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Susan Gardstrom

University of Dayton, sgardstrom1@udayton.edu

James Hiller

University of Dayton, jhiller1@udayton.edu

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Resistances in Group Music Therapy With Women and Men With Substance Use Disorders

Abstract

In this paper, we explore client resistances in group music therapy with women and men in residential treatment for substance use disorders (SUDs). We describe how we have encountered resident resistances on women's and men's units within a gender-specific treatment facility and offer suggestions for pre-empting and addressing such resistances, offering both nonmusical and musical strategies and techniques. We emphasize a person-centered approach and an experience orientation, in which we view our primary responsibility as providing opportunities for the men and women to engage meaningfully with music, self, therapists, and other residents in order to identify problems and explore alternatives and personal resources.

Keywords: substance use disorders, addictions, resistances

Introduction

In this paper, we explore client resistances in group music therapy with women and men in residential treatment for substance use disorders (SUDs)[1]. To our knowledge, no English publications have been dedicated to this topic. Our interest in and frame of reference for understanding resistances in this clinical setting comes from our work as supervisors of undergraduate practica in a 28-day residential treatment facility situated just over a mile from our university. The clients, hereafter referred to as *residents*, range in age from 17 to 65 years and represent a wide variety of biographies, environments, and current life situations. Some have sought treatment voluntarily; others have been court-ordered to attend. [2]

At the facility, SUDs are viewed as relating to a complex and widespread web of biological, psychological, social, and spiritual risk factors. As such, treatment revolves around not only identifying and addressing biological and hereditary aspects of the “disease of addiction” but also around emotional, interpersonal, and spiritual correlates and considerations. Lifetime abstinence is considered essential to sustained recovery.

Psychologists, counselors, social workers, nurses, and individuals who are themselves in recovery lead both psychoeducational and process-oriented groups. Psychoeducational presentations focus on subjects such as biological mechanisms and outcomes of use (tolerance, withdrawal, medical complications), nutrition, communication skills, boundaries, coping skills, attitudes of recovery, and relapse prevention. Process-oriented sessions focus on subjects such as personal histories of use, defenses (denial, rationalization), past and present traumas, family of origin dysfunction, and present family dynamics (violence, co-dependency). Residents also receive regular individual counseling services and are encouraged to use external supports to recovery, such as Alcoholics

Anonymous and Narcotics Anonymous and personal sponsors. Chaplaincy services are available for residents who desire spiritual and religious counseling (www.novabehavioralhealth.com)

We have enjoyed an ongoing affiliation with the facility since 2008. It is the only one in our county with gender-specific treatment units, which some argue are more effective than traditional, co-ed units, particularly for women with SUDs (NIDA, 2015; Straussner & Brown, 2002; Weissman & O'Boyle, 2000). We provide music therapy to two units: Women's Residential (WR) and Men's Residential (MR). We hold 50-minute process-oriented music therapy sessions two times per week on each unit. Group size ranges from 7 to 14 residents, and because of the facility's rolling admission process, nearly every group is comprised of both returning and new residents. Although music therapy is a complimentary service provided by our university program—as such, we have volunteer status—it is afforded visible administrative support: sessions appear on the posted treatment schedule, eligible residents are expected to attend every session, a staff member is present in the room, and staff regularly confer with music therapy teams regarding treatment needs and outcomes. Moreover, the facility has allowed data collection for three separate music therapy research projects (Gardstrom & Diestelkamp, 2013; Gardstrom, Klemm, & Murphy, 2016; Gardstrom, Neforos, & Wllenbrink, 2013).

Our clinical practice at the facility is person-centered [3]. We espouse the belief that each resident's inherent tendency is to develop to their fullest human potential and that our fundamental job is to offer “assists to the client's own self-healing process” (Bohart, 2012, p. 9). We believe that music therapy can help the residents to reclaim lost or diminished wisdom, capabilities, and strengths as they move toward the healing and wholeness that they desire and deserve. We emphasize personal choice and agency, encouraging every individual in the group to take from each session whatever works to best advantage in their self-defined trajectory. We strive to develop and maintain relationships with the residents based on genuineness and respect. We attempt to accept without condition all that they say and do (except if residents were to be verbally or physically abusive toward others) and to extend a nonjudgmental attitude to their musical preferences and responses. What this also means, of course, is that, while we work to circumvent and diminish resistances, we honor the residents' right to resist treatment.

We think integrally [4], drawing upon various practices as informed by resident need. To be sure, we are predominantly experience-oriented. In this way of working, we do not predetermine specific response outcomes for the residents; rather, we suspend expectations of outcome (Sutton, 2012) and allow clinical aims to unfold. As such, our primary responsibility is to provide opportunities for the residents to engage meaningfully with music, self, therapists, and other residents. In an experience orientation, music functions predominantly as a medium of experience through which the residents can identify problems and explore alternatives and personal resources (Bruscia, 2011).

It bears noting that at times the residents may articulate needs that point to a different way of working—one in which a desired outcome is predetermined (e.g., decreased anxiety) and in these cases, we design and facilitate a music encounter as a means to this particular end. In outcome-oriented work such as this, music functions predominantly as a *means to a nonmusical end*.

Resistances As Conceptualized From Within Various Orientations

Since the term *therapeutic resistance* was first coined by Freud and his contemporaries (Thoma & Kachele, 1994), the construct has been interrogated from a number of different theoretical

orientations. A music therapist's orientation naturally influences how they define resistances—even what they call it [5]—, what actions they perceive as manifestations of resistances, and how they view the role and function of the music, the therapist, and other group members in pre-empting, triggering, and addressing such resistance, as relevant.

From a psychodynamic perspective, resistances are viewed as the client's attempt to avoid or diminish anxiety resulting from awareness of repressed memories, emotions, thoughts, and drives (Messer, 2002). In music therapy, resistances are evident in a client's actions, words, and music. In the case of music-assisted imagery, resistances also may present themselves in the imagery. Music therapists work to reveal the client's emotional conflicts and "work through" them or, in more contemporary practices, to remediate deficits in the client's ego stemming from early and traumatic life experiences (Austin, 1998; Austin & Dvorkin, 1998; Bruscia, 1998; Priestley, 1975).

