# Playing their Song? Is it About Them or Me? A Personal Reflection on my Music Therapy Student Research Journey and Findings

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### Keywords

Music therapy student research; reflective practice; neurorehabilitation; group singing; repertoire

### Citation

Gordon, J., & Hoskyns, S. (2022). Playing their song? Is it about them or me? A personal reflection on my music therapy student journey and findings.
*New Zealand Journal of Music Therapy, 20,* 18-46.
<https://www.musictherapy.org.nz/journal/2022-2>

### Review

This article was independently reviewed by two anonymous peer reviewers.

## Abstract

This article discusses my (first author’s) music therapy placement and research experiences as a postgraduate music therapy student, together with reflections from my current practice as a Registered Music Therapist in private practice. I outline my placement and research approach, and present two main themes from an action research study of my own developing practice with two singing groups for people living with neurological conditions, supported by carers and volunteers. The research question for the study explored what were the goals for individuals and groups, and how did I support the goals through my practice? I used thematic analysis to craft themes in response to the questions. The first theme, named as Gearing for Positivity, was concerned with my efforts to support the groups to feelings of positivity within the sessions through meeting their individual or group goals. The second illustrated theme was Managing my Skills and Vulnerabilities during my placement with the groups. Three further themes were Maintaining the Feel-Good Factor, Copyright, and Safety First. I offer reflections from my current perspective as a Registered Music Therapist. Finally, I offer some recommendations to myself, as a practitioner, and to other novice researchers and future music therapy students.

## Introduction

When I (Jenny, the first author, in whose voice this article is written) think back on 2018, the practical experience and research year for my Master of Music Therapy, many memories come to mind. Mostly the thoughts are of the wonderful people I interacted with through the experiences that were afforded me during the process of attaining my qualification. My research (Gordon, 2019) focused on my developing practice while on placement[[1]](#footnote-1) with two singing groups for people living with neurologic conditions – the CeleBRation Choir and Sing Up Rodney.[[2]](#footnote-2) In New Zealand, these groups are referred to as neurological choirs (Talmage & Purdy, 2021). My co-author, Associate Professor Sarah Hoskyns, was my university research supervisor.

My first reason for writing this article was to share my findings with the group members, in recognition of their contribution and support for my placement. Secondly, after over two years of private practice as a music therapist (albeit hampered by the limitations imposed by the national pandemic response), it seems timely to review and clarify some of my processes and current practice. Finally, I believe that my work might be useful to future novice researchers, students, or music therapists working with similar groups.

## Context

### My Professional Journey

I came late to music therapy as a career, after raising children and working in business settings in my early adult years. Following education training and work in my forties as a specialist music teacher in an Auckland intermediate school setting, I was accepted in 2017, aged 55, to study the Master of Music Therapy at Te Herenga Waka - Victoria University of Wellington.

### Singing Groups for People with Neurological Conditions

The CeleBRation Choir, established in 2009, is a large group of people with diverse needs, goals, preferences, abilities, and life experiences, also supported by carers and volunteers. Sing Up Rodney, a smaller group, was formed in 2017. The focus of both groups is twofold: wellbeing and communication rehabilitation. Planned singing experiences provide opportunities to create and strengthen social bonds through a sense of community and inclusion, and to focus on voice, speech, language, and memory through singing.

Group size was the main difference I noticed, with CeleBRation Choir (50-60 people, including support people and volunteers) being much larger than Sing Up Rodney (20-25 people). This added to my cognitive load as there were many more individuals to attend to at once, with a broad spectrum of goals. The set-up was a second point of difference as CeleBRation Choir sat in rows facing a screen and I stood at the front, while Sing Up Rodney were seated in a circle and I sat with them. A higher ratio of support people also participated in Sing Up Rodney.

Both groups had extensive documentation, including member information and templates for session plans and notes. I also worked collaboratively with my placement supervisor, music therapist Alison Talmage, in these groups, broadly adopting the existing protocol (Talmage et al., 2013). Our co-therapist roles evolved over the course of the placement, enabling me to work towards taking responsibility for the whole group.

## Related Literature

### Music Therapy Approach

My approach to practice is based on humanistic psychology and a person-centred approach (Rogers, 1951), showing regard for the whole person, rather than reducing people to their pathology. The person-centred approach also acknowledges the competence and contribution that clients can bring to the therapeutic experience (Rolvsjord, 2010, 2015) and reflects an interdependent partnership inherent in a caring dyad of caregiver and care recipient (Schmid, 2018, cited in Schmid & Rolvsjord, 2021, p. 873). Aspects of positive psychology also resonate with me – for example, Seligman’s (2011) notions of flourishing; his (2018) PERMA framework (Positive emotions, Engagement, Relationships, Meaning, and Accomplishments); and Seligman and Csikszentmihalyi’s (2000) ideas about a meaningful life.

