

*Qualitative Inquiries in Music Therapy*  
2011, Volume #6, pp. 75–121  
Barcelona Publishers

## MUSIC THERAPY AS AN INTERVENTION FOR INPATIENT TREATMENT OF SUICIDAL IDEATION

Erin Bullard, MMT, MT-BC

### ABSTRACT

This study examined the role music therapy plays in the treatment of people with suicidal ideation in an inpatient psychiatric setting. Through naturalistic inquiry, the study sought to describe participant reactions to music therapy in a group treatment setting and explain how the group was perceived to be of value. Inductive analysis of data led to the emergence of three main categories under which several themes were identified. The categories were PERSONAL CONTEXT, EXPERIENCE OF THE MUSIC THERAPY GROUP, and EFFECTIVENESS. Study outcomes are explained by components of Berne's (1964) theory of Transactional Analysis (TA).

### INTRODUCTION

Having worked in different acute psychiatric settings, I noticed that many people were admitted with suicidal ideation as a chief complaint. While admission to the hospital served as a preventive measure, it also provided the opportunity for becoming aware of other issues behind the suicidal thoughts or plans since the patient would likely attend treatment groups. My formal music therapy training gave me the skills to address issues presented in an inpatient music therapy group, such as depression, symptom management, or poor coping skills. However, I was unsure how music therapy might allow the patient to process feelings related to suicide and how I would go about broaching the topic with patients if it seemed relevant to their treatment. Initial investigation revealed that few music therapy resources address this problem in the group setting. This left me curious about the clinical nature of suicidal ideation and the role music therapy plays in treatment.

I chose to pursue this topic through my graduate studies to deepen my understanding and level of comfort of processing suicidal thoughts in clinical settings as well as to learn how to answer my questions through formal research. There were few guiding principles in the literature that describe music therapy with psychiatric patients who exhibit suicidal ideation: The effects of music therapy are unknown in group treatment of such a condition. In addition to seeking to better understand my research questions, I wished to use results from the study to inform a theoretical lens through

which to view this phenomena. Since the design of the study allowed results to unfold naturally, I chose to support the findings with a theoretical orientation that serves to give a possible explanation of suicidal ideation as a treatment factor.

This study employed qualitative research using naturalistic inquiry. My role in the research was as therapist and researcher. An inductive analysis approach enabled me to consolidate the raw data collected through observation and participant interview along with self-reflection. I have presented the results in narrative form to substantiate the categories that emerged through the analysis process. The analysis informed the findings discussed here and indicates that music therapy seems to enhance protective factors that work against suicidal ideation. The outcomes of therapy were explained by components of Berne's theory of Transactional Analysis (TA), which I found useful for grounding the results through an existing theory. This relationship between music therapy and TA can be further examined in future research.

### Delimitations

This study was restricted to short term treatment of suicidal ideation. It was limited to adults ranging in age from 18-65 years who have been identified as being at high risk for suicide and admitted to inpatient treatment. The participants in the study ranged in age from 22 to 54 years. This study focused on the use of music therapy in a group setting. Negative emotions such as depression, hopelessness, grief, loss, or symptoms of various mental illnesses have been linked with suicidal feelings. The music therapy interventions chosen for this study are among those that have been researched and shown to be effective in psychiatric settings in group treatment (de L'Etoile, 2002; Luetje, 1989; Thaut, 1989). The study focused more on identifying categories of response patterns from the participants and less on the process of therapy within each session. The absence of collaboration with the participants after the interviews affected data analysis. It was impossible to follow-up with participants after the interview because of the environment in which the data were collected.

## REVIEW OF RELATED LITERATURE

The literature reviewed for this study fell into three categories: (a) general information regarding risk factors, prevention, and types of treatment; (b) theoretical frameworks and methods used for treating suicidal thinking; and (c) the use of music therapy in psychiatric settings. This review provided an overall picture of the state of suicide prevention and treatment and how music therapy has been implemented as supported by research in suicide.

### Suicide: Diagnosis and Indications

Several theories of suicide exist from the writings of Freud, to Skinner, to Schneidman (Leenaars, 1990). Suicidal ideation and behavior affects people regardless of age, wellness, socioeconomic status, intelligence, occupation, support systems, or traumatic experiences. What pushes someone to the point of wanting to no longer live? The literature identifies several factors. Still, the nature of the suicidal condition remains

unanswered. The process of moving from a state of mind of wanting to live, to one of wanting to die (or vice versa) remains a mystery. The literature has provided instances of these phenomena, and regardless of theoretical approach or techniques for treatment, it seems that each individual case is unique and must be considered before assigning a protocol for treatment.

The literature concerning suicide is heavily focused on risk factors and signs of suicidal thinking. One or more of a number of medical, biological, social, and psychological risk factors are typically involved. Several studies have found psychiatric disorders to be a significant risk factor in suicide. Sanchez and Le (2001) reviewed literature written between 1978 and 2001 and found that depression occurring with any other psychiatric illness or substance abuse increases the risk for suicide. Psychiatric illnesses considered to contribute to a higher risk for suicide include major depression, substance abuse, schizophrenia, posttraumatic stress disorder, and borderline or antisocial personality disorders (Kleespies, Deleppo, Gallagher, & Niles, 1999).