From a cognitive-behavioral perspective, resistances are viewed as any attempt on the part of the client to avoid changing unhealthy thinking patterns and the negative emotions and self-defeating behaviors associated with these cognitions (Leahy, 2003). In music therapy, resistances are evident in a client's refusal to engage with musical and nonmusical activities within the session (e.g., refusing outright to play an instrument or speak during a discussion) or failure to complete homework assignments in between sessions. Music therapists who embrace this viewpoint work to circumvent resistances—some employ musical and nonmusical contingencies to elicit and sustain more desirable responses—but may also challenge counter-therapeutic beliefs and avoidant behaviors when they arise (Luce, 2001; Reitman, 2011).

Less has been written about resistances from a person-centered approach to psychotherapy and music therapy (Patterson, 2014). In what does exist, resistances are portrayed as a natural human response to unpleasant or dangerous feelings attached to perceived threats to the self. As such, a person-centered music therapist likely would not view the resistant client as unmotivated, defiant, recalcitrant, noncompliant, and so forth—the psychotherapy literature is replete with these and other seemingly pejorative terms [6]—but rather as self-governing, resilient, and tenacious in their efforts to preserve the current structure of the self. From a person-centered stance, resistances are believed to be triggered, in part, by a therapist's judgment, evaluation, and interpretation of client's behaviors and actions (Patterson, 2014). Nordoff and Robbins (2007), who practiced improvisational music therapy, used the term *resistiveness* to describe the client's self-erected barriers to the therapeutic process. They conceptualized this dynamic as emerging in relation to the therapist, not the music, and propose that an inverse relationship exists between a client's *resistiveness* and participation in music making such that resistances decrease as participation increases (Bruscia, 1987). They also noted that an indispensable aspect of the therapist's work is "to raise the level of relationship through treating expressions of resistiveness as means of intercommunication" (Nordoff & Robbins, 1977, p. 190, italics original). Like the cognitive-behavioral music therapist, the person-centered clinician works to avoid resistances but addresses them as they arise by communicating empathy for and acceptance of the client's self-protective tendencies.

Although variously named and defined, resistances can be understood broadly as a form of communication about the client's emotional vulnerabilities (Messer, 2002) and their attempts at self-protection, whether against the anxiety attached to awareness of unconscious and traumatogenic material, distress or ambivalence associated with change, or real and perceived threats to the self. We should mention, also, that clients' reactions to confusion, fatigue, medications, and sensory overload may lead to disengagement and thus be misinterpreted as

resistances; as such, the therapist is wise to consider context, solicit client feedback about therapeutic processes, and interpret with caution, that is, to refrain from *assuming* that resistances are operating.

Core Beliefs and Observations

Moving forward, we offer the following core beliefs and observations about resistances as a context for the subsequent discussion about our work on WR and MR:

1. Although we respect the communicative function of resistances among the residents and honor their right to resist, this dynamic is unwelcome chiefly because it is counter-developmental; that is, it ultimately blocks residents' paths toward healing and wholeness. Steele (1984) wrote, "In the metaphor of the journey, one may say that at a certain time the therapist judges the chosen route to be apparently impassable; [the client's] steps must be redirected." Moreover, within the time constraints of short-term treatment—each resident attends just 4 to 5 sessions—resistances greatly minimize opportunities for exploration and development of the self. Also, one member's resistant actions can destabilize an otherwise "working" member or group.
2. We work to pre-empt and diminish the residents' resistant tendencies through maintaining an empathic therapeutic demeanor, providing opportunities for the resident to have "intrinsically pleasurable, uplifting, empowering, or meaningful" music experiences (K. Bruscia, personal communication, November 18, 2011) and, to the best of our abilities, attentively and reflexively facilitating these experiences.
3. In our view, resistances are less of an "either-or" construct and more of a *continuum of engagement*. We recognize that women and men with SUDs rarely, if ever, move through treatment toward recovery in a neat, linear fashion; thus, from week to week, session to session, and even moment to moment, a resident's responsiveness to music therapy—where they find themselves and where we perceive them along this continuum of engagement—can vary greatly. We also accept that residents who engage less than others may not be resistant to therapy. In fact, they may be genuinely fatigued, as insomnia is common among the residents. They may feel bored or disinterested, as the way we as therapists present a music experience can have a lot to do with motivation to engage. Or they simply may not be well-matched to music therapy but may find greater value in other treatment modalities, such as art therapy or dance and movement therapy.
4. In psychotherapy in general, and in treatment for SUDs, resistances can and often do indicate a *lack of treatment readiness*. Important here is the Stages of Change model of Prochaska and DiClemente (1982). Resistances to change are likely to be greater in the beginning stages of change. Additional, potentially interrelated factors that influence treatment readiness include the following: perceptions of physical and emotional safety within the facility, with the therapist and other group members, and with the psychotherapeutic process; intellectual capacity; developmental maturity; chronicity of use; duration of sobriety; understanding of treatment aims and benefits; and whether seeking treatment voluntarily or mandated to attend.

In what follows, we describe how we have encountered resident resistances on WR and MR within each of the four methods of music therapy. We then offer suggestions for pre-empting and addressing such resistances, offering both nonmusical and musical strategies and techniques.

Resistances Within the Four Methods of Music Therapy

In our sessions at the facility, we draw from all four music therapy methods: receptive, improvisation, composition, and re-creative. Factors that equally inform our decisions about which specific methods to use at any given time include the following: 1) *therapist assessment* of residents' needs and interests, both before and during the session; 2) *resident input* regarding their needs and interests, both before and during the session; 3) *needs and interests emerging spontaneously* and sometimes unexpectedly during the session; and 4) *situational considerations*, such as time, space, and availability of materials. Additionally, while planning and facilitating, our reflections on previous encounters with client resistances as related to particular individuals or particular music therapy methods often help us to anticipate and thus more skillfully pre-empt and address subsequent occurrences.

