with the influences of her music skills and music resources at the same time.

Mrs. Collins opened her discussion about the influence of a music therapist's clinical music skills on his/her practice by candidly talking about her own aural and instrumental skills. She highly stressed the importance of such music skills to Nordoff-Robbins music therapists, but asserted that the music skills with which a therapist should be equipped are different from the music skills for a general music performer. In terms of listening, a therapist should be able to listen to the music in sessions attentively and sensitively consider its clinical relevance, beyond the music she listens to in and of itself.

> *I don't have perfect pitch but I can find where I am and listen to what is the relationship of what that person is doing, developing those skills. I wasn't a performer but to be able to play in a facility, you don't have to be in performing like in center stage, but you want to be able to go where you need to go. Although sometimes the more simple the better. Sometimes, somebody can be insensitive [to his/her client and clinical situation] and a fantastic pianist. So, that's where the listening and the clinical thinking comes in. So, yeah, it's important. Those things are important* (From the first interview).

To my questions regarding the influence of her music resources, she strongly agreed with the idea. "Oh, yeah! I think so. I think the more resources we have in musicing as a therapist, the more range we have to respond with," Mrs. Collins said (From the first interview). That is, when a therapist has more musical resources—as mentioned previously, she put a therapist's music skill and music resources together—he/she will have more alternatives in making judgments or choices when analyzing and creating music in clinical practice.

> *You don't just have to play in a major scale—one, four, five. You know other chords. You know other idioms and scales, intervals to some extent. Also, knowing the song repertoire of music therapy and being able to compose, building on your ideas. I guess that's all part of the resources. So that is important. […] So, you can use them when you're improvising and trying to reach someone* (From the first interview).

In my session observations and the review sessions with Mrs. Collins, there were many occasions that informed me about how her music skills and resources affect her actual musical decisions. First, as stated in the previous section on her auditory listening, her musicologically and clinically apt descriptions and explanations of the music from the videotaped sessions prove the direct influence of her aural skills and musical knowledge on her listening experience and music analysis.

As another piece of evidence, the musical interventions she used in the videotaped sessions suggested that she makes musical decisions based on her available musical resources and related skills. Her dominant use of piano—she is a strong pianist—is a representative example. She also used a guitar for a short time in one session, and I could hear from her about the musical decisions she made then. The following quote shows how Mrs. Collins professionally adjusts her music skills to the clinical needs, and conversely, it shows how a therapist's actual music could be different based on his/her musical resources and related skills.

> *I'm not a guitarist. So this way that I'm playing was something that I used with him and I sometimes use with other clients. Just open Es and Bs, which doesn't limit where I can go as far as my scale. It could be major, minor, and mixolydian. You know, part of it is I'm adapting to what I can and cannot do. So, that's not where I have a lot of resources* (From the first review session).

Along with the internal musical resources, which have been reported so far, the use of actual music materials, such as the sheet music of her compositions and her clinical memos, is another influential factor that affects her use of music. In the videotaped sessions, she used a published NRMT song book and some pieces of paper, on which she wrote down the musical

themes that came out in other sessions with that client or others. Whether or not she actually sees them during music playing, the music scores or memos are tangible references that assist her to play the music, or extemporize or improvise with the musical ideas.

> *Perhaps, the week before or two weeks before, I went into the blues. Maybe, his mother had said that was something he liked. Or, I just had a sense of it. […]And I thought, "let me bring this back." So, we can play today that little theme, I have a feeling I wrote down. So, you bring back that idea* (From the first review session).

Different from her accounts of the overall influences of her musical resources and skills, Mrs. Collins expressed disagreement with the influence of her music preference/interest on her musical decision-making at first. However, throughout our conversations, she talked about her preference in music playing: for example, a clear modal, harmonic contrast particularly using whole tone and diatonic scales (From the last interview). She stated that she might not have been completely aware of the influences of her musical familiarity and preferences on her decision-making (From the first interview and first review session).

> *I think it [our music preference] probably influences more than we know or we'd like to say. In other words, habits. I would say preferences in our comfort zone* (From the first interview).

> *The song you started playing is something you played from Beethoven or whatever it is. Or, wait a minute. I'm playing a George Gershwin melody. So, we go with it* (From the first interview).

According to the basic principle regarding the use of music in music therapy, a therapist's ideal decision in determining music or musical attributes to use should come from a client's music preference/interest, excluding the therapist's own. A therapist's music preference/interest also might be a topic music therapists have not been concerned about and even have eschewed to discuss. However, this established, representative Nordoff-Robbins music therapist overtly acknowledged that a therapist's music preference/interest cannot be completely excluded in

realistic decision-making, while warning against the negative ramification of excessively relying on it at the same time. In terms of a therapist's own musical interest, she said:

> *Hopefully, not so much [influential]. But I'm sure it's there to some extent. We can use that because maybe I'm confident in playing in a certain way. But if that's the only way I play, I'm limiting what I'm getting to my client. So, I wouldn't say it's a huge influence. But, I'm sure it's there. I'm sure it's there* (From the first interview).

In summary, regarding a therapist's musical traits, Mrs. Collins put emphasis on musical resources as an influential factor in musical decision-making in clinical practice, and that this has clinical influences has been supported by collected verbal and observational data. Lastly, regarding the priority of a client's music preferences, she acknowledged the conscious and unconscious influences of her own music preferences/interests on her moment-to-moment decision-making in her NRMT practice.

Mrs. Collins' information about a case

To Mrs. Collins, case information is decisively influential on her ultimate musical decision. As she stressed in the domain of her reflective listening, she empathetically listens to her client's music and attempts to analyze and interpret the music for clinical purposes. Based on such a listening attitude or experience, she collects client information, which is both musical and non-musical, using her related clinical knowledge. That is, only with her accurate and insightful information about her client, is she able to understand her client's personal meaning of the music and determine the clinical relevance and significance of the music. To my direct question about the influence of her case information, she clearly answered that it affects her reflective, client-centered music listening as well as her subsequent musical decision.

> *Yes. I listen [to the music] and then there's a context around it. So without that information, I'm a kind of observing ego, or, a way to distance from "okay, this person is playing big music. You could go with it." But wait a minute. I know this person can get out of control and they need the other side of things. So, yes. It would influence my listening. It would influence my decision making* (From the first interview).

In order to examine the effect of her case information, I paid attention to what Mrs. Collins picked up from her client's musical/non-musical responses and what musical decisions she had made in her videotaped sessions. Then, I thought through the timely, causal relationships between the collected information and her musical decisions, and also heard from Mrs. Collins about the relations in the review sessions.

Regarding musical information about a client, there are countless instances that suggest its influence on her following musical decisions in the sessions, and she agreed about the influence. As an example of this relationship, I quote her responding to my questions about why she made the particular musical decisions she did.

> *I'm pretty sure that some of the trill and tremolo [of my piano improv] is because he's shaking the bell lightly. So I'm reacting almost to what he's doing* (From the first review session)
>
> *Why did I do it at this point? Maybe because he has a tambourine in his hand and I'm thinking stimulating music. He's interested. He was shaking it. So, I think some choices come because ten seconds before he started to do something* (From the first review session).
>
> *Perhaps, the week before or two weeks before I went into the blues. Maybe his mother had said that was something he liked* (From the first review session).
>
> *I know she likes to sing. She has a really good sense of pitch. And often I'm following her. [Clients] are playing on the white notes. And they tend to be in C major. Maybe that's why I changed back then. Because if there's a sameness, not this again. I don't have to play in C major. I can be in a mode. But if I follow her like [when]I said, "Let's make up a song."And she starts singing in C. Usually sings diatonically. It's what she's familiar with* (From the second review session).
>
> *Where it happens in the session may be determined by what she is asking for* (From the second review session).

According to the above, Mrs. Collins shrewdly picks up on her clients' musical choices, the musical characteristics of their music, and even, the timing of musical events, and immediately uses them for her music making. Moreover, her clients' music preferences, skills, and experiences collected through the course of her music therapy with the clients also seem to work as a strong contributor to her musical decisions in sessions.

The other type of case information is non-musical information about clients, which includes the client's behaviors, personality, and non-musical responses to music that are observed in sessions or shown in clinical records. Mrs. Collins claimed that such non-musical case information strongly affects her musical decisions in sessions. Making some examples and using the situations from the videotaped sessions, she talked about what non-musical aspects of her client she pays attention to and how they affect her actual musical decisions. Among much obtained evidentiary data, I introduce some of her accounts that support the influences of her client's behavioral responses/no responses, functional level, emotional conditions, and other non-musical events in a session as well as her client's life history.

> *They're quiet. They're lying on the floor with their head down. And I just have to say, "It's okay." with my musical words. Or. they'll make a sound back to me where they go bump, bump on the carpet. Okay, that's giving me something about where I might go* (From the first interview).
>
> *What is this child like on a sensory level? Can I pick something up with that? Walking around and the lights are too much in the room. You can see a physical reaction that they're having. So, I might start off with a very light texture. I might start with one tone* (From the first interview).
>
> *He's smiling over there. At the same time, he's kind of teasing himself, being evasive.[…] But he's interested. He's present. He's watching. So, I'm playing for or with or to someone's mood or someone's presence* (From the first review session).
>
> *Oh, she's bringing the bus in. I'm really rather her not bring the bus in, but I'm accepting it. I'm accepting of it and where can it go. Can we sing about the bus?* (From the second review session).

> *Someone who has been abused and I know that if the music gets very loud and there's a drum that could be very agitating for the person. […] Thinking about who the person is and how is the music going to affect them* (From the first interview).

Taking all above into account, relying on the collected musical and non-musical information about her client, Mrs. Collins understands her client's music and responses to music. The collected information is immediately involved in her decision making regarding musical interventions. In sum, for Mrs. Collins, case information turned out to be a highly important factor in her musical decisions in her NRMT practice.

Situational immediacy

Mrs. Collins' openness and flexibility to her client and given clinical situations is an indispensible condition for her NRMT practice, which is an improvisational music therapy approach. Regarding the influence of situational immediacy on her music listening and related decision, she was very perceptive and expressed a strong agreement about its influence.

According to her, her music improvisation with a client—especially at the beginning—is an "exploratory" process and "trial and error" through which she looks for appropriate musical choices to reach and communicate with the client. Thus, she has to be open and flexible to the client and his/her music. "That's why we have to listen and assess as we go," she added (From the first interview). To put it differently, her listening is highly affected by situational immediacy, focusing on picking up musical and non-musical events in the flowing musical situations.

Furthermore, she explained her clinical decision making as a continuum between "intuition and intention," both sides of which are important to her musical decision-making in sessions. Particularly, her accounts of the side that she called "intuition" support the effect of situational immediacy on her music listening and related decision-making.

> *Sometimes, things happen from our collective experiences in life, or our own musical selves, or from our spiritual selves. Whatever you want to call it, we make a certain choice that we may not be able to say where is that from. But it's an intuition built on life experience. So, I can't account for each thing I do* (From the first interview).

When she talked about her decision-making strategies in sessions, it was again obvious that she weighs situational immediacy heavily. She said that her musical decision-making in sessions is "a fluid scenario" (From the last interview). Planning a session, she has a scenario in her mind based on her related working experience with the client, her knowledge about musical idioms that work for the client, and her case information from clinical documents, as well as other situations. However, it cannot be pre-determined at all but needs to be flowing and changing, depending on clinical situations. Thus, her openness and flexibility in music listening and making is indispensible.

She also acknowledged environmental or physical conditions, for instance, sounds from the other room or from videotaping, the heat in the room, and the presence of others as crucial situational influences. She mentioned her own physical and emotional states on any given day, and clearly knows that ideally, she has to be able to control the physical and emotional aspects she brings with herself to her clinical work (From the last interview). In sum, the concept of situational immediacy in the model, which includes unidentified/unexplainable influence, environmental influence, and therapist feelings, is evidenced in how she works from her NRMT perspective.