Malone, Haas, Sweeney, and Mann (1995) examined patients with major depressive disorder who were hospitalized for suicidal ideation or attempted suicide. Results showed that hospitalization reduced suicidal ideation in both attempters and non-attempters; nevertheless, suicidal ideation remained higher following hospitalization in attempters. The study also suggested that severity of depression influences lethality of the attempt. A similar study by Placidi et al. (2000) examined the relationship between anxiety symptoms in major depressive disorder and suicide attempts. The study found that anxiety alone does not increase the risk of suicidal behavior.

Other studies examined the relationship between bipolar disorder, substance abuse, and suicidal behaviors. For example, it was found that co-morbidity of substance abuse and bipolar disorder leads to increased risk for suicidal behavior (Comtois, Russo, Roy-Byrne, & Ries, 2004; Dalton, Cate-Carter, Mundo, Parikh, & Kennedy, 2003). Potash et al. (2000), who examined alcoholism and bipolar disorder, also found this pattern among family clusters. Other researchers have included family history of suicide attempt as a risk factor for suicide (Gliatto and Rai, 1999). This suggests possible genetic explanations for co-occurring bipolar disorder, alcoholism, and suicidal behaviors.

Stressful life events also contribute to suicidal ideation. Weyrauch, Roy-Byrne, Katon, and Wilson (2001) looked at recent stressful life events with impulsiveness in triggering suicide attempts. The most common stressful event, which occurred in 47% of the subjects, was conflict with a significant other, and suicide attempts most frequently occurred one week following the incident. Other stressful events included loss of a significant other, financial concerns, unemployment, physical illness, and moving to a new neighborhood. Results from the study suggest that developing coping strategies and interpersonal skills help those who have experienced a stressful life event and have attempted suicide.

The Overlap Model, designed by Blumenthal (1988) demonstrates the complexity of risk factors contributing to suicide. The risk factors included in this model are psychiatric diagnosis, personality disorders and traits, psychosocial and environmental factors, genetic and familial values, and biochemical factors. Blumenthal suggests that familiarity with these risk factors and how they interact helps inform assessment and treatment planning for the patient.

Understanding risk factors for suicide is important for developing effective treatment strategies. Suicide prevention strategies and treatment interventions have been extensively studied in the literature. There is a difference between prevention and treatment interventions. Prevention interventions seek to keep a suicidal event from happening, whereas treatment interventions focus on the underlying conditions that lead to suicide (Eddy, Wolpert, & Rosenberg, 1987).

In a review of suicide prevention strategies, Mann et al. (2005) found that community and physician education of the nature of suicide and restriction of access to methods for completing suicide to be the most effective interventions for preventing suicide. Several other interventions frequently implemented include public education, screening programs, referral to a mental health professional, implementation of crisis centers, assessment for risk and diagnosis of psychiatric illnesses, and family support (Eddy et al, 1987; Gliatto & Rai, 1999; mayoclinic.com, 2007).

Early identification of suicidal behaviors, understanding the behaviors, knowing crisis interventions and preventions strategies, and promoting mental health are some suggested components of an effective prevention program (Dyck, 1995). Guidelines for managing suicidal behaviors include coming into close contact with the suicidal person, removing the means to commit suicide, diffusing reasons for committing suicide, improving the psychological state of the suicidal person, and leveraging close relationships with friends and family (Kerkhof & Diekstra, 1995). If the suicidal person resists attempted intervention, appears to be psychotic, has a persistent plan, or presents with impulsive behaviors or a change in mental status, then hospitalization is indicated (American Psychiatric Association, 2003). Hospitalization is generally the last step in suicidal intervention, and provides an opportunity for stabilization, treatment, safety, and continued monitoring (Gliatto & Rai, 1999; Granello & Granello, 2007; Mann et. al., 2005).

## Approaches in the Treatment of Suicide

Mental health professionals need to understand suicidal thoughts and behaviors in various settings and with clients presenting a wide range of diagnoses. The role of the therapist, therefore, is an integral part of the treatment. The literature often stresses the importance of therapist competency and includes guidelines for working with individuals who are suicidal (Granello & Granello, 2007; Katz, 1995; Pretzel, 1972; Schneidman, 1981).

Describing the guiding principles for counselors who work with suicidal people, Pretzel (1972) refers to the ability of having self-awareness of non-verbal communication, in addition to genuinely listening to the client or patient to gain as much understanding of the crisis as possible. Granello and Granello (2007) provide a model that focuses on the importance of a therapeutic relationship and stresses qualities such as therapist congruence, unconditional positive regard, and empathy. The therapeutic bond allows the patient to work through his or her internal struggles and for the therapist to assist in relieving the pressure of suicidal ideation. Katz (1995) suggests that the therapist takes an active role and talks openly about the suicidal ideation or the patient's perception of suicide. This implies that being able to talk openly about the issue brings hope, and hope is a key ingredient in the prevention of suicide. The therapist also needs to be able to decrease the level of constriction, or to widen the range of possible solutions that the

person can consider aside from suicide. This will, in turn, help to lower the person's anxiety (Schneidman, 1981).