Other ideas key to my thinking about practice include Baker and Ballantyne’s (2012) discussion of health and wellbeing through music-based activities that provide authentic happiness from the positive psychology standpoint. I value resource-oriented music therapy, which views the individual within their context, rather than focusing on deficits (Rolvsjord, 2010). Daveson’s (2008) meta-model of Music Therapy In Neuro-disability (MIND) helped me to navigate the intersecting worlds of music therapy, neuro-disability and neuro-rehabilitation. Daveson proposes a combination of three approaches to music therapy: (1) the restorative approach involves efforts to regain skills and restore functions that may have been lost due to a neurological condition; (2) the compensatory approach supports people to develop strategies for maintaining their sense of self, despite the irretrievable loss of some functions; and (3) the psycho-social-emotional approach involves using music to convey and influence emotions and to promote socialisation and psychological wellbeing.

### Neurological Rehabilitation

Neurological rehabilitation is an established area of practice and research in medicine and allied health. I have chosen to focus here on selected music therapy and speech science literature.

Neurological impairment – caused by stroke, trauma, or other degenerative conditions – brings either a sudden or gradual disconnection with a person’s previous life (Street, 2012). The impact on diverse functions can provide major challenges to general health and morale for people affected by, for example, Parkinson’s disease (Machado Sotomayor et al., 2021). Regions of the brain are left isolated or impaired, affecting not only bodily functions but also self-image, relationships, and social structures, with further impact on the person’s family and friends (Sihvonen, et al., 2017; Talmage & Purdy 2021).

People with acquired brain injury may be able to re-learn competencies, even though the area of their brain that normally organises that function is damaged, through processes of neuroplasticity. New neural pathways can be formed by individual synapses, neuronal networks, or even cortical remapping (Baker & Tamplin, 2006; Stegemöller, 2014). Repetition of tasks is helpful for participants – and characteristic of music, as repeating patterns are intrinsic to many musical idioms and often a rewarding and vital part of the pleasure of music. However, in degenerative conditions, such as dementia or Parkinson’s, the aim is to support and maintain function for as long as possible (Jones, 2016; Matthews, 2018).

### Group Singing and Wellbeing

Studies suggest that group singing may positively impact healthy ageing (Ridder & Wheeler, 2015). Benefits for health-related quality of life are also proposed for people living with chronic health conditions (Daykin et al., 2018), or neurological conditions (Di Benedetto et al., 2009; Fogg-Rogers et al., 2016; Jenkins et al., 2017; Matthews, 2018; Thompson et al., 2022).

Thaut and Wheeler (2010) determined three aspects of music that affect wellbeing: (1) psychophysical, where positive feelings lift people’s energy levels and mood; (2) collative, where the structural attributes of music help with experiencing order; and (3) ecological, where music helps elicit memories through association. One outcome of neurological choirs and singing groups is to create a community of its members. Under the mantle of a choir or singing group, people become part of a socially interactive ecological practice, corresponding to Bruscia’s (1998) ecological approach to music therapy.

### Group Singing and Neurogenic Communication Difficulties

Singing and speech are processed by both overlapping and adjacent neurological networks (Baker & Tamplin, 2006). At a structural level, singing is a blend of music and speech, with a spectrum from rap and recitative styles to songs and arias. Speech is made interesting and intelligible through the use of musical elements, such as pitch, rhythm, tone, and dynamics.

Group singing can have a positive impact on communication ability (articulation and verbal output) for people with aphasia post-stroke (Tamplin et al., 2013). Pre-learned and predictable lyrics can be helpful for word retrieval for speech (Tomaino, 2012). Group voice and singing activities may delay the voice and speech deterioration resulting from Parkinson’s (Elefant et al., 2012; Machado Sotomayor, 2021; Matthews, 2018). Singing can also be motivating and cognitively more accessible than traditional speech therapy (Fogg-Rogers et al., 2016; Tamplin & Grocke, 2008). The value of group music therapy for people living with dementia, characterised by memory loss, is also increasingly recognised in New Zealand (Allan, 2018; Jones, 2016; Storie, 2019) and internationally (Baird et al., 2020).

### Music Preferences

Preferred music positively impacts people’s social wellbeing by helping them to regulate emotions and by promoting social connection. This has been observed in both young people (Papinczak et al., 2015) and older adults, (Costa et al., 2018). Older people are likely to experience positive quality of life outcomes when they participate in social events where music that they enjoy is included (Theorell & Kreutz, 2012). Singing is engaging and motivating, thereby having a more positive therapeutic impact (Silverman et al., 2016).