Summary

The findings of the study with Mrs. Collins demonstrate that she has rich and delicate experiences in clinical music listening and keen awareness of her musical decision-making

process. In terms of music listening experience, she focuses more consciously on her auditory listening (i.e., perception of musical elements and structural aspects of music) and reflective listening (i.e., empathetic listening, awareness of listening purposes, and critique/interpretation of music) than her existential listening (i.e., physiological/bodily, affective, and non-ordinary/peak experience) in her Nordoff-Robbins Music Therapy practice. Her related experiences and perceptions of each type of music listening were derived from her own language in our conversations.

The inquiry into the influential factors in her music listening and decision-making revealed that her music therapy orientation and musical traits as well as case information and situational immediacy each have an impact on her judgments/decisions regarding music in general. However, she emphasized which influences she considers to be stronger and which she may not count as a significant influence. For example, she highly stressed the influences of her musical resources but not the influence of her music preferences.

While advocating Nordoff-Robbins Music Therapy and stressing its immense impact throughout her music therapy practice, Mrs.Collins was also very open to diverse perspectives through which a therapist can understand musical phenomena in practice. In this regard, the conversations with her and my following data analysis generated invaluable information for the further improvement of the proposed model, making it more comprehensible and convincing to Nordoff-Robbins music therapists. Further discussion and comparison with the other cases will follow in Chapter VII.

CHAPTER VI

CASE III: COGNITIVE BEHAVIORAL MUSIC THERAPIST

Mrs. Smith

MT-BC (Music Therapist-Board Certified)

Vignette

On his mother's lap, Chris looks at the other kids with a slightly nervous but also curious look. Another child, Anna, keeps staring at the music therapist, Mrs. Smith, while trying to sit on the floor herself. Wearing an innocent smile, Kevin runs from his mother to a staff member and back a few times. Josh with his big, surprised-looking eyes does not move in his mother's arms. With more mother-child pairs, staff members, and Mrs. Smith's co-therapist, this group sounds busy and boisterous.

"Hello, hello, hello, hello…." Mrs. Smith's clear singing voice comes through the bustling group. There is no instrumental accompaniment, but only her clapping. Mothers help their kids clap to her song, holding their hands. Mrs. Smith's clapping hands move onto her legs and stop with the last phrase of the song, "and stop."

A couple of seconds later, Mrs. Smith chants, "Get your-finger in the-air. Get-ready. It's-time to..." She swiftly picks up a guitar next to her and rings the strings vigorously to the last words "change it." Some eyes immediately direct themselves to her.

"Now, big giant arms. Ready?" Clapping slowly and heavily, she sings "Hel-LO, Hel-LO, Hel-LO, Hel-LO," just like a giant's stomping. Letting their mothers make the big moves by holding their arms, the kids have perhaps gotten the rhythm of the heavy steps. Cutely, a few kids clap themselves, although their rhythms do not quite fit.

She trills her tongue. Her enchanting voice draws the kids' attention tightly while she puts her open arms together, pointing her pinkies up. She looks so secure and makes it look easy as if she pre-calibrated every detail for these kids and as if she sees what will come next from them. She continues the hello song very quickly and softly this time. Mothers' speedy moves with their children's little hands seem to make the kids excited and even bewildered. At the end of the song we hear "And stop." At that moment, Chris' thin baby voice bursts into laughter. Mrs. Smith, mothers, and others laugh following him.

Process

The first interview

For the first interview with Mrs. Smith, I visited her music therapy room, which is located in a public school in her school district. I had had difficulty in scheduling the data collection with her, since she has a heavy caseload as well as other administrative duties. During our first interview I felt the busyness and wondered if the interview was burdensome to her. However, as our conversation ensued, such worries disappeared, and I became very impressed by her passionate and also rich responses to my interview questions.

Mrs. Smith definitely agreed that I should label her major music therapy approach as cognitive behavioral. Regarding her music therapy approach, I was impressed that she promoted the social connection of music therapy. For example, her music therapy sessions include both people with and without disability as well as inter-disciplinary work in special education. Using the interview guide for the study, I asked her to tell me about her music listening experiences in various areas and her perception of influential factors in her musical decision-making. She made herself very clear with succinct language when talking about musical phenomena in her clinical practice. Despite any presumptions I might have had about a cognitive behavioral music therapist's philosophical position, Mrs. Smith was very open to different views of how to understand music in music therapy. I was so intrigued listening to her that I lost track of time for a while. The interview took about 1 hour and 40 minutes. All conversations with her for data collection were audiotaped.

The first session observation

My session observations were made by watching the video files of Mrs. Smith's music therapy sessions in the thumb drive she sent me. For practical reasons, we decided to use her videotaped sessions, for which she had already obtained official permission to use for research and educational purposes. At that point, I had been waiting to get permission from her school district for observing her work at the site. We both assumed that getting the approval would take longer, so we chose the video files for the research observations.

As my first session observation, I watched her 30 minute-long video file. The session was a huge group of about 35 young adults, including her special need students and other students without special needs. Additionally, four staff members were helping, sitting among the group. Mrs. Smith sang a hello song for the group at first. Then, she had three movement activities that seem to be intended to facilitate active interactions between group members. In the activities, she taught students sign language and helped them interact with each other by changing seats, by moving around, and by playing drums together. In terms of music media, she played the guitar herself for the hello song and sign language activity and used the auto chord accompaniment of an electronic keyboard for a movement activity. She also used a recording by the Siberian Orchestra for another movement activity.

The video of the session was not of high quality and did not include the ending of the session. However, it presented the overall features of the large group by including most students within the camera angle and capturing important events in the session. It was good enough to generate discussion materials for the following review session.

The first review session

The remaining interviews and meetings were done in the Lansing, Michigan, where I live, since she had administrative work to do in the area and was willing to visit me for the data collection. We met in a room of the Music Therapy Clinic at Michigan State University, where I worked.

Using my laptop computer, we viewed together some clips from the video to remind her of clinical situations and to hear about what led her to the particular musical decisions she made. Considering the time delay between her music therapy sessions with the students and our review sessions, I assumed that her current perceptions might be a little different from the ones she had in the sessions—in this regard, I called our meetings review sessions rather than Think Aloud Protocols.

The music activities used in the session seemed very familiar to Mrs. Smith, and she seemed to remember the music therapy session well, revealing the intentions she had when making decisions. The review session took about 50 minutes.

The second session observation

The second observation was also made through watching another video file. The session was in the form of four separate video clips, totaling about 14 minutes. In the session, Mrs. Smith ran her early childhood music therapy session with six mother-child pairs, a few staff members, and her co-therapist. The children in the group were very young and developmentally delayed. Her music activities were mostly movement activities, for example, moving to music, dancing with a scarf, and playing shakers. To me, the intent seemed to be the facilitation of intimate mother-child interactions, as well as active group interactions, both used to improve the

children's music cognition. The music media she used were mostly her voice, with and without accompaniment, the guitar. She also played the piano for a short time.

This brief video session with a completely different population—an early childhood group—provoked me to become more curious about her musical decisions and generated many questions for the following review session. (As described above, the first video file was with a group of young adults.)

The second review session

For Mrs. Smith's convenience, the second review session was conducted at a convention center in the Lansing area where Mrs. Smith had an administrative meeting. Although it was a wide open space, and there was some noise from time to time, this did not interfere with our discussion. Using my laptop, we watched the video file of her early childhood group and talked about her perceptions of music and related decision-making in the session. We made certain that the video file of her session with clients was not seen by anyone except us. The second review session took about 50 minutes.

The last interview

Mrs. Smith and I met for the last interview in the room at the Michigan State University Music Therapy Clinic, which was the same as the first interview. I brought a hard copy of my model developed for this study, from which the interview questions were formulated. Using the model, we went through the whole set of questions I had used in the first interview once more. She was also asked to tell me about what she wanted to stress or change in the accounts she had made so far, as well as her thoughts about the model.

Although she had addressed these questions in prior meetings, she spent quite a lot of time for each, making her perspective and thoughts clear. As we did not have time pressure in the last interview, I felt this conversation went more smoothly and was more in-depth. After finishing the interview, we made small talk. For her willingness to participate in my research despite her hectic schedule, I thanked her, and we left the room. It had been about 1 hour and 50 minutes since we started the interview.

Findings

Music listening experiences

Prior to presenting Mrs. Smith's listening experiences using the framework of existential, auditory, and reflective listening, it should be mentioned that she has in-depth experiences in diverse listening areas and has a systematic listening approach. Throughout the interviews with her, I strongly felt that she has given serious attention to music listening in order to pick up the musical qualities she needs for her sessions According to her, music listening and figuring the clinical usability of the music occur automatically and habitually in her life and even beyond her clinical work, to the degree that she thought she might have to change her music listening habits. On the other hand, she seemed to have developed her own way of music analysis, and in our conversations, she provided me with concrete and systematic explanations about her music listening experiences.

Along with her listening experiences outside of her music therapy sessions, her music listening situations in her sessions are described through examples from her music therapy groups in school settings. In terms of types of listening experience, i.e., existential, auditory, and

receptive listening, she said that some listening experiences are more important and influential than others to her clinical practice.

Mrs. Smith's existential listening experience

Mrs. Smith seems well aware of what she experiences and feels while listening to music and, in particular, seems to be more focused on her physiological/bodily listening and affective listening than other types of listening experiences. According to her, while listening to music, whether it is in or outside her practice, Mrs. Smith automatically analyzes whether or not the music has clinically beneficial qualities for her music therapy sessions. She seems to do such an examination of music through her immediate physiological/bodily and affective responses to the music.

First of all, she has various types of bodily listening experiences, and they seem to be important information for her to assess or evaluate the music she listens to. Usually bouncing her body, tapping her feet, and nodding her head to music, she senses musical elements in music, for example, rhythm and tempo (From the first interview). To another question as to whether she feels music through her body, she answered that this way of thinking is pretty new to her, but she certainly has such experiences. "My stomach will feel either excited, or my stomach will feel sad," she said (From the first interview).

In the videotaped sessions, I could actually see that she kept responding physically to the music she was playing or the music from a recording or electronic keyboard. Such natural bodily responses sometimes appeared conscious and deliberate as she intentionally used her physical responses to convey music more effectively to her clients. "I want to be able to make anticipatory cues [using my body]. I want to be able to help the listeners in the room or the

people who I'm trying to engage," she said. Even in our review sessions, it was noticeable that she responded to the music from the video clips. "I am very active and it is hard for me to stay still [while listening to music]," she mentioned (From the second review session).

Furthermore, that Mrs. Smith listens to music with a keen awareness of her body responses directly helps her to find the appropriate music for her clients as well as to Mrs. Smith herself, who presents the music to the clients. Of course, she expressed her concern about the possibility that her personal listening experiences might lead her to a wrong music choice. Nevertheless, her accounts of the use of her bodily response to examine music make plausible sense. She has to explore the energy level of the music herself prior to her sessions to see whether she is able to play the music appropriately to her clients' energy level. Then, sensing her own physiological responses and moving her body to feel the music could be effective and also a practical way of checking the energy level of music in real clinical situations. Mrs. Smith stated:

> *I think this is an important one because it tells me if I'm going to have the energy to present things in the way that it needs to be for the client. Sometimes I will tip towards wanting to pick something that I'm going to have a physiological response to. I think the Wizards in Winter, when I did that one, I had a physical response to that piece. I've never heard that before. It's classical music that I might not be seeking out to listen to more. And I had a response to that and I thought that was a good one for if I needed the energy level* (From the first interview.)