Once an individual has been hospitalized to prevent suicide, the accepted protocol includes appropriate therapeutic interventions and psychopharmacology (Kleespies, Deleppo, Gallagher, & Niles, 1999). For the current study, it is more appropriate to consider therapeutic interventions. The use of group, individual, and family treatment has been reported (Granello & Granello, 2007; Katz, 1995; Richman & Eyman, 1990; Schneidman, 1981), and various psychodynamic and cognitive behavioral approaches are frequently employed in inpatient treatment. While mental health professionals frequently use a no-suicide contract, there is little data to demonstrate its effectiveness in actually preventing suicide (Kroll, 2000).

Indin (1966) and Reiss (1968) studied suicidal individuals in a hospital setting. Indin focused on the use of psychotherapy in groups and the active role of the therapist to allow the patient to express thoughts and feelings freely, and encourage widening the focus of thought processes to help the patient move away from resorting to suicide. Reiss made observations of a self-formed group of suicidal patients without therapist intervention and noted that when more than two people were in the group, it aroused caring and rescuing behaviors among the patients. In contrast, when only two people who are suicidal join together, they tend to stimulate each other's self-destructive behaviors. These early forms of treatment support later claims that groups facilitate empathy between members, provide corrective emotional experiences, and help to contain suicidal impulses (Richman and Eyman, 1990).

The major goals of intervention in an inpatient setting are to reduce or eliminate suicidal intent, help resolve problems and issues that led to the suicidal behavior, encourage the use of social networks, reduce symptoms of any underlying disorder, and to increase well being and self-understanding (Granello & Granello, 2007; Kleespies, Deleppo, Gallagher, & Niles, 1999; Richman & Eyman, 1990). Schneidman (1981) suggests increasing the psychological sense of choices and sense of emotional support when providing treatment to individuals who are suicidal. Drake and Sederer (1986) recommend an approach that strengthens the ego, or focuses on ego enhancement. Richman and Eyman (1990) support strengthening the ego's ability to handle emotions associated with suicidal ideation through expressing feelings such as anger. This also helps to develop a cohesive self, as demonstrated in case studies by Indin (1966).

Psychotherapeutic approaches in treatment must be carefully considered, as the length of stay in hospitals is limited. A study by Smith, Fisher, and Goldney (2002) found that patients exhibiting suicidal ideation tended to have a shorter stay in a hospital psychiatric unit than non-suicidal patients. There are at least three plausible explanations for these findings: (a) suicidal patients receive a more intense level of treatment; (b) suicidal behavior stimulates friends and relatives to provide additional support; or (c) the suicide attempt had a cathartic effect. Awareness of a time-limited treatment setting helps the therapist focus on current precipitants and immediate issues for concern such as what led to the hospitalization.

To focus on coping skills, problem solving, and reframing ways of thinking about suicide, approaches in cognitive behavior therapy and derivations of this approach have been used. A solution-focused approach encourages the patient to look for strengths, focus on goals instead of problems, and explore solutions other than suicide (Sharry,

Darmody, & Madden, 2002). A comparison of interpersonal and social rhythm therapy (which targets regularity of daily routines and modification of affective episodes) with intensive clinical management (which involves psychoeducational interventions, symptom management, and medication management) suggested a consistent reduction in suicidal behavior when either psychosocial intervention was combined with psychopharmacological treatment (Rucci et al., 2002). A study of Dialectical Behavioral Therapy found fewer and less severe suicide attempts, reduced dropout in therapy, and fewer inpatient psychiatric stays among people with borderline personality disorders (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

While several methods of treatment have found successful outcomes, there is little research to demonstrate the effectiveness of one approach over another (Comtois & Linehan, 2008). All chapters and articles reviewed focus on the importance of the therapist's role and providing a supportive environment. Establishing a therapeutic relationship in which the client trusts the therapist is also emphasized in the treatment of suicidal behaviors and ideation. Because people in a suicidal crisis present with hopelessness, isolation, distress, and a lack of cohesive self, providing the opportunity for self-disclosure in a safe environment is a key component in treatment (Apter, Horesh, Gothelf, Graffi, & Lepkifker, 2001). Empathy, understanding, and safety are recognized characteristics that are present in successful treatment interventions, whether implementing a crisis intervention model, psychodynamic approach, or a cognitive behavioral / problem solving model.

## The Use of Music Therapy in Psychiatric Treatment

Music therapy has rarely been reported in the literature relating to suicide. It is referred to in some texts and articles (Bright, 1999; Luetje, 1989; Priestley, 1985), although the explanations of the approaches and techniques are cursory. The studies reviewed for this section include the use of music therapy in the treatment of symptoms that are similar to those presented in suicidal ideation and generally apply to the psychiatric population.

There are numerous studies that demonstrate the effectiveness of music therapy in psychiatric settings. Consequently, music therapists are frequently employed by facilities that serve psychiatric patients. The use of music to decrease psychotic symptoms and promote mental health is well documented (De Backer & Van Camp, 2003; Brooks, 1989; Gfeller & Thaut, 1999; Nolan, 2003; Unkefer, 1990). The use of music therapy in acute, or short-term treatment of psychiatric patients has also been explored (Goldberg, 1989; Silverman and Marcionetti, 2004). In the interest of the present study, the approaches and interventions used in these particular settings will be examined.