Durham (2002) suggested that musical structure and familiar songs supported retrieval of long-term memory and elicited reminiscence. Client self-report and caregiver observation have also suggested that preferred songs can effect positive behaviour change in people living with dementia (Cevasco-Trotter et al., 2014; VanWeelden & Cevasco, 2007, 2009, 2010).

However, the active mechanism responsible for therapeutic effectiveness may not necessarily be the patient’s favourite song (Silverman et al., 2016). It could be the live music, the interaction with the therapist, various choices within the session, a song by the same artist, or a similar music genre.

### Summary

This brief overview indicates a body of research about group singing for people with neurological conditions. Singing may assist with communication abilities, improve wellbeing, and provide opportunities for choice-making, social interaction, and performance. I used this knowledge to guide me through my music therapy placement and research project.

## Study Design: Action Research

I chose to use action research, which emphasises a cycle of planning, action, observation, and reflection – an approached formulated by Lewin (1946, 1948). New understandings from one cycle are incorporated into the planning for the next cycle, with successive cycles continuing as long as necessary, or until findings are sufficient (Stige & McFerran, 2016). This approach is useful for people who are looking to critique and improve their practice (Rickson, 2009).

When I considered the question of repertoire choice and delivery, I focused on the following intertwined research questions:

* What are the goals of the singing groups?
* Do they align with the goals of the individual participants?
* What do I need to do to support the singing groups in working towards those goals?

I planned three action cycles, each with guiding questions (Table 1). I collected data from session notes and reflections by myself and my placement supervisor, who acted as co-therapist for most sessions. I also wrote a research journal with observations and recollections of my experiences in response to my action research planning.In each cycle I used inductive thematic analysis in which the themes are constructed from the Data, rather than being decided in advance (Braun & Clarke, 2006; Clarke & Braun, 2016). I then planned actions to improve my practice. I aimed to find and interpret the main aspects of my practice, and to answer my research questions. The outcomes of these cycles are summarised in Appendix A.

I note that as I was new to action research, my evolving method was developed with experience. While I was rigorous with my reflections, at the beginning I found it difficult to mine that data for insights into my practice. However, I gradually gained confidence and the ability to be more reflexive and aware with my observations.

## Findings

As my placement and action research study unfolded, three major themes emerged from the inductive coding of the data: (1) Gearing for Positivity,
(2) Maintaining the Feel-Good Factor, and (3) Managing My Skills and Vulnerabilities. Two further factors, Copyright and Safety, were also noted. In this article, based on my thesis (Gordon, 2019), I will report on the first and third of these themes.

Table 1.

Guiding Questions for the Action Research Cycles

|  |  |  |
| --- | --- | --- |
| Cycle | Focus | Guiding Questions |
| 1 | Practical issues related to my ability to support the singing groups as I worked on developing repertoire to use with this population | How can I use cueing to support the singing groups? How can I create exercises out of familiar songs and melodies that target communication difficulties caused by speech and language disorders associated with neurological conditions?How do I choose the best key for the choir to sing each song? |
| 2 | My thought processes and some emotional / psychological obstacles I was experiencing while carrying out this work: | How can I make technical decisions about the choir and myself while in the midst of the repertoire activity?How can I dispel unhelpful anxieties to fully allow me to be a natural and open therapeutic presence while making technical decisions in the moment? |
| 3 | Participants’ musical experiences | How can I simultaneously facilitate quality musical experiences of the repertoire while responding to the needs of individual participants? |

### Theme 1: Gearing for Positivity

The name for this theme, Gearing for Positivity (Figure 1), arose from my desire to support participants’ positive experiences of group singing.[[3]](#footnote-3) The thematic analysis included six subthemes: Goal-Setting, Planning, Preparing, Cueing, Making Observations, and Teaching and Learning Repertoire.

Turning to the singing programme, I also considered the Degree of Difficulty of each song or activity, the participants’ capacity to deal with Split Attention and Multi-tasking, and the benefits, but potential boredom, associated with Exercises. Pragmatism in goal-setting led me to select songs (from the choir’s existing repertoire as well as my own suggestions) that addressed multiple goals across the group. For example, a song addressing restorative

Figure 1

Theme 1 and Subthemes



or compensatory goals for some participants might simultaneously provide psychosocial-emotional benefits for others. Aiming to be inclusive, we started
simply, then added complexity and some cognitive challenge, ensuring that there was always some way that everyone could engage in the activity. This approach also provided opportunities to develop Split Attention and Multi-tasking. For example, multi-part rounds and action songs involved cognitive processes and physical coordination while singing. I considered the existing choir protocols through Exercises that focused on posture and body awareness, breath management, vocal warm-ups, and articulation of speech. I developed exercises that used parts of familiar songs and tunes, to encourage engagement.