Resistances to Music Therapy in General

Refusal. We encounter general resistances across all four methods, as evidenced by *outright refusal* to participate. Statements and postures representing this refusal include the following:

- Music is not an important aspect of my life.
- I don't want to sing/play/listen/compose.
- I can't sing/play/listen/compose.
- I don't know how to sing/play/listen/compose.
- Singing/playing/listening/creating will not help me; this does not relate to my treatment or recovery.

Avoidance. We also see responses that may be considered *avoidant*:

- Missing a session or departing prematurely (e.g., staying in one's room, leaving to use the restroom and never returning)
- Exhibiting extreme passivity (e.g., saying nothing, deferring all decisions to therapists or other group members)
- Talking incessantly (e.g., speaking while music is playing, using words to deflect an emotional response)
- Distancing physical self from action (e.g., sitting apart from the group, standing while others are sitting and vice versa)
- Dissociating (e.g., daydreaming, sleeping)
- Making excuses for lack of engagement (e.g., illness, medication, fatigue)
- Receding from music making and processing of music experiences (e.g., dropping out before a music encounter ends, becoming silent during a discussion, leaving a mandala drawing unfinished)

Pre-empting and addressing resistances. On WR and MR, we consistently employ a few strategies aimed at pre-empting resistances, as follows:

1. *Casual conversation.* While residents gather in the group room, we engage in casual conversation as a way to express our interest in their daily lives and thus build rapport. This is a time to talk about their visits with children and family members, court hearings, aftercare plans, and so forth. We may share personal information within clear facility boundaries (e.g., our roles at the university, share our musical preferences, etc.). This particular strategy is aimed at pre-empting resistances to perceived authority figures and reducing ambivalence about interpersonal joining.
2. *Information sharing.* At the start of each session, we take a few minutes to talk about what will be happening. During this phase, we first offer a cursory definition of music therapy and describe some of the experiences that are available to the residents. We then describe some of the challenges and benefits that the residents can expect from engaging with the process. With the women, we may do this by sharing findings of a survey of prior female residents of the facility (Gardstrom, Klemm, & Murphy, 2016). With both the women and the men, we invite the “veterans” in the session to comment on what they have experienced in prior sessions. Undoubtedly, someone in the room will mention that certain music experiences have evoked difficult emotions but that experiencing and talking about these were a necessary step toward improved well-being. We make it clear that the therapists cannot (and do not desire to) force participation and that each individual has control over what they “bring to and take from” each session. Finally, we ask the residents if they have any questions. Not only is this information-sharing phase indicated with the constant change in group membership, with anywhere from one to five new members in each session, but it also seems to pre-empt resistances by minimizing anxiety attached to the unknown, reducing apprehension about being controlled by a perceived authority figure, and addressing the residents’ conscious or unconscious understandings that music can bypass protective defenses and conjure intense emotions (Austin & Dvorkin, 1998).
3. *Chanting.* On WR, we sing chants at the start of the session as an antidote, of sorts, to resistant postures. Chants can be defined as rhythmic words or phrases that are repeatedly spoken or sung in unison. The songs we use are simple and repetitive and focus on a number of themes. We invite the women to sit or stand in a circle, we teach the song by rote, and we often provide a basic drum accompaniment. We are faced with and accept a range of responses to this invitation, from sitting in silence to singing exuberantly while dancing inside the circle. We believe that there are a number of ways this rather simple music experience positively impacts the women’s responsiveness to treatment. First, singing as ritual offers a sense of structure and predictability and thus stability that sets the stage for personal exploration and development (Austin, 2008; Uhlig, 2006). Second, the act of singing has been reported by the residents of WR as enjoyable (Gardstrom, Klemm, & Murphy, 2016), which establishes a positive tone for whatever lay ahead in the session. Third, singing with others can “build and strengthen community” (Austin, 1998, p. 316), or what the women have described as forming a “sisterhood” (Gardstrom, Klemm, & Murphy, 2016), which reduces the potential for resistances to interpersonal intimacy. An additional benefit is that song material can be selected or composed to communicate specific messages that the women need to hear or claim with their own voices.

Two specific chants are intended to reinforce the safety of the circle. The idea here is to diminish the women’s anxieties about revealing their authentic selves. The first is “Come As You Are” (Gardstrom, 2016a):

Come as you are to the circle.
 Come as you are and be heard.
 For here we honor all vict’ries you sing.

And here we honor all hardships you bring.
And here we honor all manner of things,
So come as you are to the circle.

The second is “Come to the Circle” (Gardstrom, 2016a), which is an invitation to move beyond fear, invest in the group process, and reap the benefits of treatment:

Come to circle, come without fear
Join with the circle, let your heart be here
Give to the circle whatever you can give
And take from the circle what you need to live

Other songs are meant to empower the residents to let go of any thoughts, feelings, or attitudes that do not serve them in their desire for healing and wholeness. “Surrender” (Moffett, 2002), a spirited chant aligning with steps 1 - 3 of The 12 Steps (Alcoholics Anonymous, 2014), has emerged as a favorite:

I step into the flow, then I let go
I open my mind, my heart and my soul (2x)
I surrender, I surrender, I surrender
I open my mind, my heart and my soul
I open my mind, my heart and my soul

Harder hitting is “Poison” (Gardstrom, 2016b), which again affirms the notion of letting go of physical, emotional, and mental burdens:

Poison in my body, poison in my soul
Poison in my head -- I’m gonna let it all go (2x)
There’s no need to hang on to this tension
There’s no need to hold on to this pain
There’s no need to cling to stinkin’ thinkin’
And just to make it clear, I’m gonna sing it again

Resistances Within Receptive Methods

Receptive methods are “those in which the client assumes the role of a listener in the music experience... Although the client is not making music, he is called upon to actively respond to what he hears, in overt and covert ways” (Gardstrom & Sorel, 2015, p. 117). We have used three receptive variations regularly in our work on WR and MR: song communication, song discussion, and music-assisted relaxation (MAR).