Owing to the lack of research on music therapy and suicide, this section will focus on the application of various music therapy interventions to the same symptoms exhibited by non-suicidal psychiatric patients. As previously mentioned, symptoms typically associated with suicide include depression, hopelessness, anxiety, low self-esteem, anger, poor awareness of emotions, impulsivity, and impaired coping skills. Music therapy has been used with psychiatric patients to improve social interactions, increase awareness of the here-and-now and reality orientation, control impulsive behavior, identify and express feelings, gain insight into feelings and behaviors, improve problem solving skills,

restructure maladaptive behaviors, and assist in trying healthy alternatives (Gfeller & Thaut, 1999; Unkefer, 1990).

Various types of interventions have been implemented and studied in psychiatric settings. The interventions used in the studies reviewed here include music listening, lyric analysis, group singing, improvisation, drumming, composition, song writing, music facilitated relaxation, and music-assisted guided imagery (Goldberg, 1989; Nolan, 1994; Slotoroff, 1994; Thaut, 1989). Nolan (1994) demonstrated how the music therapist elicits responses from the patient by encouraging active involvement through creativity, reality-testing, and social interaction. Whereas Nolan used music improvisation to elicit responses and engage patients with a mental illness, Indin (1966) suggests the therapist take an active role in verbal therapies with suicidal patients to elicit responses. Both studies highlight the active role of the therapist, whether eliciting responses through musical or verbal means.

Songwriting has been a successful method for expressing thoughts and feelings about issues that are difficult to process verbally because of intense emotions related to the issues. When in a state of crisis or when faced with life and death situations, songwriting provides opportunities for creative expression, promoting well being, providing choices, offering opportunities for counseling, and fostering communication (O'Callaghan, 1997). Songwriting has also been used to confront issues related to substance abuse and chemical dependency (Freed, 1987), in grief work with bereaved adolescents (Dalton & Krout, 2006), and with palliative care patients (O'Callaghan, 1996).

Thaut (1989) studied the effects of three treatment interventions on self-reported state of relaxation, mood or emotion, and thoughts about self in psychiatric prisoner-patients over a period of three months. The interventions included in the study were group music listening and lyric discussion, instrumental music improvisation, and music assisted progressive muscle relaxation. The subjects reported significant improvement in relaxation, mood, and thought following all interventions.

A study by de l'Etoile (2002) used several interventions to determine the effectiveness of music therapy for adults with mental illness in group psychotherapy. Following a six-week period, subjects reported improvement in six out of nine psychiatric symptoms; noted an increase in 8 out of 10 curative factors, including cohesion, altruism, guidance, self-understanding, interpersonal learning, and self-disclosure; and recognized a need for professional help and improved openness regarding one's problems. The music therapy interventions used were music listening and lyric analysis, instrumental improvisation, song writing, group singing, music-assisted relaxation, and music combined with other arts media. Effectiveness of each intervention was omitted from this study.

Luetje (1989) mentions the applicability of a crisis model adapted for use in music therapy for people who present with suicidal behaviors. Acknowledging the client's feelings and providing safety, structure, and boundaries enables the client to work through issues, begin to take risks, and try new ways of coping. Interventions used in Luetje's article included lyric analysis and songwriting, music-assisted guided imagery, and musical role-playing.

There are three brief case examples in the music therapy literature that cover treatment of suicidal behaviors and ideation. Two of them are presented by Priestley

(1985). One illustrates the use of music and movement and the other is an improvisational intervention titled *Suicide*. The purpose of *Suicide*, as described by Priestley, is “to allow clients—or more often patients—who want to kill themselves, to go through the feelings about such an experience” (p. 142). The case studies present the fully conscious patient going through the act of suicide through music and verbally processing what happened with the therapist. Both occur in individual settings and given today’s acute treatment setting, it is unlikely that such interventions can be directly applied. Understanding how the suicidal issues were confronted and processed through music does, nevertheless, provide some guidance.

A case study by Bright (1995) presented a 17 year-old girl diagnosed with schizophrenia and admitted to a hospital due to a recent psychotic episode and suicidal ideation. The patient’s suicidal ideation was identified, although it remained unaddressed in any of the sessions reported. Instead, the foci of treatment were the underlying issues. This demonstrates yet another layer in the treatment of suicidal behaviors. The non-confrontational approach allowed the patient to express *forbidden* feelings and exhibits the therapist’s unconditional positive regard and ability to empathize with the patient.

Based on the available literature, it appears that there is no identified approach for treating suicidal ideation in an acute psychiatric inpatient setting. The variability expressed in both verbal interventions and music therapy interventions indicates that these modalities are equally effective. The distinguishing factors between someone who is non-suicidal or suicidal cannot be identified (Mann, Waternaux, Haas, & Malone, 1999). Perhaps this can be attributed to the ambiguous nature of suicidal ideation: One cannot draw a distinct line between a person’s wish to live and desire to commit suicide.