Four aspects of planning emerged as important: Session Plans, Pacing of the sessions, Volunteers as a resource, and Choosing the Key for each song. I used existing templates, based on the published CeleBRation protocol (Talmage et al., 2013). This said, the sessions themselves were always about the people in front of us at the time, and the plan evolved as the session progressed. I considered the pacing of songs and activities, ensuring enough time for participants to process instructions and to manage our differing energy levels. I considered roles for the Volunteers, such as leading a group in the singing of rounds or managing lyric projection. I also considered the vocal range of choir members and my ability to play the necessary chords when Choosing the Key for the songs and exercises. When Preparing for sessions, I considered the reasons for selecting each song and how I would lead it. I prepared large font chord sheets for songs, resources that allowed me to move away from the song sheet. My aim was to be able to sing and play from memory, but I felt less anxiety if well-resourced and rehearsed.

Cueing occurred not only in the song introduction but continued throughout the song. When actively considering how the group was singing, I sometimes cued for more volume, a fuller tone, or clearer vowels and consonants; I cued musically tricky moments and gave reminders of the song form when switching from verse to chorus. As a student music therapist working with large groups, this was a significant focus in my practicum. The cueing techniques that I considered and practised were Modelling, Physical Cues, Verbal Cues, Visual Cues, Musical Cues, and Priming.

Modelling was the technique I used most consistently, as it conveys many different, simultaneous types of cueing. Sometimes it was clear that actually ‘doing it’ was more effective than ‘talking about doing it’. Physical Cues – such as gestures, facial expressions, and the head bobbing that accompanies the beat – were helpful for indicating changes in tempo or to keep the singers in time with each other. Verbal Cues included the standard calls of “Sing up” and “Big breath”, as well as the advance calling out of lyrics. Visual Cues, such as lyrics and pictures, were helpful, and I learned about aphasia-friendly text formatting guidelines (Rose et al., 2014),

Musical Cues were a major part of my preparation. These included Introductions, where I might hum or sing to “la” the last two lines or phrase of a chorus or refrain. At other times strong rhythmic strumming with an emphasised stop became the cue to sing. Stronger, musically clearer introductions helped to get everybody starting to sing at the same time. Augmented Anacruses were useful for cueing the key of the song, or for leading warm-up exercises that moved up by a semi-tone or tone. I often played a dominant seventh chord, paused, and looked up at the group, my head and torso moving to the beat, with the expectation that people would join in. Priming involved mentioning a song “coming up after the break” or playing an audio or video recording during the break or before the session started.

The subtheme of Making Observations included Being Ready, Assessing the group to make decisions, and Allowing Time to Process. Being in a position to visually take in and hear the whole group depended on the size of the group and how we were seated. I needed to assess that the participants were collectively ready to sing before starting. When assessing the group to make decisions, I needed to be able to visually take in the collective posture, mouth shapes, etc., as well as giving encouragement and prompts as needed to support projection or breath control. Sometimes I found it difficult to determine whether or not the group had enjoyed a song or activity, even after directly asking the participants. I realised I needed to allow them enough time to process the options before responding.

Teaching and Learning Repertoire included using Call and Copy activities to introduce unfamiliar or forgotten songs. When I introduced a new Māori waiata, E Toru Ngā Mea (Anonymous, 2009), the choir (with no fluent speakers of te reo) produced a good, solid sound. I heard later that some found this song difficult. Singing in another language can be difficult - some members liked a challenge while others preferred singing familiar songs. Additional strategies included breaking songs into Manageable Tasks, and Backward Chaining (e.g. learning the chorus first) so that people can join in from the beginning of the activity.

### Theme 3: Managing my Skills and Vulnerabilities

The complementary theme I illustrate now concerns managing my own skills and vulnerabilities (Figure 2).[[4]](#footnote-4)4 I reflected that, while I did have many skills in this area, there were times when I felt I did not have the right skills, or the ones I had were not adequate at that time. The subthemes related to either my skills or my vulnerabilities about these: Ways to Support, and Teaching and Learning Relationships, each with additional subthemes.

Figure 2

Theme 3 and Subthemes



My analysis showed several Ways to Support the singing groups: by using my Skills for Accompanying, by taking a Strong Lead in the singing, by Taking it Easy, and finally by adding the Benefit of My Singing. I had reasonable proficiency in 3- and 4-chord songs on the guitar, ukulele, and piano. I could usually play these songs by ear, although I needed printed lyrics. I tended to refer to the chord sheets when playing songs, especially those with more complex chord progressions or modulations. I played barre chords on the guitar, making transposition easy if another key suited the choir better. An alternative would be to use a capo. Through practice, I improved in my skills in playing instruments. Another way to support the groups was by providing a Strong Lead in the singing. Taking it Easy gave me permission to relax and not overwork myself or the participants. Notions of Performance vs Rehearsal vs Therapy Session, Multi-tasking Confusion and ‘Flow’ (Csikszentmihalyi, 2014), and Constructive Reframing were also related to this code, in that any vulnerability I had in any of these areas could be aided by Taking it Easy.