Next, Mrs. Smith's affective responses to music are also critical information for her listening to music for clinical uses. Often blending her affect with her accounts of physiological/bodily responses to music, Mrs. Smith stated that she experiences various emotions and retrieves memories that often come with her bodily responses. According to her, such affective experiences are "really powerfully influential on [herself] and strong," especially when the music works in a session or she feels the music is going to work for her clients (From

the last interview). That is, her affective listening experience is tied to her clients' music experiences. She said that the mutual music experiences between her and her clients would often elicit her affective experiences more fiercely than simply listening to a piece of music by herself (From the last interview).

As she is aware that her affective response is still her own music experience as an individual, she keeps debating the balance between her perception of the affective aspects of music and her theory-based judgment for her clients. These two aspects are interactive and are not completely separable. They also require her professional reflection. She perceives her own excitement, liking, and even tiredness when listening to music, as evidenced by her disclosure in our review sessions. For example, regarding the piece "Wizards in Winter," which she used in the video, she expressed that it was not boring but exciting to her and she personally liked it (From the first review session). Offering a different example, she also expressed that she is tired of a children's song, which she has used for years since it has been successful for her clients, although she always becomes refreshed by her clients' active response to and enjoyment of it (From the second review session).

Another interesting finding is that Mrs. Smith's affective experiences in music seem to her to be the internal reward that keeps her thrilled and animated about her music therapy sessions. According to her, affective listening experiences also affect her way of music playing and listening in her sessions, and this is consistent with her accounts regarding the use of her body responses. Roughly speaking, when she has been affectively engaged in the music in a session, she could be more vibrant in presenting her music and could be more successful in promoting her client's musical success.

To my question about non-ordinary listening in the pre-developed model, she shared her related experiences. Based on her descriptions, her non-ordinary listening experience seems to be an extreme type of affective listening experience. Describing it as a spiritual feeling, Mrs. Smith elaborated the intense, precious affective experience that she has in the musical moment when she has found the music she believes to be right for her client.

> *If I think it's going to work, the emotion will be excitement. I'll feel a connection to the music, like it's a gift to me. I think I'll feel grateful. Gratefulness is an emotion I feel frequently because I may worry if I'm not going to find the right music for my client. And we're all so rushed in our daily practice that I never have enough time to plan. When I find that music, I feel a spiritual emotion that it's maybe a gift sent. That that might be a gift for me or it might be a gift sent that needs to be brought to my student* (From the first interview).

With respect to the existential music listening area in the model, Mrs. Smith candidly shared her personal listening experiences, particularly in the bodily and affective listening areas. While firmly keeping her priority on clients' music experiences, Mrs. Smith sensitively perceives her own listening experiences as an individual therapist. As evidenced by her frequent accounts, her perceived bodily and affective responses to music turned out to be critical information she uses in order to analyze the musical quality and examine its clinical usability.

Mrs. Smith's auditory listening experience

As presented previously, Mrs. Smith analyzes the music she listens to into specific musical attributes which could elicit various responses in her clients. In terms of auditory listening, according to her, she attentively and consciously listens for both musical elements (e.g., timbre, beat, tempo, pitch, and volume) and structural aspects of music (e.g., rhythmic, melodic pattern, and musical structure and form). Through my session observations, I found that she pays great attention to both of these musical aspects, and she is conversant with using them to elicit

specific behavioral responses/reactions from her clients. Such a translation between the functional use of musical attributes and possible corresponding human behaviors in planning music therapy treatments is a basic principle of the cognitive behavioral music therapy approaches and other related approaches such as neurologic music therapy (See Thaut, 2005, p. 131).

> *I'm always looking for what music elements that my clients respond to. And then I'm trying to orchestrate how I use those elements. If there're strong, rhythmic beats or if there's ethnic music, if cadences or tempo changes, that's really what I use to do behavioral reinforcement of behaviors we want them to do* (From the first interview).

First, Mrs. Smith seemed to give weight to specific musical elements at a micro level. In particular, temporal aspects of music are the ones she considers as the most fundamental and important, and she said that it is "because the rhythm, tempo, and musical accents are what really help coordinate my student's thoughts with their actions," (From the first interview). While watching her videotaped sessions, I found that she focused on capturing her clients' rhythms, which were usually shown in their motor movements or the sound they made using body percussions or instrumental drums. Then, she skillfully manipulated her music to their rhythms. Her accounts below provide the examples of her rhythmic perception and its use in sessions.

> *I'm really conscious that musical accents have to be strong for my students. So I'm more worried about where the accents are and where the other kids are clapping. […] I felt like when I was singing, I did not feel like the kids were giving me strong enough beating. So, I wanted to go back and review that [instruction in how to play the rhythms] so they would make a louder slap sound* (From the first review session).

Besides the temporal aspects, other musical elements such as timbre, volume, harmonic progression, and cadence were also her concerns in music listening. Furthermore, she mentioned

a couple of times that pitch would be the one she might become very sensitive about, for example, when a musical instrument or someone's performance is not in tune.

In terms of structural aspects of music, Mrs. Smith also perceives, recognizes, and uses them to facilitate specific target behaviors in her clients. She concentrates more on an overall shape of music, and the examples she gave were repetition, alternation of music playing and stops, alternation of instrumental and non-instrumental parts, and length of music phrases. They are the structural aspects of music she frequently uses to help her clients understand musical tasks, to keep drawing their attention, to help them improve related functional skills, and so on (From the first interview). As an example, when she was asked about what musical attributes she considered when choosing the piece she used, "Wizards in Winter," she responded:

> *I liked that it had a predictable shape where it had the phrases within it where there were about six counts and then there was a break. And then six counts again and then a break. And I liked that it had the form of going to the more free instrumental section where we could put [clients' drum playing]* (From the second review session).

In summarizing Mrs. Smith's auditory listening, she attentively listens for both musical elements and structural aspects of music and aptly uses what she perceives and recognizes in order to understand her clients' behaviors and to develop music treatments. Suggesting the relationships between her auditory perceptions and her musical decisions, which will be presented later, she stated that she really leans on both musical aspects when making choices, for example, in her assessment process (From the last interview).

Mrs. Smith's reflective listening experience

Regarding reflective listening, Mrs. Smith's music listening in practice is solidly targeted at her clients. Prior to presenting her reflective listening experiences (i.e., empathetic listening,

awareness of listening purposes in music therapy protocols, and critique or interpretation of music), I would like to remind the reader that she works with many students with special needs on a tight schedule, and she works collaboratively with other therapists mostly using behavioral approaches.

First, Mrs. Smith reported that she is aware of herself being empathetic to her clients and with their music and also raised the issue of the necessity of a reconsideration of a therapist's own empathy. When I brought up the direct question of whether she becomes empathetic when listening to her clients, she began her answer, putting a great value on the question. "We have to look at it harder. I think it's a very important topic that we have to really, really remember we're working with human beings," Mrs. Smith said (From the first interview). According to her, she has made a great effort to be empathetic to her clients in her sessions and while listening to their musical expressions.

She, however, said that we therapists are not able to know the experiences of our clients accurately, since they often cannot express themselves clearly, and so we may misunderstand them. Then, she told me a story from many years ago that has taught her to stay humble in knowing clients' experiences and become more empathetic. She honestly disclosed that she misinterpreted the experiences of a client with severe cerebral palsy, who was in distress in her group but looked happy all the time (From the first interview).

In her practice, she works with student groups in a school setting, and she needs to use behavior modification techniques to decrease or extinguish undesirable incidents in sessions. Under these clinical circumstances, she still seems to remind herself to be aware of each client's inner experience, for the sake of the realistic need of such behavior-control techniques. Saying "we can be arrogant in our music making," Mrs. Smith suggested that we re-think whether we

are really empathic in listening to clients and whether we understand clients' music adequately from their position (From the last interview).

Mrs. Smith differentiated purposes of her music listening in different music therapy protocols. Depending on the phase of her music therapy service (i.e., assessment, treatment implementation, and evaluation) her listening focus seems slightly different. During assessment, she focuses more on being open to clients' musical behaviors and sensing the rapport being built with clients. If she is in the treatment stage, she tries to shape her clients' musical tasks and use clients' musical responses as a cue for her to decide whether the task was achieved and whether she will give the client another task. Regarding the last stage, she tries to assess whether or not the client can be independent in doing the musical tasks he/she has achieved and also tries to be aware of her own emotional feelings towards the termination of therapy with the client. I quote her talking about her music listening in assessment and treatment phases.

> *For instance, in an assessment session, we have to be careful what kind of judgments we put on the client's responses, especially if it's a first visit. I was very aware that I didn't have a deep rapport with, especially, the parents in the early childhood [group]*(From the last interview).

> *When I'm doing treatment, I'm very aware of where the client is at as far as their ability to respond to what I want to do with their skill building. […] As far as listening, I'm listening for cues that tell me in their music expression that they're ready for another step. The little boy [in the videotaped session] who maybe can't talk and maybe he's going to always just use his voice open like that. Well, if he started using his voice with more regular rhythm and so on, I would go, whoa! I think I can have him do a more complicated, cooperative exchange* (From the last interview).

Lastly, regarding her reflective listening experience, Mrs. Smith analyzes, evaluates, and interprets music to understand the clinical meaning of her clients' music and examine the usability of particular music. Needless to say, she makes moment-to-moment clinical judgments on clients' musical responses, as demonstrated by her related accounts and my observations of

her spontaneous musical moves in response to her clients' music. As she often mentioned, when she listens to music inside/outside sessions, her clients come to her mind first most of the time. She immediately analyzes the "mechanical portions of the music" and looks for clinical appropriateness of the music, exploiting client information, such as social age, developmental stage, family situation, culture, and so on (From the first session). To reiterate, her music listening perspective, which is firmly client-focused, takes the course of action of analyzing, evaluating, and interpreting music for her further decisions. Suggesting the influences of her case information on her musical decisions, which will follow in the later section, her experiences in the reflective listening area are inevitably linked to her musical decision-making.

Influences on musical decision-making

While sharing her perception of her experiences in the existential, auditory, and reflective listening areas, Mrs. Smith had revealed that what she experiences and perceives from music directly affects what musical decisions she makes. In order to inquire into other influences on the mental process from her listening to her following decisions, I asked Mrs. Smith another set of questions based on the developed model. Our conversations focused particularly on the influence of Mrs. Smith's music therapy orientation (i.e., music therapy knowledge, personal belief in music therapy, and major music therapy approach), her musical traits (i.e., music skills, music resources, and music preference/interest), and her information about a case (i.e., pathology/psychology related to a client, non-musical attributes of a client, and musical attributes of a client).

Mrs. Smith's music therapy orientation

Mrs. Smith's music therapy orientation has a very strong effect on her music listening and her subsequent decision-making. To restate her accounts, her music therapy orientation functions as a philosophical, theoretical foundation based on which she understands music in music therapy and takes any action in practice. Mrs. Smith said that her music therapy orientation influences "how we train ourselves, how we look at ourselves, and what our [music therapy] skill is like," (From the first interview). In this vein, her music therapy orientation works the same way for her clinical music listening. Based on our verbal discussions and my session observations, her general music therapy knowledge, her major therapeutic approach, and her personal belief in music therapy turned out to be significant contributors to her music understanding and decision-making in practice.

To begin with, her knowledge in general music therapy has an immense impact on her music listening and decision-making. While she listens to music, her knowledge regarding the clinical use of music, gained through her studies and clinical experiences, compels her to concentrate on picking up musical qualities and inquiring into the clinical meaning of the music. She said that this is so influential that she "can't turn off [her] music therapy mind" during music listening (From the first interview). Another effect she mentioned is that the basic principle of the priority on clients' music preference and their successful music experience has taught her to be more open to diverse music throughout her professional life (From the first interview).