## PROBLEM STATEMENT

This study focused on music therapy as a treatment modality in a psychiatric inpatient setting with individuals exhibiting suicidal ideation. The purpose of this study was to gain insight into the role that music therapy plays in the treatment of people with suicidal ideation. Sub-topics that were investigated include the reactions to music therapy in a group treatment setting, the perceived value of the group in relation to overall treatment, and possible indications or contraindications for the use of music therapy with this population.

The minimal indications provided in the music therapy literature for working with suicidal ideation highlight the need for this study. There were three motivating forces for the study: (a) to add to the body of music therapy knowledge; (b) to gain a deeper understanding of the general treatment process as clinician; and (c) to examine the perceived effectiveness of specific treatment options.

Five main research questions were considered in this study:

1. What is the role of music therapy in the treatment of people with suicidal ideation?
2. How do individuals with suicidal ideation experience group music therapy?
3. What are the indicating and contra-indicating factors for music therapy with these individuals?
4. How do participants believe music therapy impacts their overall treatment?



5. What do the participants perceive as the most effective intervention?

## DESIGN AND METHODOLOGY

### Overall Approach and Rationale

Fristad and Shaver (2001) present psychosocial interventions for suicidal children and adolescents based on research in cognitive-behavioral therapy, dialectical behavior therapy, and the youth support team. The authors also advocate for the necessity of well established, empirically supported treatments and argue that many of the protocols implemented do not meet the requirements to qualify as such. A more important point made by the authors focuses on the gap in research addressing the efficacy versus effectiveness issues. We are reminded that efficacy is “the effect a particular treatment has under optimal research conditions” and effectiveness is “the effect that treatment has under normal clinical conditions” (p. 196). The gap between the two concepts appears when trying to apply a research protocol to a natural clinical setting. By applying naturalistic inquiry to the qualitative research design, this gap may be minimized by allowing for conditions that are normally controlled, such as diagnosis, individual stressors, environmental factors, and enthusiasm of the researcher to occur and be accounted for.

A naturalistic paradigm is most appropriate for this study based on several assumptions: (a) Each participant will construct his or her own reality, contributing to multiple realities within the group; (b) the researcher will be present with the participants, and researcher actions will influence participant reactions; (c) each case, or *sample*, is context-bound, and the nature of the group and intentionality of its members will be considered; (d) as the research develops, it may be impossible to distinguish cause from effect; and, (e) the values of the participants and the researcher are crucial to understanding the outcome of the study (Lincoln & Guba, 1985).

### Population and Site Selection

The hospital in which the study took place first gave me permission to conduct the research and carry out all necessary procedures related to the study. The Institutional Review Board (IRB) of Temple University approved the protocol for this study, ensuring protection of the rights of the participants, appropriate consent forms, and risks and potential benefits of the project. It is important to note that with this study, I had difficulty gaining permission by a hospital to allow for video and audio recording for data collection. Some hospital policies simply prohibited use of recording methods to protect the confidentiality of the patients. To ensure confidentiality, in addition to the consent form, participants were required to sign two forms for permission to videotape and audiotape: one for the IRB and one for the hospital. All participants were identified by a participant letter or pseudonym, and no actual names appeared on labels of videotapes, records or observation analyses, labels of audiotapes, or transcripts. All materials were stored in the social work office in a locked cabinet used exclusively for this study.

The population selected focused on individuals with suicidal ideation admitted to an acute psychiatric unit. Patients with any diagnosis were considered, as suicide is a

problem among those with various mental illnesses, intellectual abilities, and socioeconomic classifications. Ages were limited to between 18 and 65 years due to existing limitations set forth by the behavioral health unit. The site was chosen based on approval of the study and permission to collect data via recording methods, which was necessary because of my dual role as researcher and therapist.

At the time the study took place, I was employed by the hospital. In addition to the research groups open exclusively to participants, I provided music therapy groups for all patients, including participants. This also allowed me to be present with participants outside of the research session and build a stronger therapeutic relationship with participants, which is frequently identified as a necessary component in effective therapy (Granello & Granello, 2007).

Due to high turnover rates and often sudden discharge of patients, the sampling emerged as the study progressed and was not pre-selected. Selection criteria were established prior to screening patients for the study. These included the presence of suicidal ideation, the ability to speak and understand English, voluntarily admission to the hospital, and the absence of active psychotic symptoms. These factors were screened during the initial assessment through interview and researcher's observations. The length of treatment varied, such as number of sessions attended. The research groups included between two and four participants in each session, for a total of 12 participants over eight sessions.