Our singing sessions included several modes of operating: Performance, Rehearsal, and Therapy Session. The parameters of these modes were fluid, and we moved from one mode to another in response to subtle changes in the groups’ goals. I found performance mode the most complicated to internalise. Usually, the participants were not performing to an audience, yet I felt I was performing. On occasion the group performed to others in the community, but we encouraged our audiences to sing with us. Pre-performance sessions were more like rehearsals, and performances often included warm-ups, because everyone, even audiences, needed to warm up to sing. We also reiterated exercises in some parts of our sessions to work on a particular speech component, e.g. respiration, phonation, resonance, articulation, and prosody – a more overtly therapy-focused part of the sessions. When I performed at community events with both groups, there was magic about being together and sharing with others, despite perceived vulnerabilities.

I often worried about making mistakes because of Multi-tasking Confusion – the challenge of simultaneously singing, playing, engaging, encouraging, and the cycle of cueing, observing, decision-making, cueing again. I found I panicked when I tried to focus on everything. My growing clinical knowledge, and growing familiarity with existing choir repertoire, reduced some of these anxieties. I decided that I would just try to be myself and let other learnings come gradually, rather than try to do everything at once. Focusing on the psychosocial goals was easier for me; however, I was also aware of the speech and language goals of both groups.

In contrast to this sense of confusion at other times, I experienced a sense of *flow*, in which one has a strong sense of control and altered sense of time – in response to clear goals, a balance between challenge and skills, and immediate feedback (Csikszentmihalyi, 2014). In those moments I felt more confident to facilitate the session, make observations, provide responses, and the time would fly by. Trying to juggle all the needs, goals, and processes involved is difficult indeed. However, I began to feel that, while it was a balancing act, I was not on a high wire without a net; I was on the ground with encouragement and support.

Constructive Reframing of feedback was a helpful technique to learn – a process of rewording negative language and rephrasing positively when I responded to participant requests. For example, instead of saying, “I don’t have the words or chords” or “I don’t know that song,” I could respond that I would try to have them for next time. This relieved some of the performance anxiety pressure that I placed on myself.

An important means of supporting the groups was to offer the Benefit of My Singing. Accompanying without singing allowed me to listen carefully, but invariably I would re-join the singing. I regarded my voice as my first instrument, and I felt that singing along was often the best support I could give the group. At times, as a trainee, I misjudged this, missing opportunities to observe and reflect. However, I felt strongly that my motivation for doing this work was to use my skills and manage my vulnerabilities to support the groups towards their goals.

Finally, Managing my Skills and Vulnerabilities focussed on Teaching and Learning - Relationships, specifically the Māori concepts of Ako, Tuakana, and Teina, and Whanaungatanga. I recognised my strengths in teaching and learning repertoire. At times, as members of both singing groups, we were either teachers or learners. Sometimes we learnt from others and sometimes we taught others. Because of this, the interrelationships between teachers and learners, and by analogy community music therapist and participants, was an integral part of my work with and within these singing groups. Although I am a Pākehā, I am familiar with these concepts, both from my childhood in a rural area with a strong, Māori community and culture, and through my journey as a music teacher. These concepts are included in the values of the New Zealand curriculum (Ministry of Education, 2009).

The concept of Ako is “a reciprocal learning relationship [where] teachers are not expected to know everything. Each member of the learning setting brings knowledge, from which all are able to learn” (Keown et al., 2005, p.12). A central tenet of the concept of Ako is the relationship between Tuakana and Teina (Ministry of Education, 2009). While Tuakana literally means older, it is understood as the more knowledgeable Tuakana mentoring the younger, or less knowledgeable, Teina.

These concepts flowed through to relationships within the singing groups. There was a real sense of Whanaungatanga – relationships formed through mutual respect and caring, as in families. At times members advised, modelled, and led activities and discussions, taking the Tuakana role. For example, one participant enjoyed helping to lead some warm-ups:

Session plan: Sirens but more extensive than at the start. See if Mark[[5]](#footnote-5)5 would like to lead.

Student: Mark was very obliging.

Supervisor: Good – Mark enjoys this role and […] understands what to do as well as creating some humour.

(Clinical notes, May 14, 2018)

On another occasion a Māori participant assisted with pronunciation:

Very interesting that Deborah felt able to bring her expertise of Māori language and pronunciation to the group [Figure 3]. It is lovely seeing her come out of her shell, share her knowledge, and engage in this.