> *I watch "American Idol" not because I would watch "American Idol" but because the music is going to be most likely what my young students that I service are going to listen to. And I need to know 'what are the dynamics' and 'why this song is popular'* (From the first interview).
>
> *[My music therapy knowledge] has helped me allow different music into my life. When I was younger, there were certain styles that I stayed away from because I*

> *was worried if I could perform those, and so I might hold myself back from listening to it and trying to make that kind of music. But my therapy knowledge has allowed me. The positive is that now I'm not afraid to listen and try to make music from different cultures or music that has arrhythmic qualities to it or something that seems very difficult that I might feel like I'm going to have to work too hard to do it* (From the first interview).

The contribution of her music therapy knowledge to her musical decision-making was discussed mostly in relation to her cognitive behavioral music therapy practice, although she articulated that she also has been influenced by other therapeutic methods such as the improvisational one (From the first interview). For this reason, the findings below about the influence of her major approach will cover the impact of her general knowledge in music therapy.

Cognitive behavioral music therapy approaches are predominant in her sessions, and she strongly agreed with its influences on her listening and related decision-making. In other words, as she is tuned into her client's behaviors, she is concerned about how to use music functionally to help them improve. "I'm always looking for what music elements that my clients respond to." "It really makes me listen to the rhythm of music that I listen to much more than I would have," she said as an example of how her major approach has altered her listening perspectives.

Besides her verbal support, her music therapy sessions as such were observable evidence of the influence of her major therapeutic approach. Mrs. Smith had highly goal oriented and structured music activities that she preplanned for the groups. It was also obvious that she implemented them within a strong cognitive behavioral conception, for example, the spontaneous use of musical elements to evoke clients' specific responses as well as the use of her music as a consequence for clients' behaviors, which was used to increase or decrease certain behaviors. Among the many events that reveal the influence, I introduce several below, and note that her language is strongly cognitive behavioral.

> *I wanted them to clap not long after he got in his seat, because then I wanted him to have the reinforcer. So, if we are thinking behaviorally, I wanted him to feel like he did something grand* (From the first review session).
>
> *I had the objective in my mind of what I wanted to accomplish, how much the students were engaging. If I kept going, I'm getting something else out of the group* (From the first review session).
>
> *[The transposed song with a fun quality] is also giving a non-verbal reinforcing to everyone that we're doing it right* (From the second review session).

Mrs. Smith's personal belief in music therapy, which seems intertwined with her increasing experiential knowledge throughout her life, affects her music understanding and the subsequent decision-making. As an elected leader in a music therapy association, she has been a passionate advocate for music therapy, and in our interviews, she fervently expressed her faith in music therapy. "I so passionately believe that music therapy is critical to our human growth and health that I want to experience it and I want everyone to experience it," Mrs. Smith said (From the last interview).

As specific actions to actualize her belief, she has put great efforts into enhancing social engagement and expansion of music therapy, for example, by having an inclusive music group with her clients with special needs and students in general education and also a group with her clients and people in the community. Although we did not have much discussion about the direct impact of her music therapy beliefs on her musical decisions, I found evidence of this in my first session observation with her. Her music activities have a clear focus on promoting quality interaction through music between her clients and general education students. For example, she made supportive musical gestures on guitar or in her voice when the inclusive group interacted well together. To put the influence of her music therapy orientation in a word, her general music therapy knowledge, her major approach, and her belief in music therapy are enormously

influential factors that shape her music listening perspective and actual musical decision-making process.

Mrs. Smith's musical traits

The major finding regarding Mrs. Smith's musical traits was that her musical traits including music skills, music resources, and music preference/interests affect her music listening and related decision-making overall. Another interesting finding is that her perception of her own musical traits and of their impact on her actual musical decision-making has been changing throughout her professional life. As her accounts often dealt with the items above simultaneously, I shall report them in combination with each other.

Regarding music skills, she affirmed that her aural and performing skills affect her musical decision-making and provided evidentiary accounts while reviewing her music therapy sessions with me. She disclosed that in the younger years of her professional work, her musical decisions were more limited to the music she could recognize and perform well. She also deemed its impact on her clinical decisions as something less professional.

However, as she has had more clinical experiences, the focus of her musical decision-making has shifted from whether she feels competent or inadequate about music material to her clients' musical wants and needs and to the development of her adaptive ability, which compensates for any of her perceived lacking of music skills. This also makes her clinically more capable of focusing on her client. Reflecting on her changing thoughts over the years while often talking about her past and the entry level therapists she works with, she stated that now she accepts her music skills as they are and feels more comfortable and confident about them.

Nevertheless, she still acknowledged their influence on her musical decisions in real clinical practice.

> *Yes, they do [affect my decisions]. I always thought that was a bad thing. But now in my older years, I know that it's okay for me to make a decision to not do something that* I think *the client might need to hear. But if I can't deliver it well, it will ruin the association that I would want to create for the client. So, I might have to go back and plan something on that type of music making for the next session and have some practice. […]So I'm more confident now* (From the last interview).

As reported in the section of Mrs. Smith's auditory listening experience, her clear focus on musical elements when listening aims at the functional use of the musical elements to help her client achieve given tasks. Thus, her aural ability to pick up those musical attributes that are clinically meaningful has a direct effect on her subsequent decisions in listening situations. This was very much in evidence. To my question of whether she attentively listens to the music she is making while singing and accompanying herself on guitar, she responded:

> *I do think I am. Once I get going in a setting like this I'm always very tuned in. It bothers me really big if my guitar is not tuned. […] Right here on the end I have a loose screw, so it will vibrate and I know those sounds don't make it sound as nice. So I try to manage those as much as possible. And then if my guitar is not enhancing what I want well enough or I'm mechanically not able to, I will try to affect my voice more dramatically to carry it more. Sometimes I end up that I might be pushing my voice too much. I might have decided at that time that the volume of my voice became more important than if I was projecting properly* (From the first review session).

As an example of the influence of her performing skill, when she wanted to give her music a splendid quality after her simple *acapella,* she played the song on piano while freely transposing its key. According to her, along with other clinical reasons, it was because she is more comfortable and skillful on piano. "I can't [transpose] on guitar as many keys chromatically as I can at the keyboard," she said supporting the realistic impact of her music skills (From the second review session).

Another compelling fact is that her need of playing unfamiliar or technically difficult music on the spot has established her various strategies over the years of her clinical work, that is, the "expanded use of [her] music skills." If she needs to sing a song with instrumental accompaniment that she cannot pick up immediately, she said that she may attempt to play it although it is not perfect, may play it in a different or simpler version, may suggest that the group members sing it if they know it, may plan to practice it before the next session, etc. (From the second review session). That such strategies were developed, demonstrates the influence of her music skills on her musical decision-making in sessions.

Moving to another aspect of Mrs. Smith's musical traits, her established music resources play an important role particularly when she decides upon musical interventions. When she was asked whether she has such music resources, she responded:

> *I call this to my interns 'my bag of tricks' that I have a depth of those things, and they're very important. I also though think that with all those different experiences that I have as resources that I can make new resources by putting pieces of other ones together. So I don't feel restricted as much as I did when I was a younger therapist* (From the last interview).

Mrs. Smith develops a session plan with specific goals and objectives, applies it with her clients, and evaluates whether it works for them. Through such work over the years, she has compiled a song and activity repertoire that has been successful. She said that as she has a lot of experience of using successful songs in various instances for years, she is not only competent in using the music materials but also knows what music responses she may get from clients.

> *I've been doing it for years and I pretty much have experienced every different kind of response that people can give me with it. So I felt like doing this [song] would give me musical freedom and also decision making freedom because I didn't have to worry about what I'm going to. I know all the different things I could do with the song* (From the first review session).

> *The song is one of my originals. It doesn't have to be that song that we use, but the elements of it. I wrote it for a group of preschool children who were totally*

> *out of control. The staff couldn't keep them together. And music therapy sessions were a disaster. So I wrote this song in order to help those children. And it worked. So then I kept on using the song in a number of ways over many years. And so that's why we started with that [in this session]* (From the second review session).

Along with the direct impact of the music and activity repertoire she has, she utilizes her human network as a supplementary music resource. She is open to the musical ideas of other music therapists and even her internship students. Furthermore, as she aims to expand her music therapy with special need clients to society at large, she welcomes external music resources such as community musicians into her music therapy sessions. This functions as an effective compensation in the areas where her music skills or resources might not work best, and she seems to feel confident about using her social network as an important music resource.

> *I just talked about how I want real sounds, but I really do enjoy high quality technology to help me. So I will look for that to assist and then I do a lot of partnering with local musicians. For example, I have brought in several jazz artists to work with my students.[…] I'm intimidated by the performance of it because it's complicated. I've been able to utilize that style where I can perform it at a level, but I also bring in the real artists that perform it well. So I think I become more resourceful* (From the first interview).

Regarding the influence of her music preference/interest, Mrs. Smith clarified that her clients' music preference is always her priority, and she has made conscious efforts to reflect their preference/interests in her musical decision-making. On the other hand, she also acknowledged the unintended influence of her preference or comfort level in music, considering that if she has an emotional connection with a selection of music, she may "be able to perform the music with [her] client in a convincing, authentic, excited way" (From the first interview).

Throughout the years of her professional work, she has found herself more comfortable and competent in working with any type of music for clients, for example, music from different cultures or from a different generation than hers. In our conversation, she candidly shared that in

her younger years, she might have tried to impose her musical taste on others, such as brand new songs, the younger generations' music, and her favorite numbers (From the first interview). She also shared a story from many years ago about when she was not very successful in accepting and correctly playing Middle Eastern music, to which she had been rarely exposed (From the first interview). Thus, she acknowledges that there is still the influence of her music preference/interest; however, the goal of her decision-making is "based on what's the right thing for [her] client," (From the second review session), and now, she is "able to discern when [her] personal impressions of [her] musical tastes are impacting [her musical decision]" (From the last interview).

In sum, Mrs. Smith's musical traits, including her music skills, music resources, and music preferences/interests have influences on her musical understanding in listening and related decisions in general. With a good understanding of the phenomenon in which a therapist's musical traits and musical decisions are interrelated, Mrs. Smith does not limit herself to her own musical traits and uses her own musical assets aptly for her practice.

Mrs. Smith's information about a case

Case information, which includes pathology/psychology of a client, non-musical information about a client, and musical information about a client, is a prime consideration for Mrs. Smith when she examines the clinical meaning of music and makes related decisions. Her accounts and my observations support that information about her clients has a direct impact on her musical decision-making. Additionally, her experiences in the environment where she collaborates with other teachers and therapists in special education seem to add rich, factual evidence for the function and value of case information.

First of all, Mrs. Smith strongly agreed with the importance and influence of both the pathology/psychology related to a client and the non-musical information about a client. Her accounts, however, often dealt with client pathology/psychology and non-musical information at the same time, so, the findings regarding their influences are presented in combination with each other.

According to her, in her music therapy context, clients' non-musical attributes (e.g., behaviors and personality) and the psychology/pathology related to individual clients is highly important information for her to run her music therapy sessions in concert with the educational policy of her school as well as to effectively assist her clients in having successful music experiences. Thus, she needs to stay informed about her clients' behavioral, psychological attributes. To do so, she attends IEP (Individualized Education Program) staff meetings, studies clients herself, observes them in and outside music therapy, and employs her related knowledge of developmental psychology and disability.

Regarding her information collection, she expressed her concern that she may not be informed in a timely manner of her clients' changing medication or psychological information and that realistically, she is not allowed time to gather detailed information about clients due to her intense schedule (From the first interview). Nevertheless, Mrs. Smith seems to stay alert, stressing the great necessity of in-depth investigation of each client, and this is consistent with her account that she is humble in knowing her clients' conditions and experiences (From the first interview).

Particularly, regarding its influences on planning music therapy sessions, she affirmed that the information about clients' non-musical attributes affects her decision-making.