Song Communication and Song Discussion

Although song communication and song discussion are distinct receptive variations, they are closely related, and we find that resistances manifest similarly; thus, we will address them together in this section.

The essence of song communication is that a resident selects a song at the therapists’ request to communicate something about themselves to the group. The song may relate to their past life experiences, present feelings about treatment, future aspirations, and the like. The song is presented, usually via a recording, and residents and therapists listen to the song together and then explore what the resident intended to communicate and any emergent thoughts and feelings. For

women and men with SUDs, song communication can function as a means of sharing something deeply personal that they have not yet been able to reveal and to experience the feelings that accompany this genuine self-disclosure. Sometimes there is shame, but most often there is a sense of relief. Either way, the disclosure can promote empathy among group members for the person who is disclosing.

Song discussion is a similar experience in which the therapists and residents listen to a song together and then discuss the song's meaning and relevance to their lives. Unlike with song communication, however, the therapists pre-select suitable song material on the basis of whatever therapeutic themes the group may need to explore together. The therapists prepare a "listening set" to focus the residents' listening process (e.g., "Take note of anything that seems meaningful for you in the music or the lyrics or both."). The therapists then present the song either live or via a recording and facilitate the discussion following the presentation (Gardstrom & Hiller, 2010). Among women and men with SUDs, song discussion allows for exploration of themes related to use and abuse, treatment, and recovery, and "functions as supportive therapy—helping clients to experience meaningful connections and a decreased sense of isolation as they communicate with others" (Gardstrom & Sorel, 2015, p. 117).

Resistances manifested. We have found that resistances manifest in the following ways as song communication and song discussion unfold:

Before the listening (when the resident is responsible for selecting a song)

- Refusing to select a song
- Failing or forgetting to select a song in spite of a prior request or commitment to do so
- Selecting a song in which the thematic material lacks relevance to the person's life

Before the listening (when the therapist is responsible for selecting a song)

- Criticizing the song choice
- Refusing to accept a lyric sheet to guide the listening process

During the listening

- Dissociating (e.g., daydreaming, nodding off) during the song presentation.
- Engaging in interruptive actions during the song presentation (e.g., having side conversations, laughing)
- Suppressing emotions (e.g., wiping away tears, stifling laughter)

After the listening

- Remaining silent
- Denying or diminishing the personal/emotional impact of the song
- Deflecting the conversation away from emotional content (e.g., talking about the band/singer, going off on tangents)
- Engaging in interruptive actions during the discussion
- Criticizing the live performance

Pre-empting and addressing resistances. We suggest three distinct strategies for pre-empting resistances to song communication and song discussion:

1. *Allow for resident choice/control of music material.* Song communication is consistent with our belief that the residents deserve opportunities to exercise free will and take ownership of their treatment process. They select the song and we honor their selection, no matter what it is. For song discussion, we extend this attitude by preparing multiple songs per session and asking the group to negotiate which song we address. Similarly, at the end of the session, we may invite the residents to make song suggestions for future sessions, asking them to articulate why they believe their songs would be of value for the group to hear. We then double-check the clinical relevancy, learn the song (if presenting it live), and prepare the lyric sheets for use in the following session. On WR, this strategy has become a ritual of sorts; when a woman announces that her next music therapy session will be her last, the group members safeguard her “right” to select a song for the group to hear.
2. *Acknowledge the song’s emotional intensity before listening.* If a song is particularly emotionally intense—whether because of the lyrics or the music or the union of the two—we may make a statement such as, “This song tells a story about addiction and overdose. The lyrics are raw (there is profanity) and the music is forceful. You may hear gunshots. Uncomfortable feelings may arise within you as you follow along. Please know that it is normal to feel deeply in response to certain songs, and that it is okay to experience and express those feelings here, in a place of support. Know also that you will ‘survive’ these feelings; they will pass.”
3. *Accept all responses.* We offer lyric sheets but never force anyone to take one or use it. If a resident refuses the sheet, puts it under her chair, crumples it, etc., we simply allow this to be, trusting that these actions do not necessarily mean that the resident will not engage during the listening and discussion. It is important to consider that some residents may refuse to take a lyric sheet not because they have dis-engaged with the process, but rather because they do not read or see well enough to make use of it.

When we encounter resistances, we may employ the following strategies in the moment:

4. *Acknowledge the silence.* If the group is silent or minimally conversant, we acknowledge this and might invite the group to explore what the silence means. Austin and Dvorkin (1998) write about using instrumental referential improvisation to concretize inner experience -- that is, inviting the residents to “play the silence” or “play the resistance.”
5. *Work with the discomfort of experiencing and talking about feelings.* We do this in a variety of ways. We might simply acknowledge the fact that uncomfortable feelings have come to the surface. We might encourage inner reflection: “We know that some of you are in pain right now. If you can’t speak about this, it’s okay to simply sit with these feelings and reflect on what you can learn from them.” We might also pose a question in the hopes of jump-starting the conversation: “Can anyone share how talking about these uncomfortable feelings has helped them in the past or might help them now?”
6. *Offer to play the song a second time.* A second playing may help to minimize resistances in a couple of ways. First, it may break through defenses: with residents who “stuff” their feelings while listening the first time (e.g., choking back tears or displacing emotional

energy into a jittery leg), a second playing -- perhaps with a different listening set (e.g., “This time, I suggest that you close your eyes and focus on what’s going on inside.”) may help them to access emotional meanings. Also, among the women, songs commonly conjure feelings resulting in crying or even sobbing. In fact, some of the women realize in hindsight that this catharsis, or release of emotional energy, was their primary intent in selecting the song! In these cases, the song serves as a container for the expression of these profound feelings (de Backer, 1993), and a second playing can afford the women extra time to allow these feelings to dissipate enough to be able to talk about their experience. Obviously, this strategy of re-playing a song should be used with caution; there must be ample time for processing feelings that surface during a repeated listening.