(Clinical notes, October 4, 2008)

Figure 3

Extract from Waiata, Tēnā Koe (Anonymous, 1991)



## Reflections

### Reflection: Research Design

While I actioned three distinct cycles, I did not closely adhere to the action research protocol regarding the generation of new actions for each cycle. For example, the questions for Cycle 2 did not arise solely from the findings of Cycle 1. Instead, I found myself taking a pragmatic approach, considering practical issues that arose from my placement experiences, rather than from detailed research findings. I found it difficult to come to grips with the nuances of academic research at the same time as grappling with developing my practice and managing the amount of information I needed to process while working with the two singing groups. What transpired was a more ad hoc questioning response to the practical information I needed at that time. I found that much of my focus was on developing my practical skills as a music therapist, rather than a detailed understanding of research methodology. On reflection now, I believe that secondary analysis might have been an alternative approach, providing opportunities to look back on my experiences (Ruggiano & Perry, 2017).

### Retrospective: Music Therapy Student Experience

Being an older person with life and work experience and armed with the confidence that this brings, I thought I might have been less self-conscious and self-critical when I began my second-year placement with the two singing groups. However, evolving a theme about managing skills and vulnerability actually seemed especially relevant for the student or novice researcher.

Finlay (2002) proposed a typology of reflexivity with five aspects:
(i) introspection, (ii) intersubjective reflection, (iii) mutual collaboration, (iv) social critique, and (v) discursive deconstruction. Because I was researching my own practice, I particularly engaged in introspection. I needed to ensure that my process was a “springboard” for insights and that it could inform my next steps in the action research (Finlay, 2002, p. 215). As I wrote my reflective journal and session notes, I acknowledged feelings of nervousness and vulnerability. Sometimes these feelings were not helpful, because they caused me to harbour self-doubt. It required energy to re-build self-confidence, rather than using that energy to focus on the requirements of the two singing groups. With supervision, supported by growing experience and confidence, I formulated new learnings and incorporated these into my practice. These new learnings enabled me to be more reflexive during sessions, allowing me to recognise unhelpful thoughts and place them to the side. The two themes illustrated here include contrasting practice-based and personal themes. This delivers a realistic representation of myself as a developing music therapist. I realise now the strength of my developing reflections with my supervisors that evolved in my study, and I am grateful to have co-authored and discussed this article.

Music therapy training is known to be challenging (Smyth & Edwards, 2009; Wheeler, 2002). Would you expect to be more confident as a mature student? Or would you expect the nervousness of a school-leaver? Mature students and younger adults may have different experiences of university study (Mallman & Lee, 2016). Older students are often resilient and highly motivated, with valuable life experience, but are more likely to abandon their studies (Boston, 2017). I recognised my own considerable experience and life skills, stable personality, and knowledge and understanding of my own and others’ ways of being. However, the academic and clinical knowledge required to become a music therapist had been outside my purview and took much of my energy throughout this placement journey. In hindsight, valuing and relying more on my interpersonal skills might have countered some of my anxiety leading these large group sessions. Allowing myself to be honest and vulnerable in my research reflections enabled me to have more confidence going forward. Reflecting on this journey, I feel proud to have followed my passion into this rewarding field and persevered through the times of self-doubt. I also feel lucky and grateful to be supported so thoroughly by clinical and academic supervisors, student peers, and loving family and friends.

Looking back on my student experiences from my current perspective as a Registered Music Therapist, I find continued value in the findings of my action research study. I plan carefully, ensuring that I can sustain any group that I take on. I still rehearse and prepare, but I am now far more comfortable in my efforts with the groups I work with. As John Denver sang, days can be “diamonds” or “stones” (Feller, 1981), but even the tiniest pebbles cast ripples. I experience days of flow and days with some anxiety, but I believe in perseverance. I try not to be too self-critical on matters of lesser importance and focus on being an authentic therapeutic presence, supporting the group in the moment.

## Limitations

This practitioner-researcher action research study was useful in supporting me as an emerging music therapist but is context-specific. I considered ways and means of improving my own practice during this research, and the findings are likely to be helpful to me as I develop similar work in other settings. While the findings cannot be generalised to other settings, they may be useful for other practitioners and students.

## Conclusions and Recommendations

The strengths of this placement and study included being a good fit for my personality, skills, preferences, and knowledge of the repertoire. I received support and encouragement from my clinical supervisor, university teachers, participants, student peers, and other music therapists and allied professionals I was able to meet or observe. This experience has furnished me with a wealth of songs for my kete[[6]](#footnote-6)6 – my basket of tricks of the trade.

In retrospect, I wish I had understood the literature more competently when I started my research. I would also like to have narrowed down my research focus. I recommend that other students or novice researchers familiarise themselves with thematic coding early on, and ask for support, as this was a time-consuming aspect of my study.