> *Yes, it's very much in our planning. Frequently that is the focus of an IEP or it's a focused on problem for the other staff in trying to educate that child. So the non-musical characteristics very much are at the surface and they're hyper-scrutinized* (From the first interview).

Based on my observation, I found that she used her previous knowledge about clients and their behaviors observed at the site to find emotionally safe, aurally compelling, and educationally effective music for the clients as well as to use her music as a positive reinforcement for their achievement. She also seemed to use her information about clients' non-musical attributes to understand their musical responses. Supporting my observation, her accounts in our review sessions show that, based on what she perceives in terms of clients' behavior or emotional expression, she makes musical decisions based on this perception and does it on the spot.

> *I was so glad that he sat there. But then I didn't know if he was going to stay there. Because he's like a little boy with springs on the bottom of his feet, because he socially doesn't know that because everyone else is sitting, he should sit. So I thought that if I cued everybody to give applause, which is a common thing that many times they do with young children is clap to tell them that they did a good job, and then with the sheer volume of everybody clapping that would be almost like a physical like, yeah! wow! they're clapping for me* (From the first review session).

> *Their body language makes me feel happy when I see that. And then because they were not distressed, it was easier for me to keep the music going and to stay calm* (From the second review session).

> *I didn't want to be continuing the music if the mom was working against what actions the little boy was trying to do. You know a child with cerebral palsy, the more you ask them to get into action, the harder it is for them. So I didn't want this little boy to have the association that when I hear this hello song I got to tense up* (From the second review session).

Along with her knowing clients' non-musical attributes, her knowledge of child development, special education, and developmental psychology is also involved in her musical decision-making process. For example, in her early childhood group session, she was proficient in working with the pairs of young children and their mothers, and she said in the review session

that her knowledge of this population might make her reach particular decisions, which might be different from her decisions with a different population.

Besides the clinical examples I witnessed, Mrs. Smith shared several stories of when clients' non-musical attributes and her knowledge related to the attributes directed her to specific musical decisions. She once decided not to work with a student in her relaxation group who turned out to have a mental illness. He had hallucinations in which he was hearing voices speak to him. For a student who lost his grandfather and missed him very much, she used songs about the grandfather, dealing with the student's emotional feelings. When she worked with students who could not get jobs due to their loud voices, she developed a strategy for teaching them how to adjust the volume of their voices (From the first interview). With these cases, she stressed how important it is for a music therapist to know clients' non-musical attributes in order for music and music activities to make good sense to them, leading them to successful and meaningful experiences.

Lastly, regarding the influences of clients' musical preferences, Mrs. Smith agreed unconditionally, saying "I don't think you can do music therapy, unless you're focused on their preferences," (From the first interview). Without knowledge of clients' music preferences, aptitudes, previous experiences, and music-playing skills, it is almost impossible to plan and deliver clinically appropriate music to them. Additionally, depending on the musical responses she perceives in a session, she makes spontaneous decisions of how to present music and even what musical material she will use. To the question of whether clients' musical responses in a session affect her musical decisions, she responded:

> *Very much so, because there are times, depending on what my immediate objective is, but there are times when I need to totally change what I'm doing according to what the group's music response is* (From the last interview).

Among many observed events that show how Mrs. Smith perceives clients' music responses and how she makes decisions in response to them, I shall introduce two examples borrowing from her accounts. They are her answers to why she did not have an instrumental accompaniment while introducing an activity to the inclusive students group and how her clients in the early childhood group contribute to her music making.

> *I chanted at first and I want them to really feel the pulse. And I want them to know that I want them to echo me back. So if they don't do that I can use the lack of accompaniment and as soon as I stop it's silent. And then I can just say to everyone, 'I really need you to echo back to me' and 'you have much stronger voices' if they don't use strong voices (From the first review session).*
>
> *The children's contribution to me was more rhythmic, although he was telling us a lot with his voice. But more rhythmic contribution because I'm looking at the timing of when they responded. When did they? How long did it take them before they stopped responding (From the second review session).*

Mrs. Smith clearly sees the phenomenon where a therapist's musical decisions cannot be made solely relying on his/her client's musical traits, but rather the therapist's own musical traits are involved in the decision-making process to some degree. However, the salient principle in her musical decision-making is the priority of her clients' musical traits. As mentioned previously, she has made practical efforts to feel and understand clients' music truly, and this veteran therapist in her fifties is vigilant and aggressive in learning the new music her young clients like by watching TV shows and looking for music online. As her procedural investigation in her music therapy protocols, she also methodically collects the information of clients' musical traits and music-related behaviors through assessment sessions she designed.

Being at the center of her clinical standards and concerns, case information turned out to be the most influential factor in Mrs. Smith's music listening and related decision-making. The three types of information from the model, i.e., clients' non-musical attributes and her knowledge in psychology/pathology related to the attributes, as well as clients' musical attributes

which she has observed in sessions, were advanced as critical influences on her musical decision-making.

Situational immediacy

Situational immediacy functions as an unavoidable influence on Mrs. Smith's immediate perception of music and her spontaneous decision-making in sessions despite her meticulous session preparation. As she develops her music activity agenda prior to a session, often with the music activities she has found to be successful in many instances, the effect of situational immediacy may be minimal. Since she feels more comfortable and competent while implementing pre-organized music activities she is familiar with, however, Mrs. Smith seems to be able to focus more on situational circumstances in her sessions. Furthermore, she mentioned that she is flexible in adapting the sequence of her preset music activities to the situational needs, and when unexpected events happen, she tries to deal with them and still keep the flow of her music activities (From the last interview).

Particularly, she agreed with the influences of physical environment, such as classroom size, noise level, the availability or quality of musical instruments, and so on. Regarding the impact of the presence of others, she shared her related experiences of when she has needed to make some musical decisions to keep the attention of her clients, and of when she has to adjust her music activities to greet visitors to her sessions, for example, a U.S senator or school superintendents. Additionally, the incident in the video session when the CD player she was using did not work all of sudden, causing a break for a while, could be another example of the influence of physical environment. She also agreed with the possible influence of a therapist's physical, emotional condition, sharing her story of having to decide whether to continue for the

remaining time when she was told in the middle of her session that her grandmother had died (From the last interview).

As a strategy to cope with possible situational incidents, she develops scenarios in her mind about what response she may have from clients, what else may happen in clinical situations, and then what backup plan she is going to use. Nevertheless, clinical situations cannot be completely predicted and require her to make musical decisions on the spot. She called such decision-making in a session the art of a music therapist's work.

> *I feel like [on-the-spot decision making] is a gift given to me that my thoughts created something that was effective for the client. I think a lot of what we're doing is this. This is the art of us doing music therapy* (From the last interview*).*

In sum, situational immediacy is inevitable in her musical decision-making in practice as supported by her accounts and my observations. While she carefully prepares music interventions prior to sessions, she values moment-to-moment musical decision making in a given clinical situation as a critical work of a music therapist.

Summary

Mrs. Smith actively and systematically uses her own music listening experiences to perceive musical qualities and to investigate the clinical meaning and practical use of the music. In the existential listening area, she provided rich accounts of her experiences, particularly physiological/bodily and affective listening experiences. In auditory listening, she focuses more on picking up and functionally using musical elements to promote clients' non-musical changes. Regarding reflective listening experience, she highly values a therapist's empathy in listening to clients, she discerns different listening purposes in the process of music therapy service, and she

analyzes, evaluates, and interprets music for the sake of clients having clinically meaningful experiences.

In the second part of the case report, her music therapy orientation (e.g., music therapy orientation, major therapeutic approach, belief in music therapy) was discussed as a foundational influence on her perception of music in music therapy and subsequent clinical decision-making. She also acknowledged that, realistically, her musical traits (e.g., music skills, music resources, music preferences/interests) affect her musical decisions to some degree and also expressed that throughout her professional life, she has perceived that the impact of her own musical traits has decreased. Furthermore, her information about clinical cases (e.g., pathology/psychology related to a client, and non-musical and musical attributes of a client) turned out to be the most important influence on her musical decision-making. Without this, one cannot understand the client's music and provide appropriate music for the client. Lastly, situational immediacy (e.g., physical environment, her own emotional/physical conditions) also functions as an inevitable, in-the-moment influence on her decision-making regarding the use of music. Taking these all things together, I will discuss the case further in conjunction with the other cases in chapter VII.

CHAPTER VII

Discussion

Individual and collective analysis of the three cases

In previous chapters, the three music therapists' music listening approaches and musical decision-making processes were presented within the bounded systems of each case. In terms of the perspective through which I presented the findings, I tried to reside in each individual music therapy approach when reporting a case, using language that was more acceptable in that approach.

In this chapter, I discuss the research findings of the three cases from both local and collective standpoints. Regarding the ultimate aim or destination of this particular study, the research focus stays on elucidating the three cases' listening experiences and musical decision-making and how the proposed model works in the local conditions of each case. On the other hand, through the cross examination of the cases and the theoretical triangulation of the findings, I attempt to understand each case from the perspective of the others. The cases in the research present themselves as an assemblage or a kaleidoscope of the similarities and differences regarding music therapists' music listening and related decision-making.

Additionally, I discuss the implications of this multiple-case study for the further development of the model, which is one of the functions of case-study research as a preliminary process towards developing a theory (Glaser & Strauss, 1967). Through inquiring into how the framework of music therapists' clinical music listening works using the model and how it does

not work for each particular case and for the cases collectively, I establish the basis of a future project to develop a theory that could be workable in general.

The point that I need to clarify is that the three music therapists—although they are seasoned and outstanding practitioners in each approach—do not represent in totality the Guided Imagery and Music (GIM), Nordoff-Robbins Music Therapy (NRMT), and cognitive behavioral music therapy approaches. Rather, they should be understood as experienced individual therapists who can share invaluable information from their long and efficacious clinical practices in which they have used GIM, NRMT, and cognitive behavioral music therapy.

As a format for the discussion, I employ the theoretical propositions in the model once again, i.e., the three types of music listening experiences and four considerations for musical decision making. Since the three therapists agreed that their listening had a direct influence on their musical decision-making and that logical relations existed between their listening experiences and the considerations for musical decision-making in the model (See the model p. 62 in chapter II), I discuss the research findings in a reconstructed order such that each type of listening experience is paired in turn with each type of consideration.

Existential listening

Regarding existential listening, all of the three therapists seem to have related listening experiences to some degree (i.e., physiological/bodily, affective/emotional, and non-ordinary/peak experience). However, they put different weights on the importance of each

category. In general, Mrs. Snow (GIM)[2] and Mrs. Smith (cognitive behavioral) highly stressed the value of existential listening, since they explicitly use their own listening experience to assess music as clinicians. On the other hand, Mrs. Collins (NRMT) put the least value on existential listening as an influence on her NRMT practice compared to the other types of listening experiences.

Particularly, both Mrs. Snow (GIM) and Mrs. Smith (cognitive behavioral) use the awareness of their physiological/bodily and affective/emotional experiences to explore and examine the music they listen to. Interestingly, however, the actual listening experiences of Mrs. Snow (GIM) and Mrs. Smith (cognitive behavioral) have quite different qualities and are conceptually very different.

Mrs. Snow's bodily experiences are strongly connected with her affective/emotional and non-ordinary experiences. Her bodily experiences are not only a means by which she senses the musical qualities she needs for her GIM clients, but also a direct expression of her experienced emotions in general and her spiritual experiences in non-ordinary states of consciousness. The thing that makes Mrs. Snow's bodily experiences different from the other two therapists is that her "affective-intuitive" listening through her body occurs in various levels of consciousness (Bonny, 1987, 1993). This music listening approach is the "body listening" that the founder of GIM, Helen Bonny, has taught GIM practitioners (Bonny, 1993) and that has been used by many

[2] From here on, the music therapy approach of each individual will occasionally be referred to in abbreviated form in parenthesis, (viz. GIM, NRMT, and cognitive behavioral). This does not mean that the individual therapists represent each of the three approaches, but in order to avoid confusion among the names of the three therapists, I take this abbreviated form.

practitioners as an effective self-learning tool for GIM music analysis (Pickett, 1994; Viega, 2011).