Music Assisted Relaxation (MAR)

Anxiety is prominent among women and men with SUDs (Brady et al., 2013). Music listening for relaxation purposes has been used on both WR and MR units. Murphy (2013) suggested that MAR is useful in all stages of recovery and can help clients learn how to “manage symptoms of stress and anxiety” (p. 451). Instrumental recorded music is used most often to support progressive muscle relaxation (PMR)(Jacobsen, 1938).

Resistances manifested. Even when requested by the residents themselves, MAR with PMR sometimes yields resistances to physical and mental relaxation. Lowering of physical defenses may be disagreeable because muscular tension often carries psycho-emotional meanings. When we quiet our bodies, slow our breathing, and consciously relax our large and small muscle groups, we may find that emotions we have harbored “come to the surface” and demand expression. This, in and of itself, can be an unwelcome experience for the individual. In group psychotherapy, this emotional outpouring can lead to an unpleasant sense of vulnerability as others bear witness to it, particularly among men, who receive strong societal and cultural messages to disavow or hide their emotions from others and among both women and men who have lost access to the “true self” as their addictions progressed.

Resistances to MAR are manifested in the following ways:

- Poking fun at the process; making diminishing comments (e.g., “This is silly”)
- Leaving the room before or during the process
- Leaving eyes open
- Dissociating (e.g., daydreaming)
- Disengaging with the physical component (i.e., refraining from tensing and releasing muscle groups as directed)
- Interrupting verbally or otherwise (e.g., walking across the room for a tissue)
- Perseverating on a distaste for the musical selection(s)

Pre-empting and addressing resistances. With both MAR and music imagery (see below), it is the case that certain individuals in the group are unable to assimilate into the process as it unfolds; yet they choose to remain in the session room. They sit quietly with eyes open, gazing around the room or out a window, but they do not follow through with suggested directions. In this case, we typically do not address what we observe, mostly due to the importance of maintaining a fluid, well-paced procedure, and one that is focused on each individual’s inner experience. It is important that the process is uninterrupted for the benefit of those members who are deeply engaged. Diverging from the sequential procedures to attempt to re-engage certain individuals would “break the flow” for

the other residents, thereby potentially disrupting their movement toward the desired relaxation and imagery responses.

One strategy that we have employed to bypass resistances when introducing MAR with PMR for the men, in particular, is as follows:

Articulating benefits. We emphasize what other residents have voiced about the immediate benefits of MAR, such as decreased state anxiety, increased sense of control in dealing with difficult feelings, and experiencing rejuvenation in the middle of a day. We also emphasize long-term benefits; MAR can serve as a sleep aid, and learning how to relax with the support of music is a coping skill that may help them to maintain sobriety after discharge from the facility.

Music Imagery

We have used both live and recorded instrumental music to support the process of music imagery (MI) toward connecting with inner emotional states and improving self-awareness. In particular, these experiences aim at evoking positive imagery in non-altered states of consciousness. We are particularly mindful that all MI experiences have the potential to evoke disturbing images and feelings, particularly among individuals who have experienced trauma and those diagnosed with psychiatric disorders (Bruscia & Grocke, 2002; Eyre, 2013). In this regard, we make sure to have facility staff in the room and to give the residents in-the-moment tools for managing disquieting responses, such as opening their eyes to stop the flow of imagery and raising their hand to signal a need for individual therapist attention while the group continues in the experience.

On WR, the women are invited to assume a comfortable position in their chairs, close their eyes as able, and focus on slowing and deepening their breathing. As a feature of this *induction*, we may use MAR (see above). We then provide a positive “seed image” (Borling, 2011), such as the following: “Imagine yourself in a safe place, whether that be a room in a home or someplace outdoors, such as a beach or field. As the music begins, allow it to join you like a friend in this safe place and bring you something that you need.” At this point, we may play an instrumental recording or improvise on a melodic theme on a Native American flute with an ostinato accompaniment on a frame drum or small djembe. The listening portion is generally brief (less than five minutes), owing primarily to resident distractibility and session length. Processing always occurs and typically takes the form of discussion or mandala drawing and discussion about their mandalas.

Resistances manifested. Following are some possible manifestations of resistances in music and imagery experiences:

- Difficulty assuming a vulnerable position (e.g., rigid posture, keeping eyes open)
- Disassociating or engaging in interruptive actions during music listening
- Conjuring images that suggest resistances (e.g., walls, fences, dead end roads)
- Criticizing the music choice or performance
- Avoiding meaningful verbal or other processing of personal experience (e.g., verbally diminishing the emotional impact of the music, choosing not to draw a mandala or to discuss their drawing)

Pre-empting and addressing resistances. To pre-empt the women’s tendencies to resist MI, we have employed the following strategies:

1. *Hand control to the residents.* We always make a point of stating to the women at the outset that they are “in control” of their listening experience—as noted above, we suggest that they can manage anxiety resulting from distressing feelings and images by opening their eyes and asking for help (Murphy, 2013).
2. *Warm-up with perceptual listening.* We have facilitated brief perceptual listening experiences (Bruscia, 2014) as a precursor to directed imagery. We use any number of recorded instrumental pieces approximately three minutes in length, typically Western classical music from the Baroque or Classical eras (Note: Bizet “Intermezzo” from Carmen has been useful). These pieces are characterized by a major modality, predictable phrasing, low rhythmic and dynamic variability, and clear figure-ground relationships (melody-harmony). To focus the listening, the therapists might suggest that each woman turn their auditory attention to a particular instrument for the duration of the piece.