In my practice, I continue to value and integrate the perspectives of person-centred and resource-oriented approaches, positive psychology and PERMA, and the MIND framework. Although not fully explored in my research, I regard myself as a community music therapist and plan to read more about this approach.

Reflecting now on my training, my recommendations for my own professional include:

* Keep going, keep reading, reflecting, and connecting with other Registered Music Therapists;
* Value the self-confidence that comes from preparedness and experience; and
* Be confident in being my authentic self, and know I have the ability to hold the space and the group, irrespective of glitches and things that go awry!

So is it about them or me? It is about all of us. It is about relationships: me with myself, me with the group members, and member to member. We are part of a group, a community, and everyone counts.

I conclude with a Māori whakataukī (proverb) that I found helpful:

Hurihia tō aroaro ki te rā, tukuna tō ātārangi kia taka ki muri i a koe.

(Turn your face to the sun, and let your shadow fall behind you.)

Here I think of the sun as representing a continuum between opposites, e.g., one’s greatest joy and greatest fear. If you have concerns or anxieties about your abilities, then face them head on. The hard part is behind you, because recognising and naming those fears is half the battle to overcoming them. Similarly, if you are being praised or thanked, then turn directly to that and let any feelings of insecurity fall behind you.

## Acknowledgements

This research would not have been possible without the members of the CeleBRation Choir and Sing Up Rodney singing groups, and their collective willingness to share themselves generously and provide encouragement.

I, Jenny Gordon, extend my grateful thanks to Alison Talmage NZ RMTh, who, as my supervising music therapist for this placement, guided me through an exciting and very busy time in my life. She was calm, generous with her time, and very encouraging. She has encouraged me to continue questioning and reflecting on my student and professional experiences, and to persevere with my reading and writing about music therapy.

I am very grateful to Associate Professor Sarah Hoskyns who, as my academic supervisor, was very patient and helpful, guiding me through the research process, and Professor Suzanne Purdy for agreeing to my placement with the CeleBRation Choir. I greatly appreciate the Centre for Brain Research and Kahikatea Music Therapy and Community Arts Trust for encouraging me to publish my research; and my current supervisor, Rachel Foxell NZ RMTh, for her support and encouragement.

I am grateful also to my loving family – my husband, Flash, son and daughter, Michael and Grace – who continue to love and support me and my new profession, which I love so much.

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## Appendix ASummary of Data Collection during each Action Research Cycle

|  |  |  |  |
| --- | --- | --- | --- |
| Cycle | Actions | Outcomes | Reflections |
| Cycle 1 (May 14-June 3, 2018) | Action 1.1 Cueing Techniques: |
| Consider song introductions | I considered, rehearsed and delivered stronger introductions, e.g. humming last two lines of the verse or chorus, strong cadence, or rhythmic strums  | Clearer, more confident start by the group |
| Practise types of cueing | Physical cues, using body and eye contactVerbal cues, e.g. “Big breath!”Visual reminders, using projected words and picturesPriming, e.g. pre-song activity or song | I recognised the need for preparation, anticipation and combining cues, and found it difficult to decide mid-song how to cue  |
| Stronger modelling | Being more confident and providing a stronger leadAllowing time for participants to process cues, e.g. adding pauses, or slowing the tempo  | As above |

|  |  |  |  |
| --- | --- | --- | --- |
| Cycle | Actions | Outcomes | Reflections |
| Cycle 1 cont. | Action 1.2 Exercises |
| Consider target areas | Speech production: respiration, phonation, articulation, resonance, prosodyLanguage: word retrieval  | The spectrum of the group and balancing individual needs, goals, preferences, and prior knowledge  |
|  | Match elements of song to the target area | Parts of songs and melodies | Songs familiar to some may be unknown by others  |
|  | Create and deliver to the group | Exercises based on *Be-Bop-A-Lula* (Vincent & Davis, 1956); *Blueberry Hill* (Rose et al., 1959); *Little Brown Jug* (Winner, 1869); *William Tell Overture* (Rossini, 1829) | Don’t labour the song, or the fun is lostChallenging to provide new, fresh exercises – consider a collection of exercises with similar goals that can be rotated |
|  | Action 1.3 Song Keys |
|  | Consider pitch range of speech | Approximately A3 -A4 for women’s voices (i.e. A below middle C to A above middle C)Some songs require to F3 - C5This is usually adapted for men by having them sing an octave lower. | Continue to monitor this. A higher or lower range takes concentration away from other challenges, such as word retrieval or articulation |
|  | Consider my own instrumental skills | I prefer to play in particular keys on different instruments: piano: C, F, G, Eb, Ab, Bb;Ukulele: C, D, G, A; guitar: C, D, E, G, and barre chords for 3- and 4-chord songs | Practising helps! |