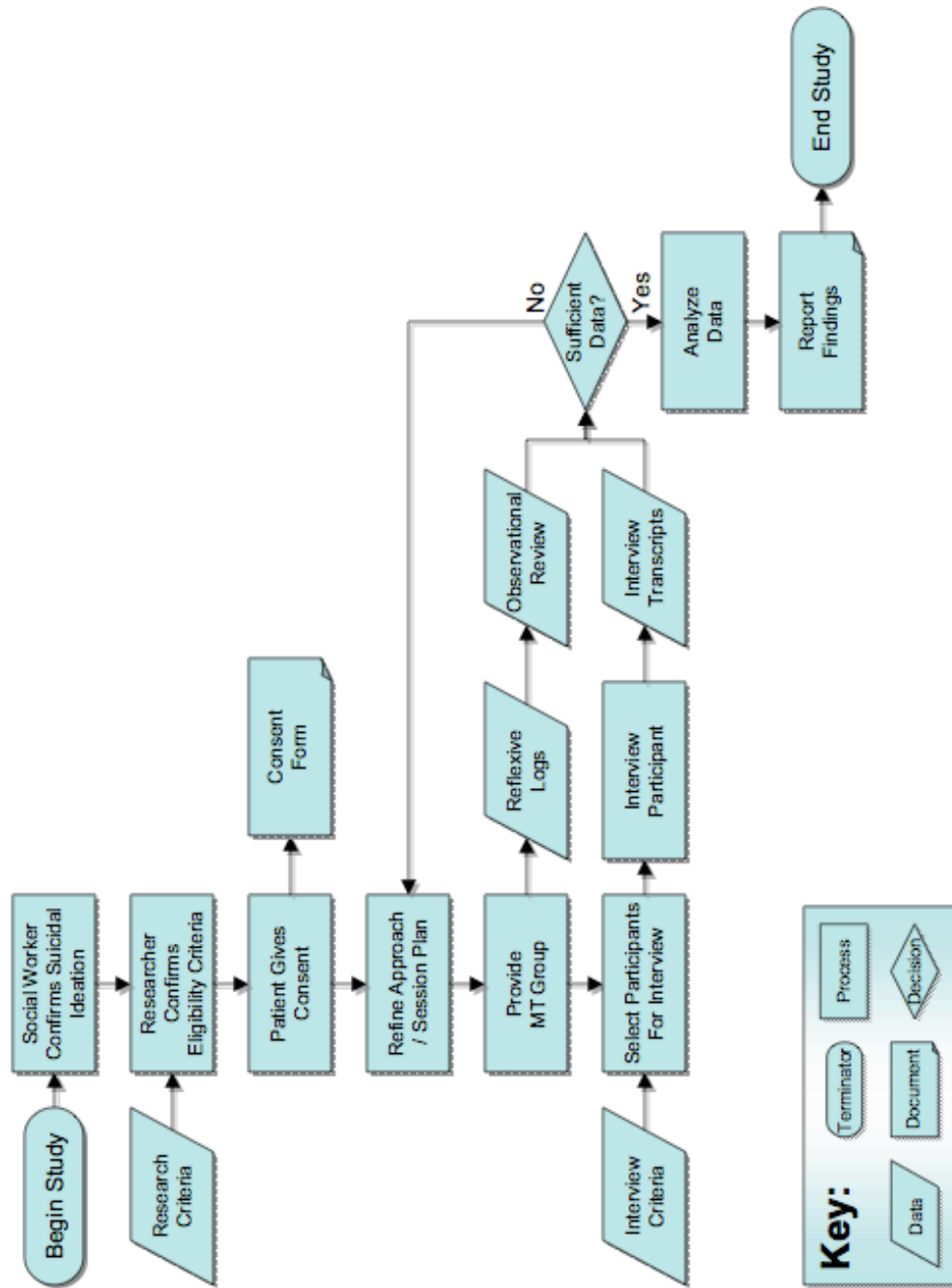
## Data Collection

The study was designed to include the participants' input through interviews, along with the researcher's observations. Figure 1 depicts an overview of the procedure. The procedure consisted of the following steps:

1. Upon admission to the adult psychiatric unit, the social worker screened potential participants for suicidal characteristics and referred appropriate patients to me.
2. I conducted an additional informal screen to determine if the patient met criteria for the study.
3. If the patient was appropriate for the study, I met individually with each participant and explained the procedure and purpose of the study.
4. Upon receiving consent, the patient was included as a participant in the study.
5. Before each session, I constructed a session plan based on the treatment goals and chart review of the participants. A valuable input into this process was also taken from the researcher's reflexive logs and observational reviews as the study progressed.
6. Two 60-minute groups were available per week for the duration of the study. Participants attended at least one 60-minute music therapy group. The group changed throughout the study as participants were admitted and discharged. A maximum of six participants were permitted, however the group size never exceeded four. All research sessions were videotaped.

7. After each session, I reflected on what happened in the group and made notes on thoughts, ideas, and feelings.
8. The videotapes were reviewed after each session to clarify the reflexive logs and to consolidate learning from the music therapy groups.
9. Data was collected from my reflexive logs and observational review of the video tapes. The field data was analyzed after each music therapy group and recorded in a time log. It is important to note that this portion of the data was not used to inform the analysis of the interviews, but as a source of other data to enhance the discussion of the analyzed data.
10. Upon determination of patient discharge by the treatment team, I selected one or two participants per week to interview in a private room on the unit. Interviews were audio taped for transcription and analysis. A total of five participants were interviewed. I transcribed all interviews.
11. Upon completion of all interviews and transcriptions, transcripts were analyzed.

Figure I. Process flow chart depicting music therapy research groups, participant interviews, and data collection procedures.