A warm-up such as this provides an opportunity for the residents to “dip their toes in the water”—that is, to acclimate to some of the idiosyncrasies of a listening experience. They can practice closing their eyes and quieting their bodies and minds. They can try their hands at shifting their perception away from multiple sights and sounds in the session environment and their racing thoughts [7] and directing it toward a singular musical stimulus. In the brief processing that follows the listening, the women can practice talking in the group. There is no pressure for them to access emotions or generate imagery, although this may occur. We have found that these experiential understandings through brief perceptual listening form a foundation for a less intimidating and more pleasant subsequent imagery experience. Our sense is that resistances to emotionally-focused music imaging are pre-empted through these strategies because the women come to realize that a) they are able to focus on the music for brief periods of time and thus can be “successful,” b) they can relax and allow the images to come forth, c) the music cannot control their inner experience without their permission, and d) they will “survive” and the therapists and group will support them in expressing any and all distressing feelings or images that arise.

Once we are “in” the experience, we attend carefully to pacing:

3. *Take time with the induction.* By definition, the induction is a preparatory phase in the procedure; one of its purposes is to lower defenses and embolden the residents to “jump into the unknown.” As such, we watch the residents’ breathing and postures for cues about what pace is best suited to their needs.
4. *Take time with transitions.* As with the induction, it is important to allow ample time for the transition from the listening phase to the processing phase. Resistances to self-disclosure of personal experience may arise if the residents are rushed from an individualized, internal state of being to an external group focus. In addition, it is important to recognize that individuals who do not disclose may not be resistant but rather may simply need more time than other people (or than time constraints allow) in order to process their experiences out loud.

Resistances Within Improvisation Methods

Instrumental Improvisation

We use instrumental improvisation on both WR and MR units. Generally speaking, instruments consist of freestanding drums (djembes, tubanos), smaller hand-held drums (doubbeks, bodhrans), and hand-held rhythm instruments (cabasas, guiros). Both referential (theme-based) and non-referential improvisations are employed.

Resistances manifested. We interpret the following responses as potentially indicative of resistance:

- Selecting the same instrument over time
- Avoiding the same instrument over time
- Selecting the smallest instrument, playing inaudibly, offering a paucity of sound, and remaining entirely silent (hiding)
- Selecting an instrument that is incongruent with one's identified emotional state or the state to be explored through referential improvisation (Austin & Dvorkin, 1998)
- Playing the same thing over and over (getting "stuck")
- Playing without apparent expressive or conscious communicative intent

Pre-empting and addressing resistances. Our efforts at pre-empting resistances take place during the presentation of the materials and the procedures.

1. *Highlight attractiveness and accessibility.* We strive to make the instruments and the process of improvising as attractive and accessible as possible. One way we do this is to first present what we call a *sound vocabulary*. The sound vocabulary consists of naming each instrument and demonstrating basic playing techniques and, in so doing, highlighting timbral, dynamic, and rhythmic possibilities. The process of modeling basic techniques can bypass resistances by allaying anxiety attached to doubts about musical competency. These doubts are typical of first-time or novice players and individuals with minimal self-confidence. Additionally, we emphasize that in improvisation we have no preconceived standards for musical performance; that is, when it comes to self-expression, there is no right or wrong. Finally, we emphasize that the drums and handheld percussion are not toys -- a perception that some men have voiced and that inhibits their inclination to play -- but rather are professional quality instruments used in a variety of musical cultures and traditions around the world and available for their creative expression.
2. *Initial exploration.* Once all residents have selected an instrument, we encourage simultaneous, individual exploration. We might say something like, "Take a moment and find a number of different ways to create sound on your instrument." This experimentation (during which time no one player is in the spotlight) provides a useful transition to collective play.
3. *Empower to make a change.* We have noticed that players who are dissatisfied with the sound of their chosen instrument or who become frustrated as they try to create a certain sound tend to recede from the improvisation. To avoid this, we make sure to bring extra instruments. A useful rule of thumb is to have at least one and a half times the number of players (Gardstrom, 2007). We always let the residents know before we begin that they have the option of switching instruments midstream if they so choose.
4. *Employ musical facilitation techniques.* We find that some of the musical facilitation techniques work to both forestall resistances before they occur and address them as they

occur. (See Bruscia, 1987, for a comprehensive list of musical facilitation techniques used in clinical improvisation.) Techniques of empathy such as *imitation*, *synchrony*, *reflection*, and *incorporating* provide a way for the therapists to reassure the residents that their music making is heard and valued. This can be a powerful message for individuals whose “voices” have been repeatedly invalidated through disregard, criticism, or ridicule, or who have been punished for their attempts to express themselves.

If we sense, see, or hear that a client’s level of engagement is diminishing during the actual music making, we might employ one or more of the other techniques. For instance, if a client recedes from an improvisation or becomes “stuck” in their playing and seems to need new musical materials in order to re-engage, the therapists might establish eye contact with the resident and then use *modeling* to demonstrate varied ways of playing, thereby providing new musical ideas in hopes of re-igniting the motivation to play. We might *leave spaces* within our own musical phrases as a means of inviting a resident to fill in these spaces with a unique musical response. We might *introduce changes* of tempo, meter, and dynamics in an effort to re-arouse and entice a resident to join us with their own playing. If a resident is in close proximity, we might offer our instrument to share (technique of *intimacy*) or, if the resident seems willing, make sounds on their instrument. (This technique should be employed only when there is no risk of violating the resident’s protective boundaries.)

Resistances Within Composition Methods

In composition methods, residents engage in generative processes of creating original music, most typically song material. One particular variation, song transformation, has been used on both units, although more frequently on MR.

In our experience, resistances during the process of composition may not only thwart individual healing but also may lead to interpersonal strain within the group. For example, members might recede from the discussion out of frustration with the negotiation process, thereby forfeiting their opportunity to contribute, and leading to a sense of defeat or resentment toward certain members. Moreover, a resistant process often leads to a less than satisfying final product (song), one that lacks internal integrity, aesthetic value, or meaning for the group.

Song Transformation

In song transformation, the residents alter certain aspects of a pre-composed song through a creative process. Typically, the residents engage in rewriting lyrics, guided by a theme that is relevant to recovery and determined by the residents themselves. A *cloze* procedure (Freed, 1986) is most often employed, in which the therapist removes certain words or phrases from the original lyrics, leaving blanks to be filled in with original ideas.