|  |  |  |  |
| --- | --- | --- | --- |
| Cycle | Actions | Outcomes | Reflections |
| Cycle 2(Aug. 6 – 18, 2018) | Action 2.1 How can I make technical decisions about the choir and myself while in the midst of the repertoire activity? |
| Being aware of the choir: seeing, hearing, being able to critique | Multi-tasking is challenging:* Seeing and hearing is difficult, e.g. looking the other way, people talking quietly, or more than one conversation at once
* Talking time to ask participants what they want or prefer.
* Will they express (verbally / non-verbally their preference?
* Can I interpret their expressions?
 | Life-long challenge!  |
| Considering the inner and outer tracks simultaneously  | My own ability to critique while busy thinking about lyrics & chords, i.e. my own performance vs. focusing on the group | Deciding whether / when to stop the choir – stop / start (to focus on a song element) vs. flow |
| **Action 2.2 How can I dispel unhelpful anxieties to fully allow me to be a natural and open therapeutic presence while making technical decisions in the moment?** |
| Dealing with performance anxiety, multi-tasking and preparation | Preparation and rehearsal lead to more confident delivery, e.g. less concern about making mistakes or not knowing |  I began to manage my anxiety more successfully during impromptu parts of the session – e.g. a song request that I had not prepared.As I came to know participants more, I found it easier to just be with them, and realised it is about the whole experience, not just about the songs |

|  |  |  |  |
| --- | --- | --- | --- |
| Cycle | Actions | Outcomes | Reflections |
| Cycle 3(Sept. 17-Oct. 7, 2018) | Action 3.1 How can I simultaneously facilitate quality musical experiences of the repertoire while responding to the needs of individual participants? |
| What is a quality musical experience?My notion or theirs? | Considering my version vs. offering a song and letting them sing it their way, the challenge when people know different versions  | What kind of therapist am I intending to be – a musician doing therapy or a therapist doing music (Aigen 2012)? |
| Managing the technical aspects of the music:Thoughtful instructions and cueingBreak the activity into stepsStart simple, build complexity | Introducing harmony vs. feedback that they prefer unison singing: is harmony just harder work and perceived as not worth the effort? Unison singing to the best of their ability might be the experience they desire | In Community Music Therapy, “the music is not the end goal or purpose of the group” (Pagad, 2015, p.27) |

## Appendix BThemes 1 and 3 and Subthemes (Tabulated)

|  |  |
| --- | --- |
| Theme | Subthemes |
| Theme 1: Gearing for Positivity | 1. Goal-Setting
 | 1. Spectrum of the Group
2. Degree of Difficulty
3. Split Attention and Multi-Tasking
4. Exercises
 |
| 1. Planning
 | 1. Session Plans
2. Pacing
3. Volunteers
4. Choosing the Key
 |
| 1. Preparing
 | 1. Song Selection
2. Song leading
3. Resources
 |
| 1. Cueing
 | 1. Modelling – including Stop Talking and Sing
2. Physical Cues
3. Verbal Cues
4. Visual Cues
5. Musical Cues, including Introductions and Augmented Anacruses
 |
| 1. Making Observations
 | 1. Being Ready
2. Assessing the Group
3. Allowing Time to Process
 |
| 1. Teaching and Learning Repertoire
 | 1. Call and Copy
2. Manageable Tasks
3. Backward Chaining
 |
| Theme 3: Managing my Skills and Vulnerabilities | * 1. Ways to Support
 | * + 1. Skills for Accompanying
		2. Strong Lead
		3. Take it Easy – including Performance vs Rehearsal vs Therapy Session, Multi-tasking Confusion and Flow, and Constructive Reframing
		4. Benefit of my Singing
 |
| * 1. Teaching & Learning Relationships
 | * + 1. Māori Concepts of Ako, Tuakana-Teina, and Whanaungatanga
 |

1. Due to the community setting I do not refer to this as a clinical placement although some aspects of the work had a more clinical focus. The music therapy programme at Victoria University of Wellington Te Herenga Waka, chooses to use the term music therapy placement and practitioner, rather than clinician, in order to de-emphasise medical terminology where appropriate, in the diverse settings used for student placements. [↑](#footnote-ref-1)
2. Permission has been received for the two groups to be named in this article. Names removed for anonymous review. [↑](#footnote-ref-2)
3. My language choices here built on my teaching background and lesson planning. Through reading participants’ membership forms and through verbal feedback, I realised that their own psychosocial goals focused not only on singing but also on the enjoyable social context. [↑](#footnote-ref-3)
4. 4 A text version of Figures 1 and 2 is provided in Appendix B for accessibility. [↑](#footnote-ref-4)
5. 5 All participant names are pseudonyms. [↑](#footnote-ref-5)
6. 6 Kete: a basket, traditionally woven from harakeke (flax) leaves. [↑](#footnote-ref-6)