On the other hand, the physiological/bodily listening experiences of Mrs. Smith (cognitive behavioral) rely more on the corporeal perception of concrete musical qualities through knowing her own physiological responses and her own natural physical movements to music. Such bodily listening experiences occur in combination with her affective responses to music, which also contribute to her examination of music. To put it another way, Mrs. Smith's physiological/bodily and affective/emotional listening is goal-oriented, as it is specifically targeted toward detecting musical elements and evaluating the music for its use in her practice.

This type of listening approach is in accordance with the way that cognitive behavioral and neurologic music therapists have examined and demonstrated the effect of music on human responses and behaviors in their research (See p. 26 in chapter II). Music therapists' attention to human responses (e.g., gait and heartbeat) to specific music stimuli (e.g., stimulative/sedative music or single musical elements) is exactly the listening mode Mrs. Smith takes in terms of bodily and affective listening.

As mentioned before, Mrs. Collins (NRMT) does not consider her existential listening, particularly physiological/bodily experiences, as an influence on her NRMT practice. It is notable that although she seems to have related experiences, she does not give conscious attention to them as a critical factor for her musical decisions. While Mrs. Collins shared her enriched affective/emotional experiences, she did not emphasize the connection between her affective and bodily experiences as the other two therapists did.

The question item of non-ordinary/peak experience seemed to be accepted differently by the three therapists. Mrs. Snow (GIM) highly valued the clinical importance of this listening

mode, while enthusiastically sharing her own experiences. Certainly, what Mrs. Snow reported were not down-to-earth reactions to music but spiritual, creative experiences, which may occur in Altered States of Consciousness (Bush, 1995).

The non-ordinary/peak experiences of Mrs. Collins (NRMT) and Mrs. Smith (cognitive behavioral) seem to be extreme types of their affective listening experiences, which are different from spiritual or unconscious experiences. Rather, their peak experiences in listening were described as precious, rewarding feelings regarding their clients' successful experiences in music.

The influence of music therapy orientation

All three of the therapists agreed that their music therapy orientation (e.g., knowledge in general music therapy and a specific approach, and belief in music therapy) is highly influential on their music listening perspectives as well as their musical decision-making in practice. Interestingly, the accounts of their music therapy orientations often overlapped with those of their major/specific music therapy approaches (i.e., GIM, NRMT, and cognitive behavioral music therapy). A therapist's music therapy orientation is generally viewed as conceptually broader and is not entirely determined by a type of therapeutic approach; however, their accounts imply how strongly their overall clinical practices are related to their major/specific approaches. Along with the global effect, the therapists' major/specific music therapy approaches contribute to forming their listening perspectives and listening objects as well as their musical decision-making in sessions (See "Music therapy orientation" in chapter IV, chapter V, and chapter VI).

While talking about their music therapy orientations, Mrs. Snow (GIM), Mrs. Collins (NRMT), and Mrs. Smith (cognitive behavioral) enthusiastically expressed their conviction about the therapeutic power of music and their beliefs about their therapeutic approaches, and

they strongly agreed with the influence of such music therapy beliefs on their musical decision-making.

These findings regarding the therapists' music therapy orientations are supported by the findings of Amir's qualitative research (1999) investigating experienced music therapists' perception regarding their use of verbal and musical interventions. In particular, her research revealed that "a therapist's theoretical orientations," "professional knowledge of therapeutic process," and "belief in music and therapeutic power" were the primary factors influencing the therapists' decisions regarding the use of musical interventions, for example, when to use them, what intervention to use, and how to use them (See pp. 57-59 in chapter II).

Auditory listening experience

All three therapists agreed that a therapist's aural listening is important for the clinical use of music, but Mrs. Snow (GIM), on one hand, and Mrs. Collins (NRMT) and Mrs. Smith (cognitive behavioral), on the other hand, have different listening approaches. First, Mrs. Snow (GIM) does not analyze music from a music theory perspective in terms of musical elements and musical forms. Rather, depending on her overall impressions of the music, she focuses on determining the "amount of stimulation" in music, which is related to the energy levels of the music and which should be matched with her client's energy level (From the first interview).

In terms of listening objects, Mrs. Collins (NRMT) and Mrs. Smith (cognitive behavioral) both pay great attention to the aural analysis of musical attributes, but they focus on different musical attributes. In the case of Mrs. Collins (NRMT), both musical elements and structural aspects of music are her listening objects. Since she helps clients to be aware of musical qualities in mutual music making and to organize their music consciously, it seems very natural for her to

concentrate on and be aware of all musical aspects and to organize them "musically good" and clinically meaningful. In this regard, Mrs. Collins' auditory listening approach is related to the findings regarding the great influence of music skills and music resources on musical decision-making. The importance of aural skills along with performing skills is also supported by the training guidelines for NRMT musicianship (Robbins & Marcus, 2007). In all, Mrs. Collins' auditory listening is a weighty and vital listening area for her as a Nordoff-Robbins music therapist.

Mrs. Smith's (cognitive behavioral) auditory listening focuses more on musical elements than musical structures, although she stated that she pays attention to both. To put it in a word, her auditory listening is functional. She is very skillful at dissecting music into musical elements and using them systematically to promote specifically related responses or behaviors in her clients. This functional transference between human responses/behaviors and related musical properties (as described by Thaut, 2005; Unkefer, 2002) contrasts with Mrs. Collins' (NRMT) approach and the objects of her listening.

Musical traits of the three therapists

The influence of the therapists' musical traits on their musical decision-making was investigated with the assumption that music therapists' music perception and music playing in clinical situations is an amalgamation of their musical experiences and proclivities (e.g., music skills, resources, and preference/interest). However, the influence of therapists' musical traits has not been a prominent topic in music therapy, where a client's musical traits are always the first and foremost concern. This is despite the fact that a therapist's musical traits are not completely separable from his/her musical decision-making in real practice. As Mrs. Collins (NRMT)

mentioned, we music therapists might not be fully aware of the impact of our musical proclivities or we may avoid speaking about them (See p. 136 in chapter V).

The findings of the research also revealed the disparities among the therapists' perceptions of each question posed to them, although the three therapists acknowledged the influence of their musical traits in general. Unlike their common agreement with the effect of compiled music resources on their musical decisions, the therapists took multifarious and sometimes inconsistent positions regarding music skill and music preference/interest. Mrs. Snow (GIM) stated that her music skills, particularly aural ability, do not affect her perception of music and her music choices in her GIM practice. She acknowledged the possible influence of her music preference/interest to some degree, yet she stated that she has made efforts to lessen its impact by learning the music she might not have been familiar with and interested in.

On the other hand, Mrs. Collins (NRMT) highly valued a therapist's aural and performing skills as a vital factor for musical decision-making in NRMT practice. She also acknowledged the possible influence of her music preference, replacing the word "preference" with musical comfort or habits; at the same time, she reminded me that her top priority is the client's music preference, expressing the hope that her own musical preferences are not very influential in her work (See p. 136 in chapter V).

Mrs. Smith (cognitive behavioral) agreed that her aural and performing skills as well as her music preference/interest affect her musical decision-making. Despite this general acknowledgement, she claimed that their effect has decreased as she has had more clinical experiences and becomes more mature as a clinician.

As noticed in the report above, their accounts show the disparity between their ideal and realistic musical decision-making in terms of the influence of music therapists' musical traits.

The seasoned therapists certainly see that therapists' musical decisions in practice cannot help but being influenced by their own musical proclivities to some degree. Such a finding is supported by Amir's research (1999) which found that experienced music therapists considered their musical ability and experience with music in their life, in their own therapy, and as professionals to be influential on their decisions regarding musical interventions (See pp. 57-59 in chapter II). Nevertheless, it must be remembered that their clinical focus firmly stays on clients' successful music experiences and the use of their preferred music. If the therapists feel that their decision-making is not limited by their music skills and musical comfort zone, this may be the result of vast work experience and clinical maturity.

Reflective listening experiences

Reflective listening, which means client-centered or clinically focused listening, was identified as the most important listening area for all three of the therapists. In particular, they emphasized empathy in music listening so intensely and enthusiastically that it is not worth dwelling on the degree to which each therapist stresses it.

In this regard, I present my impression of each therapist's empathetic listening to impart some highlights of their experiences. Mrs. Snow's (GIM) experiences could be epitomized by her calm and supportive presence with a client in a session, based on her insight into the client's listening experience. Mrs. Collins' (NRMT) empathy could be represented by her musically active presence with her client through expressive music making, based on her keen perception of the musical process in the child. It was also impressive that Mrs. Smith (cognitive behavioral) raised a question poignantly about whether therapists fairly understand individual clients' experiences in everyday practice, giving lived examples from her school setting.

In terms of critique/interpretation of music, the three therapists agreed that they listen to music analytically to understand a client's music or judge the clinical usability of music. Different from Mrs. Snow (GIM) and Mrs. Smith (cognitive behavioral) who may work on a different level of meaning in music, in terms of psychodynamics or behavioral science, Mrs. Collins (NRMT) focuses more on a client's music itself and analyzes it from musical standpoints. In this regard, an interpretation of music that includes a translation of music to a different dimension of human consciousness or behavior might not suit her listening perspective in NRMT practice.

The interview item, awareness of different listening purposes in music therapy protocols, does not seem to be the main concern of Mrs. Snow (GIM) or Mrs. Collins (NRMT). On the other hand, Mrs. Smith (cognitive behavioral) clearly expressed that she listens to music for different purposes during the phases of assessment, treatment, and evaluation. In formulating this question, I may have been drawing on my own conceptions regarding music therapy as a scientific treatment procedure, and this is perhaps close to Mrs. Smith's conception in her cognitive behavioral music therapy approach.

Case information

As discussed above, the three therapists highly stressed the clinical importance of their reflective listening, and in this regard, case information was also rated as the most influential factor for their musical decision-making. Regarding the information about clients' non-musical attributes (e.g., personality, behavioral characteristics, and personal history), they all stressed that collecting such information is a necessary condition for their music therapy practice. My observation that these therapists made musical decisions in immediate response to clients'

emotional, behavioral, physical reactions to music bolsters the influence of their information about clients' non-musical attributes. Amir's research (1999) supports this proposition with a similar finding regarding music therapists' perception of the use of interventions, such that therapists' knowledge of clients (e.g., age, population, needs, responses to interventions, and goals) is a factor in deciding upon musical interventions (See pp. 57-59 in chapter II).

In conjunction with the information about clients' non-musical attributes, the knowledge of psychology/pathology related to a client was another area about which there was agreement among the therapists. Although the therapists' mental processes of employing the knowledge during decision-making were not discussed in detail, all of the therapists strongly agreed with its influence on their musical decision-making.

The other item about clients' musical traits (e.g., music preference, skills, experiences, knowledge, and so on) was also one of the vital influences on musical decision-making, without which mutual, clinically meaningful music experiences cannot occur. The different ways that each therapist collects the information about a client's musical traits may provide readers with interesting and valuable information regarding the therapists' formal/informal music assessment (See p. 109 in chapter IV as an example).

Situational immediacy

While the influence of music therapy orientation is paired with existential listening, the influence of a therapist's musical traits is paired with auditory listening, and the influence of case information is paired with reflective listening, situational immediacy does not have a pair from the categories of music listening experiences. Rather, it is understood as a phenomenological

arena where music therapists listen to music and make related decisions and/or a situational variable, which affects "on-the-spot" musical decision-making by three therapists.