In collective song transformation, the therapist guides the group members to negotiate with one another new lyrics to be placed within the remaining song structure. In so doing, the residents: exercise creativity; take risks by generating and giving voice to ideas and feelings relative to addiction, treatment, and recovery; open themselves to the ideas and opinions of others; provide support and feedback to peers; and experience both the frustrations and satisfactions of investing in the collaboration to create a potentially meaningful and often aesthetically pleasing product. The participants typically perform completed songs, and residents may request a print copy of the newly composed lyrics.

Sometimes the group members work individually to develop song lyric ideas in their own quiet space and time. They are then invited to share their finished products with other group members. Some residents do not share; some read through their original lyrics; others elect to sing them with musical assistance from the therapist.

In both collective and individual song composition, a culminating discussion of both the creative process and the final product usually occurs after the performance. Residents sometimes describe feeling proud of their work during these sessions, which suggests that the experience may boost self-esteem.

Resistances manifested. Collective and individual song composition present different intrapersonal and interpersonal challenges for residents. In fact, such challenges may influence the therapist's decision to engage the group in one or the other process. Because of the differential challenges, we note that general resistances manifest variously in each. During collective song composition, we see more resistances to interpersonal intimacy and the feeling of vulnerability that can result from sharing one's personal thoughts and feelings with another. However, intrapersonal resistances may also manifest during collective composing as an individual experiences the challenges of generating and accepting responsibility for highly personal lyrical ideas. During individual song composition, we see resistances primarily to intrapersonal exploration and insights as residents meet the challenge of generating and articulating self-referential lyrics.

We interpret the following responses as potentially indicative of resistances:

Before composing:

- inability to identify relevant themes
- choosing an irrelevant theme

During composing:

- inability to generate lyric ideas; becoming "stuck"
- becoming overly focused on the rhyme scheme or the way the new words fit the melodic rhythm
- offering ideas that are incongruous with the emerging emotional tone (e.g., humorous lyrics for a serious topic)
- giving-in to frustrations related to negotiating with peers and withdrawing from the process

After composing:

- demeaning the final product
- disclaiming personal contributions

Pre-empting and addressing resistances. In preparation for facilitating a song transformation, we form predetermined thematic ideas to offer as suggestions, but only when the group is unable to determine its own theme or when residents' suggestions are too far afield from a topic related to addiction, treatment, and recovery. Specific in-the-moment strategies for diminishing resistances are as follows:

1. *Keeping the music alive.* As therapists, we try to hold the group within the accompaniment while individuals generate and shape lyrics to fit the musical phrases. In other words, we repeat the accompaniment softly as a background to the working-through of the lyrical phrases, and we may periodically perform or invite the residents to perform “snippets” of the unfolding creation. We refer to this as “keeping the music alive” while the residents ponder ideas, speak them aloud, and subsequently hear them in context as the therapist sings them within the song structure. We have noticed pride and a deeper engagement in the process when residents hear their lyrics being “tried out” in the song structure. As therapists, we attempt to reflect their ideas with stylistic integrity and to communicate not only obvious feelings, but also latent emotional content that we sense in their lyrical offerings. While it is not possible to use each and every suggestion that is put forth, we strive to validate all ideas.
2. *Take some responsibility for the aesthetic.* When a resident’s focus is singularly directed toward the aesthetic attributes (e.g., rhyme scheme, alignment of words with melodic rhythm) to the exclusion of lyrical content or group process, we verbally honor their attention to this aspect of the emerging piece, but then clarify that it may be more important to articulate meaningful ideas, whether or not they fit perfectly within the song structure. With certain groups, the therapists may need to take considerable responsibility for making the residents’ ideas fit rhythmically; we do so by modifying melodic rhythm and by using rubato in the accompaniment.
3. *Join with the resistances through music.* We once wrote a blues song unexpectedly in response to resistances on the part of all ten members of a group session. The residents chose not to engage with anything we had planned, because they were frustrated and angry that they were forced to cut short their walk outdoors on a beautiful spring day and come inside for the scheduled music therapy session. The three-verse song that we created together became a tirade about the silly and overly restrictive rules on the unit. The process of expressing feelings within the blues structure, as well as performing the completed song as a group (with an improvised saxophone solo by one of the group members) led to a palatable sense of solidarity that transferred to the balance of the session. In other words, we joined with the residents’ resistances, in a sense, by providing a “container” (the song structure and composition process) for articulating their immediate feelings.

Resistances Within Re-Creative Methods

The nature of group re-creative experiences is that each member plays a specific role in reproducing a musical model. Examples include imitating rhythmic patterns on a handheld rhythm instrument, singing a pre-composed song with frame drum accompaniment, and playing tone chimes to realize an instrumental piece. In some long-term addiction treatment settings, bands or choirs might be established (Murphy, 2013). The processes involved in re-creative music therapy are essentially musical as an individual asserts effort to learn and perform a musical part within the ensemble. Verbal processing of re-creative methods may occur but is not a necessary or required aspect of the process. Clinical benefits range from individual self-esteem building and strengthened interpersonal bonds to enhanced sensorimotor and expressive music skill development.

There are a few reasons to believe that clients with SUDs might engage more readily with re-creative methods than with the other previously described methods. First, there is greater emphasis on the didactics of learning and rehearsing music and less focus on the personal,

emotional experiences of the participants. Further, learning and rehearsing means “bite-sized” encounters with the music, such that participants do not experience emotional flooding that seems to be more common in sustained music experiences. In group settings, the nature of engagement during performance seems to be less emotional in that the song or piece being performed is not so much a reflection of the individual’s life or present state of being as it is a culmination and reflection of a group process.