### *Session Interventions*

Participants experienced several types of music therapy interventions including music therapy improvisation, song writing, lyric analysis, music listening, song choice for singing, and instrument choice. The interventions allowed participants to address various issues such as anger management, stress reduction, symptom management, self-awareness, self-esteem, or social and emotional support. Verbal processing of the interventions concerning suicidal feelings, triggers for stress or depression, and other treatment issues also occurred in the sessions. These interventions were the same ones routinely offered in music therapy sessions that were not being researched.

### *Interviews*

Participants were interviewed prior to discharge. They were selected for interview based on three criteria: (a) demonstrated active participation in the group; (b) showed the capacity for self-reflection and ability to articulate insight into issues addressed in the research group; and (c) appeared comfortable expressing self verbally in the sessions. The interview served to enable the researcher/therapist to learn the participant's perspective on and experience of the research music therapy group, and to clarify the researcher/music therapist's observations and interpretations of the sessions.

Many of the participants met the criteria for interview. The primary reason a participant was not chosen was discharge timing. Often the patient was discharged quickly and with little notice. Other reasons for not choosing some of the participants were limited cognitive functioning and a diagnosis of personality disorders. One participant in particular seemed to use suicidal thoughts to gain attention and displayed other characteristics in the sessions that indicated the presence of a personality disorder. I believed that, had this participant been interviewed, it would have supported his inappropriate behaviors and thoughts and may have been counterproductive to treatment.

Of the 12 subjects, 5 were interviewed. Four of the five subjects who were interviewed attended two sessions, while one subject attended a single session. Questions were designed to elicit the overall experiences and understandings of the participant's view of the music therapy group as treatment based on the research questions (see Appendix A). Participants were asked to explain their experience in the group, reflect on any significant moments in the group, explain any turning points in treatment, or talk about how a specific intervention affected them. Topics focused on the music therapy research group and the role it played in the participant's overall treatment. A sample of an interview can be found in Appendix B.

### *Influence of the Researcher*

One must consider the effect that the dual role had on the relationship with the participants, the influence on the interview, and the impact this had on the study as a whole. The relationship between the participants and me may have been enhanced since they were familiar with me as therapist before agreeing to participate in the study. The participants also attended the unit music therapy group that I led and often referred to this large group while in the small research group. The rapport may have improved the

participants' motivation for the study and openness to the type of treatment group since they had experienced a music therapy group in their regular treatment group.

As researcher/therapist, I was able to individualize the interviews to the extent of using participant information from the session to influence the type of questions I asked and determine how to expand on those questions. Often times in the interviews, I referred to experiences from the sessions. Tailoring the interview to each participant undoubtedly affected the data collected. General questions were roughly the same for all participants. I used a conversation-like approach instead of a more formal interview style employed in some qualitative studies.

The fact that I examined my own clinical work influenced all aspects of this study. I worked through data taken from the interviews in raw form, as well as information from the sessions that put the interviews into context. Since I had a relationship with the participants, I drew conclusions based on my experience as a therapist with them. This also enabled me to use therapeutic judgment in selecting the participants for the interviews, which, in turn, affected the data collected.