In the case of Mrs. Snow (GIM), she seemed to consider situational immediacy not only as situational variables, such as physical environment and what is happening in the moment, but also as a phenomenological arena, in which the whole process of her music listening and decision-making occurs and works in interplay with other conditions, much like the concept of "field" in Kenny's field of play (See Kenny, p. 98-102). Her perspective is also in conformity with Bonny's conception of "music as a language of immediacy," which could explain the effect of her immediate music reception on her own experiences and related musical decision-making, as a music listener, as well as a therapist (Bonny, 1979).

Agreeing with its influence, Mrs. Collins described and explained situational immediacy with the concepts of Nordoff-Robbins Music Therapy. Referring to Robbins' concept of the "creative now," she stressed the importance of the spontaneity, creativity, and newness in NRMT situations (Robbins & Forinash, 1991). She tended to explain situational immediacy as the process of trial and error as well as the combination of her intuition and clinical intention, rather than attributing it to an unexplainable or unconscious area.

Slightly differing from the other two therapists, the accounts of Mrs. Smith (cognitive behavioral) tended to consider situational immediacy as a variable factor, which may affect her final decisions as things occur or happen in given situations. Her prescribed music interventions and systematic implementation of them may not allow much room for situational immediacy. Nevertheless, her keen observational skills and awareness of situational influences seem to contribute to her "on-the-spot" musical decision-making in her cognitive behavioral music therapy practice.

Implications of the three cases for the proposed model

The findings in the three cases yielded important information about the "goodness of fit" regarding how fairly the framework of the proposed model illuminates the therapists' music listening and related decision-making process and how it worked for my investigation of such mental processing by the therapists. Since I interviewed the therapists with the questions developed from the model, the therapists' agreement, objection, emphasis, and attention towards each question item helped to determine whether an item (e.g., empathetic listening, situational immediacy) applies to each case. The suitability of each item of the model has been demonstrated throughout the reports of each case and in the discussions above.

The model seems to illustrate Mrs. Snow's musical decision-making process in clinical music listening relatively fairly. Mrs. Snow (GIM) agreed with most components of the model and particularly with how the components function together and how the process in the model flows. She said that while working with me for the research, she got to think more seriously about the various influences on her music therapy practice. Because of the detailed analysis of the phenomena in the model, she mentioned its possible "application for teaching music therapy students how to think about making their musical decisions" (From the last interview).

From the case of Mrs. Collins (NRMT), I obtained invaluable information to revise and improve the model so that it could be more comprehensible to those with various music therapy approaches. In her case, there were some components which she might not have paid attention to or does not consider as critical factors for her decision-making (See chapter V). She pointed out that specific parts of the model (e.g., unexplainable, situational immediacy) might not fit NRMT as they are not in complete conformity with the conceptions of NRMT. However, Mrs. Collins claimed that she does not limit herself to that specific approach and is influenced by her own

therapy and her own experiences in life. She added "[the model] may dilute a little bit what we think [that] Nordoff-Robbins is, but I think if this model is about creativity and openness then that fits" (From the last interview).

Mrs. Smith (cognitive behavioral) expressed her strong agreement with most items in the model as influences on her musical decisions, but her focus stays on the ways that music is understood and used in cognitive behavioral music therapy. Her perception was more open and multifarious than I expected, breaking my previous and tentative assumption of what cognitive behavioral therapists' thinking processes might be. However, rather than discussing the suitability of the model to cognitive behavioral music therapy, I would say the model seems to describe Mrs. Smith's musical decision-making process fairly as an individual therapist. Regarding its possible application, she mentioned its usability to educate people in and outside music therapy about music therapists' complicated and systematic work in practice to advocate for music therapy (From the last interview).

The proposed model of music therapists' clinical music listening (Bae, 2010a) has been a guideline throughout the whole research process, as a useful tool for investigating the façades and hidden areas of the three therapists' musical decision-making in clinical music listening. The ample, in-depth information from the three seasoned therapists and the research findings should help me to revise the model in the future, so it can be generally logical and maximally applicable to other cases, from the student therapist to the veteran therapist in various music therapy approaches (Creswell, 2007, p. 127).

CHAPTER VIII

CONCLUSION

Music therapists' music listening and subsequent decision-making

Through this multiple case-study research with three seasoned music therapists in three different approaches (i.e., GIM, NRMT, and cognitive behavioral music therapy), I investigated their experiences and perceptions regarding musical decision-making in clinical music listening using the *a priori* model that served as the framework of the research. The research questions, which were developed based on the model, were addressed substantially, although the findings of the research are not in the form of clear-cut equations or explicit conclusions. Rather, the research yielded extensive but critical information about music therapists' musical decision-making process, creating further questions about it.

This consequence matches one of the general functions of case-study research, which is exploring the bounded system of a case (See "multiple case-study research design" pp. 70-71 in chapter III). It also coincides well with my initial plan to investigate this type of mental processing in seasoned therapists and to generate informative findings about this abstract and unexplored topic.

The research questions were:

1) What do music therapists experience while listening to music in clinical practice in terms of a) existential listening, b) auditory listening, and c) reflective listening?

2) What do music therapists consider when making decisions in clinical music listening situations, in terms of a) their music therapy orientation, b) their musical traits, c) case information, and d) situational immediacy?

3) How music therapists' music listening experience and clinical considerations influence their musical decision making? (See "research questions," pp. 22-23 in chapter I)

Each question was dealt with through illustrating each therapist's experience and perception in the case reports (Chapters IV, V, and VI), and then the findings corresponding to the questions were discussed individually and collectively in Chapter VII. Next, a précis of the research findings in this chapter is included to help readers to integrate the information from the research reports so far. It will also add enlightening points regarding the relations among music therapists' listening experiences, clinical considerations, and musical decision-making.

First, each of the three music therapists had in-depth experiences in various listening areas; however, the individual therapists from different approaches tended to put different amounts of emphasis on various listening areas. Second, the three therapists' perceived influences on their musical decision which shared commonalities as well as differences in each inquiry item. Lastly, I found across the cases that what the therapists experienced and perceived from music directly affects what musical decisions they make. Conversely, what they consider when making clinical decisions also immediately affects their music listening experience. Suggesting a strong relationship between music therapists' listening approaches and considerations for their musical decision-making, those internal thinking processes turned out to be critical factors for these three music therapists' musical decision-making.

As I anticipated in the research-design stage, the research participants imparted copious amounts of specific information, coinciding with the rationale of the "critical case" sampling

strategy used for the research (See "participants," p. 76 in chapter III). The information the three master therapists provided in the research conveys mainstream, sophisticated knowledge in the field, which is also found in research with other experienced music therapists or exceptional research dealing with similar topics. Furthermore, the core philosophies, theories, and techniques of the music listening approaches discussed in the literature review are found in these three therapists' accounts as well—although they are extremely abbreviated in the review (See "systematic music listening approaches" in chapter II). Mrs. Snow emphasized her bodily experiences as an experiential music analysis tool as Bonny did (1993), and Mrs. Collins' agreement with the effect of a therapist's music skills was similar to that of Lee (2000).

Replicating findings within different contexts is a critical function of case study research. The similarities among the cases literally replicate the findings regarding the therapists' musical decision-making. The contrasting findings also make theoretical replication in the differently situated cases, supporting my research assumption regarding possible dissimilarities among individual therapists using different music therapy approaches (See Yin, 2009, p. 54). Furthermore, confirming past research and writings outside the research context, this research generates additional knowledge from the music therapy experts' life experiences.

Implications of the research

In the introduction, I discussed the practical reasons why the inquiry into music therapists' music listening and subsequent musical decision-making is important (See pp. 20-22 in chapter I). As this research has generated substantial outcomes, the discussion must now turn to its empirical contribution to the field of music therapy. I shall now discuss the implications of the research for music therapy research, practice, and education.

First, regarding clinical practice, the research elucidates a core mechanism of music therapy interventions, namely, music therapists' musical decision-making, and thus will give professional and student therapists critical information about how music is assessed and evaluated and how music interventions are selected and implemented in practice. Such knowledge may be used to enhance a therapist's own clinical practice, as well as to communicate with other professionals about music therapy practice in a more effective and professional manner. It will also stimulate practitioners to check and probe into their own philosophical, theoretical standpoints with respect to the making of judgments/decisions regarding music. As therapists devote themselves to specific approaches, while still developing their own styles of clinical practice, having a big picture of this phenomena and learning other therapists' working processes in various approaches may contribute to improvement of their clinical practice.

Second, for music therapy research, this work innovates by incorporating decision research into the field of music therapy. As an investigation of clinical, musical decision-making is in a nascent stage in music therapy discourse in terms of research topics and approaches (See "decision research," pp. 51-52 in chapter II), this research elucidates how a decision-research technique can provide exploratory, yet pivotal knowledge about the decision-making of music therapy professionals.

Additionally, it could contribute to making other research logically and empirically more convincing. Although demonstrating the effectiveness of music therapy treatments has been the primary focus in research, many research reports often do not give thorough rationales for the particular therapeutic treatments used and tend to focus on the effect itself or the effect size. To assist in raising researchers' awareness of the topic, my research may provide them with a piece of the puzzle that makes their own research more credible.

Third, regarding music therapy education, these findings could teach students and novice music therapists how musical decisions are made in clinical practice. Particularly, in that the research data came out of music therapy experts' experiences and perceptions, students may find exemplary experienced music therapists from whom they can learn. Music therapy educators could use the rich information from the therapists' accounts in classes to help students understand substantial clinical work and to promote the students' personal growths as prospective therapists. Additionally, although the model used for the research is still in the development process, it may be used as a simple guideline from which to teach about musical decision-making in practice, as Mrs. Snow (GIM) and Mrs. Smith mentioned (cognitive behavioral music therapy).

Concluding the implications of the research, I would say that the investigation of human mental processes, including those both within a therapist and a client, should be spotlighted in music therapy. Wilson (1990) wrote about the historical change from the early idea of music therapy as simply providing positive music experiences, to the routine, regulated protocol of methodical music therapy documentation, as in the Clinical Standard of Practice (National Association for Music Therapy, 1988). Considering the historical metamorphosis of music therapy, the contemplation of and inquiry into human mental processes, particularly music therapists' clinical thinking processes will contribute to the sophistication and improvement of the discipline as a whole.

Limitations and future research

I accept the fact that there are difficulties in researching and presenting different approaches equally in one study, since no one researcher has an in-depth knowledge of all music therapy approaches. As a tactic, I have consulted with my music therapy professors about whether I have understood and described each case from a meaningful standpoint or whether I might have misunderstood the accounts of each therapist due to limited knowledge of a particular approach. Their comments on my data analysis have been useful checks for my research findings and have also provided critical information to help maneuver my position and research skills when necessary, as data triangulation.

Second, the limited time and space allowed for the research process might have kept me from fully illuminating the phenomena and discovering more hidden phenomena. Working with therapists with incredibly hectic schedules in a limited number of meetings might have functioned as a constraint to my data collection. The geographical distances, for example, a ten-hour trip, also might have been another limitation, which could have affected the amount of data collected and my interviewing skills at the interview sites. In that a long, persistent engagement with research data is imperative for doing good qualitative research, the time limit of conducting a study as a fulfillment of a degree program might be another constraint.

Third, as a critical consideration for the research, the research participants' experiences and perceptions about the research topic should be understood as only these persons' experience and perceptions in the bounded system. In particular, although the three research participants are outstanding, seasoned therapists in each approach, they cannot fully represent these music therapy approaches, and the research data do not serve as representative sample of all music

therapists' experiences. In addition, the therapists' gender, age, location, educational and work experience, personal character, and so on, should be understood in the same way.