Whereas it would seem that these “nonthreatening attributes” of re-creation would promote a willingness to engage, in all honesty, we have been minimally successful at moving past resistances from the men and thus have seldom used re-creative experiences with them. It is our sense that the residents on MR tend to compare themselves to models in popular culture—singers and bands with a high level of musical skill and celebrity status. Accordingly, if residents perceive themselves as having some skill on popular instruments such as guitar, bass guitar, keyboard, and drum set, they may be less apt to resist re-creative experiences involving these instruments. In fact, they may request opportunities to individually showcase their talents for others. Yet, given the transient nature of the MR unit and our time limitations—as noted above, we meet only two days per week for 50 minute sessions—it is not feasible to establish a selective performance ensemble on the unit. With a group of 10 residents with heterogeneous skills and interests, then, we are required to use basic instruments and simplistic arrangements, which the men tend to perceive as meaningless and perhaps even juvenile.

Additionally, it seems difficult for the men to ascertain how re-creative experiences, with their focus on performance, are directly related to treatment, which has a distinct emphasis on identifying unhealthy patterns of response and on developing new and immediately applicable coping skills. That is, the men have trouble understanding how rehearsing and reproducing the melody of a song, for instance, might support their sobriety and recovery once they leave the facility.

More fundamentally, we have encountered fairly consistent reluctance among the men to expose any aspect of incompetence as might be revealed in structured music making, a tendency that seems less acute in improvised music making where there are no preconceived standards of proficiency. Fragile egos and enculturated perceptions about masculinity as related to expression of artistic creativity (and thereby of personal emotions) are further barriers on this particular unit.

Emotional socialization is different for women; thus, we encounter little opposition on WR. We have used tone chimes for harmonic support to singing and have arranged pieces such as “Lean On Me,” “Stand By Me,” and “Fight Song” for vocal and instrumental re-creation, employing solo and group singing and a variety of tonal and rhythm instruments (e.g., chromatic bells, electronic keyboard, frame drums, tubanos, cabasas, claves). To date, the residents’ comments after the fact have been wholly positive, but it is important to note that certain women disclose that, although they were attracted to the idea of singing and playing, they were initially reluctant to engage because (as with the men) they were fearful that they would not be able to learn their prescribed part or “measure up” to the group’s expectations. Perceptions of incompetence appear to be less of a barrier for the women than the men, however, as these residents tend to spontaneously and verbally support one another in taking risks and enthusiastically praise one another’s accomplishments. In processing how they have been able to quickly move past their resistances, the women make statements such as, “I said to myself that I’ve overcome a lot more than this in my life,” “I know in my heart that no one is here to judge me,” and “I realized that everyone is probably a little scared to try something new.” In fact, once a particular group of women have experienced vocal and instrumental re-

creation, they often request continuation of this from session to session. They have identified that these experiences promote a sense of personal pride and group solidarity, and that the enjoyment of singing and playing together contributes to desired changes in emotional states.

Conclusion

The purpose of this article has been to offer our ideas relative to client resistances in group music therapy, with a focus on adults with substance use disorders. We have offered strategies and techniques that have helped the residents to avoid and diminish general resistances, as well as those arising within each of the four music therapy methods and their variations. Exploration of our countertransference reactions to client resistances and our own resistances to the therapeutic process, while absolutely relevant, lay beyond the scope of this article and deserve separate attention due to the complexity and presumed length of such an examination.

Although we share our ideas with the hope that they will assist other clients and clinicians, it would be naïve to proliferate the notion that the strategies and techniques themselves are what make the difference between a client who minimally engages and one who engages fully in the therapeutic process. There are many, many factors that influence therapeutic engagement, not the least of which are the unique characteristics and dispositions of the therapist. As McConaughy (1987) wrote:

... it is the character and interpersonal style of the therapist that determine the nature of the therapy that is offered to clients. The actual techniques employed by therapists are of lesser importance than the unique character or personality of the therapists themselves. Therapists select techniques and theories because of who they are as *persons*: the therapy strategies are manifestations of the therapist's personality. The therapist as a person is the instrument of primary influence in the therapy enterprise (p. 303).

In this regard, what we have presented herein is an outgrowth of our unique biographies, the clinical approach we take with our clients, and concerted reflection on our experiences in music therapy with women and men who are attempting to reclaim their lost lives. We advance that, contrary to myths articulated by some practitioners, *music can be invasive and is not always non-threatening* (Gardstrom, 2008). It can push or pull a client into difficult emotional territory where fear and memories of trauma, betrayal, and abuse—even the pains of loving—are alive and, indeed, worthy of resisting. Yet we also recognize that music can support, guide, and nurture a client along the path of discovery and recovery. Relative to resistances, the music therapist's charge remains to reflexively create meaningful opportunities for clients to develop a health-promoting relationship with music and to act with patience, respect, and compassion throughout the process.

Notes

[1] As therapists, we also manifest resistances in this clinical context, which may be addressed in a subsequent report.

[2] The majority of these people have an opioid use disorder, characterized by significant time spent in activities related to their drug of choice, craving, tolerance, withdrawal, and seven other criteria. See <http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf>

[3] Although therapist interpretations are not foundational to person-centered practice, in our attempts to fully understand and ultimately better serve our residents, we find it helpful at times to consider their musical responses as potentially symbolic of inner experience. For instance, we may interpret a resident's improvised rhythmic play as indicative of their emotional energies or their instrument choices as representative of aspects of their identity (Bruscia, 1987).

[4] This terminology stems from Bruscia's (2011) *Ways of Thinking in Music Therapy*, in which he defines and describes three distinct orientations to clinical practice, which, when flexibly and reflexively applied to address a client's priority health need, reflect an integral practice.

[5] For consistency and ease, we reluctantly use the term *resistances* in this report. The plural form reflects that authors in the literature have labeled many discrete forms, such as resistances to experiential forms of therapy, resistances to interpersonal intimacy, and so forth.

[6] Messer (2002) wrote, "resistance should not, and need not, be viewed as the enemy of therapy. In fact, the term itself is in some ways unfortunate. It leads the therapist to think in oppositional terms rather than to view resistance for what it is: the inevitable expression of the person's manner of relating to their inner problems and to others" (p. 158).

[7] Racing thoughts are a common symptom of opioid withdrawal.

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