As I wrote regarding the function of process tracing approaches to investigate decision makers' internal thinking process (See "Process tracing research and verbal protocol," pp. 53-55 in chapter II), the findings of decision-making research using this type of qualitative research approach could be examined again in differently structured qualitative research or quantitative research designs, using, for example, information boards or quantitative experiments. The data collected from the music therapy experts, which provide invaluable information for the revision of the *a priori* model, and my learning from conducting this research intrigue me to do more qualitative research to generate additional detailed, in-depth information about each item in the model. As another way of developing related knowledge, quantitative experimental studies using information boards, with which decision makers make choices among alternatives, or quasi-experimental research design, could be conducted based on the findings in the research about the influences on music therapists' musical decision-making.

EPILOGUE

It was inspiring, educational, and productive to look into three seasoned music therapists' thinking process about music in music therapy. During my encounter with the therapists, I was impressed by their vibrant enthusiasm, even after their long clinical careers. The expertise naturally engraved into their descriptions also taught me as the researcher and as a junior music therapist, and also provided the research with invaluable information. I am grateful for acquiring from these three impressive thinkers and eloquent therapists much knowledge and understanding regarding the musical decision-making process. Along with this fruitful experience, their support for my endeavor to elucidate such clinical thinking processes stimulates my curiosity about what others' thinking might be and ignites a strong desire for me to better elucidate these processes in future research.

> *After having done this with you, I started thinking about 'how are we teaching our students?' […] I was thinking that this could be a great application for teaching music therapy students how to think about making their musical decisions* (Mrs. Snow in the last interview).

> *There are so many influences, and I think that's what you're trying to capture and I like that. There are many levels. And it's pretty difficult work when we think about 'how are we expected, with all this going on, to actually be playing something and relating to someone?'* (Mrs. Collins in the last interview).

> *I will be anxious to be able to use this as a visual when I'm talking with interns. […] The other reason I think this is useful is for me—I'm very driven by having other people understand why they need us, to show that we have the skills. This is what complicated things are happening while we're playing* (Mrs. Smith in the last interview).

I shall be eternally grateful to the clients and music therapists who participated in this study. What I have learned from them has opened up not only a deeper understanding of how music therapy works, but also renewed energy to continue my quest to understand therapist's

music listening and decision-making. This quest has been transformative in my own growth and development as a professional music therapist. I remain humbled at the dedication and sincere concern for the betterment of clients exemplified by the three music therapists who participated with me in my journey toward greater understanding of how we as music therapists achieve the results that we do.

APPENDICES

APPENDIX A

DEMOGRAPHIC INFORMATION

Table 10. Demographic information on the research participants

	Mrs. Snow	Mrs. Collins	Mrs. Smith
Professional Credentials	MT-BC (Music Therapist-Board Certified) FAMI (Fellow of Association for Music and Imagery)	MT-BC (Music Therapist-Board Certified) NRMT (Nordoff-Robbins Music Therapist)	MT-BC (Music Therapist-Board Certified)
Work experience	Over thirty years	About thirty years	About twenty seven years
Work setting	-Private Guided Imagery and Music practice -Music therapist in a music therapy center belonging to a university -Music therapy professor	-Music therapist at a music therapy center	-Music therapist for a school district -President of a regional music therapy association
Educational background	Bachelor's degrees in music and music therapy Master's degree in music therapy	Bachelor's degrees in psychology and music therapy Master's degree in music therapy	Bachelor's degree in music therapy Master's degree in music therapy

APPENDIX B

RESEARCH INTERVIEW GUIDE

1.1. What feelings do you experience when listening to music in practice?

- ✓ Experienced physiological, bodily experiences
  - o Your perception of your experiences
- ✓ Experienced emotional experience
  - o Your perception of your experiences
- ✓ Experienced intuitive or non-ordinary experience
  - o Your perception of your experiences
- ✓ Other

1.2. How have these personal listening experiences influenced your musical decision-making?

- ✓ Influence of your music therapy knowledge on your personal listening experience
  - o Influence of your music therapy knowledge on your musical decision-making
- ✓ Influence of your personal beliefs on your personal listening experience
  - o Influence of your personal beliefs on your musical decision-making
- ✓ Influence of your major therapeutic method on your personal listening experience
  - o Influence of your major therapeutic method on your musical decision-making
- ✓ Other

2.1. What do you hear and what do you pay attention to in your music listening?

- ✓ Musical elements you attend to (e.g., volume, pitch, and timbre)
  - o Your perception of your acoustic listening
- ✓ Formal elements you attend to (e.g., rhythmic and melodic pattern, harmonic progressions, and musical form)
  - o Your perception of your musicological listening

2.2. How does what you are hearing influence your musical decision-making?

- ✓ Influence of your aural or performing skills on your musical decision-making
- ✓ Influence of your music resources on your musical decision-making (e.g., music recording, and sheet music)
- ✓ Influence of your musical interests or preferences on your musical decision-making
- ✓ Other

3.1. What do you consider when listening to music that relates to a specific client?

- ✓ Empathetic, client-perspective listening
  - o Your perception of your empathetic listening
- ✓ Your awareness of listening purpose in the given clinical process
  - o Your perception of purposive listening
- ✓ Critique and/or interpretation

- Your perception of critical or interpretive listening

3.2. How does reflective listening influence your musical decision-making in practice?

- ✓ Influence of information about a client's pathology or related psychology on your musical decision-making
- ✓ Influence of information about a client's non-musical characteristics on your musical decision-making
- ✓ Influence of information about a client's musical abilities and preferences on your musical decision-making
- ✓ Other

APPENDIX C

SAMPLE OF FIELD NOTES (FOR REVIEW SESSION PREPARATION)

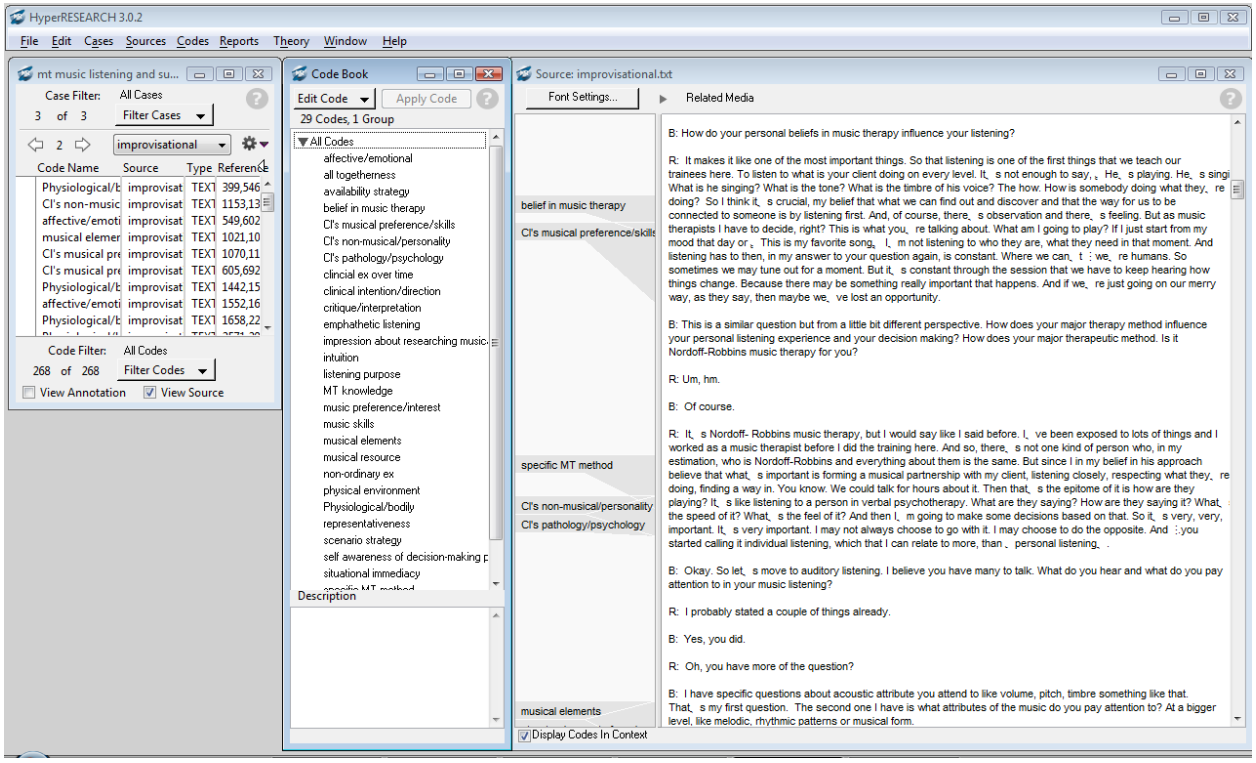
Table 11. Field notes (Mrs. Collins)

Time	Event	Questions for Therapist
13”	opening music	-You haven’t started hello song yet, but played some tunes using trills, short rhythmic phrases. How/why did you pick those musical ideas?
40”	hello song	-You started singing. Did you think it was the time to greet him by singing? How did you decide on the timing? -Why the ‘hello’ song? Is that the song you have used for him?
1’20”	Th’s piano with Cl’s xylimba during hello song	-Is the style of your piano for the ‘hello song’ like this (woom-pa, woom-pa) usually? If your piano playing on that day is different from another day, where did that come from? -When Cl started playing xylimba, you changed your piano a little bit. Is the change related to the characteristics of the client’s xylimba?
1’42”	Cl vocalizing & Th singing ‘la la la’	-Cl made ‘woo’ sound for the first time in this session, and you started singing ‘la la la.’ Why did you start doing this at this moment and why ‘la la la’?
2’27”	Th talking to co-th	-You asked your co-therapist to change Cl’s beater to a wooden one. Why did you do that?
2’45”	different rhythmic phrases	-What did you intend with the rhythms? Was your decision based on his xylimba sounds? Or, did you think he needed new musical stimulation here?
3’18”	Th assisting cl to sing ‘woo-woo’	When Cl brought a beater to his mouth, you immediately sang ‘woo woo.’ What’s your intention with that?
4’13”	Cl’s ‘woo’ in his high voice	After grinding his teeth quite long, Cl eventually made the sound ‘woo’ in his high voice, and then your piano immediately made the distinguishable phrase. What did you intend with it?

APPENDIX D

SAMPLE OF INITIAL CODING USING HyperRESEARCH ™

Figure 2. Initial coding (Mrs. Collins)



APPENDIX E

SAMPLE OF ANALYSIS NOTES

Analysis notes (Mrs. Collins)

04/11/2011

1. Ref. 3401.. She talks about her emotional response to both cl's music and to cl's behaviors. Could go to 'case information.'

2. Ref. 3878. Mentioned that some memories related to her relatives came to her while working with cl.

3. Ref. 4266. I put 'we can't let them (th's emotional experience) overcome us' to 'listening purpose' for now. It neither fits well with 'empathetic listening' nor with 'feelings towards cl' in situational immediacy.

4. New literature I can use when writing this case: "clinical musical responses of Nordoff-Robbins music therapists…." M. Copper in Qualitative Inquiries in Music Therapy, vol. 5.

5. Ref. 8710: Her answer to the question about her peak experience. This can stay in affective/emotional experiences, not in non-ordinary/unconscious ones.

6. Ref. 7173: I need a new word to replace 'non-ordinary experience' with for this case. She talks about a client's 'peak experience in music' and her feelings about it at the same time. The name of the code may have to be changed.

7. Ref. 9417: I assign this to 'interpretation/critique' for now. I may have to replace the term with a NR friendly word.

8. Ref. 6029. This went to a tentative code, clinical intuition. Decide to put this to 'non-ordinary' or to 'unexplainable.' Or, I may keep the code, clinical intuition, in relation to decision-making strategies.

9. Ref. 12549. She ARTICULATES that a therapist should not play based on her own mood or musical preference. I assign this to 'client's musical traits' relying on the focus of her talk. May have to put it to 'therapist's musical traits' as well, for related discussions. Give more thought to this.

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