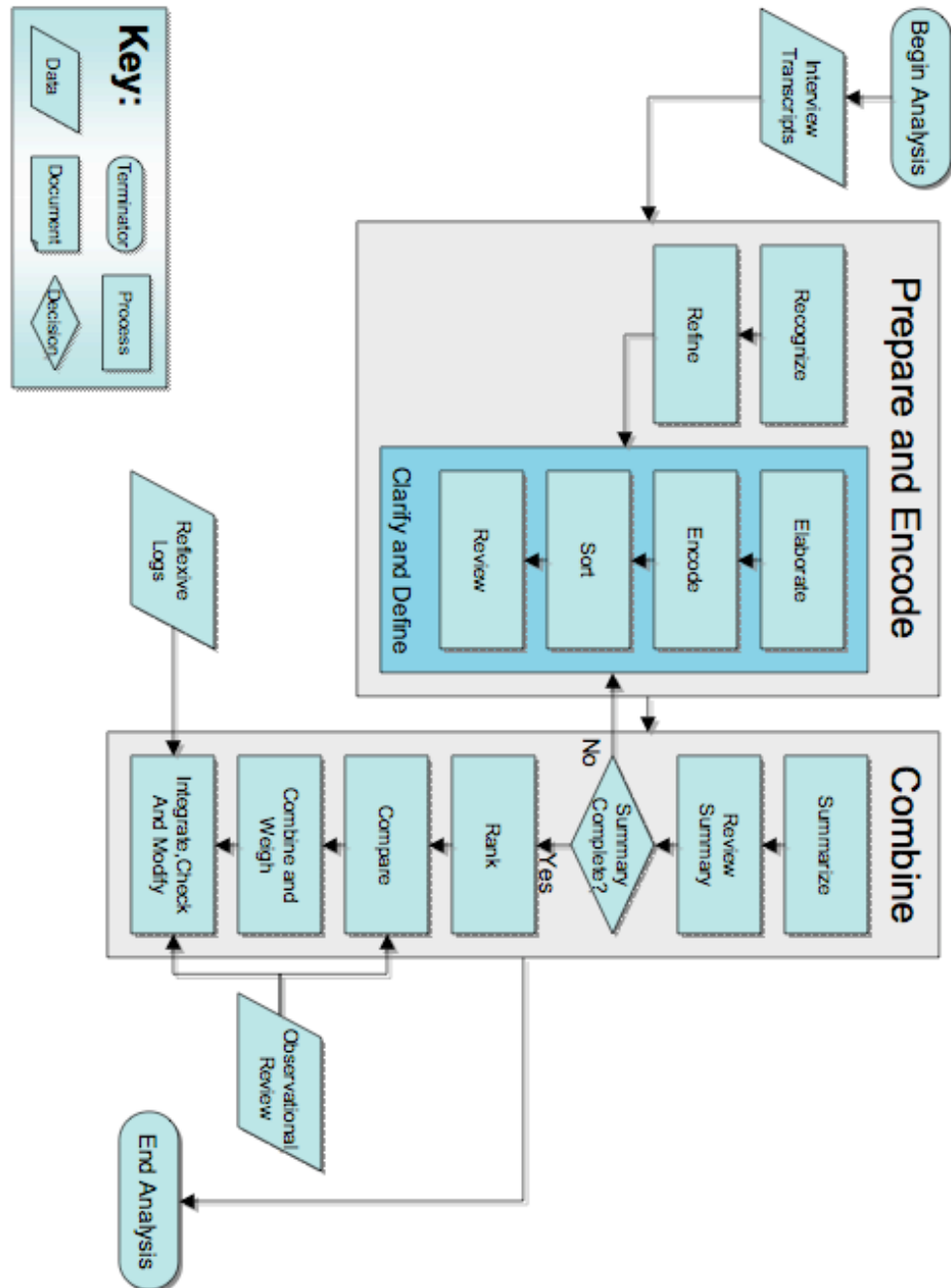
It was possible, though unlikely, that I may have implemented a specific intervention for the sake of eliciting data. I worked to maintain the integrity of the therapy session with the needs of the clients as the priority for the session. My therapist and researcher roles were further clarified by one informing the other. That is to say, when issues surfaced (such as the inclusion of who to interview), I consulted with other members of the treatment team to ensure that clinical goals and objectives were not diminished in the interest of research.

## Data Analysis

The analysis of interview transcripts served as primary data for this study. Data from my reflexive logs (recorded following each session) and information from the observational review of the videotape were used in the analysis process as a way to "check" the data and ensure retention of context since the responses in the interviews were isolated for ease of coding.

Rubin and Rubin (2005) have identified steps for analyzing the final set of data. Figure 2 depicts the overall analysis process. A detailed explanation of the analysis procedure includes definitions of Rubin and Rubin's procedures. This process was used to analyze the data. There were two phases for analyzing the data. Phase One involved preparation of the transcripts and the analysis of individual interviews, which included identifying codes. *Recognize* and *Refine* were the first steps. This meant finding concepts, themes, events, and topical markers in the interview data. The initial process involved making a list of codes that emerged after a preliminary analysis of the first interview. I evaluated each statement made by the participants for significance and relevance to the purpose of the study. Each unit of data, or participant response, was coded separately based on inductive interpretation of the unit. Significant statements were highlighted by hand with notes. A code word, or label, was chosen that best described the concept of the statement.

Figure 2. Process flow chart depicting data analysis process based on Rubin & Rubin, 2005.



The statements were then refined by clarifying and synthesizing the meaning of each concept. Other units from other interviews were scanned to identify similarities of ideas to determine the initial codes or labels. The identified concepts and themes were then grouped together to determine whether the codes resulted in similar concepts within each code. Each code was then examined to determine its nature and function and where it fell in the process of therapy related to the purpose of the research. For example, the connection the patient made from outside the group to inside, or inside to outside the group was coded with the label *Transfer/Association*.

The process of generating new concepts and themes based on clarification and synthesis, as described in the previous paragraph, is known as *Elaboration*. This process allowed codes to become clearly defined and units to be recognizable based on the codes. *Encoding* refers to the process of labeling and marking concepts and themes found in the data. The next step, *Sorting*, is simply grouping the data units with the same label into a single file. The coded data units were then moved into a separate spreadsheet. Each interview then had a clear layout of the coded data units. See Appendix C for a sample of the sorted data. This was the end of the first phase.

Phase Two is the process of combining interview data from all interviewees. The first step, *Summarizing*, combined all the data units with the same code and listed main points of the coded categories. This allowed me to view all data units in their entirety and to determine how to manage the data. This also allowed me to plan how the data would be ranked, compared, combined, checked, and modified. The next step, *Review Summary*, placed each sub-code and the units of data in individual spreadsheets. Each unit was checked for themes, similarities, intensities, and whether it truly belonged in that category. Summarized categories that contained units that were found to fit better with other categories, or codes were re-examined. This meant that I took the data back to Phase One, the *Elaboration* step. This process also provided a way for me to check initial data labeling and significance of units or labels initially chosen.

The process of summarizing revealed that many of the codes were not appropriate for the data. I also found that some codes had to be redefined, re-named, and re-organized. For example, more sub-categories were placed under the category of EFFECTIVENESS, such as *Beliefs*, *Action/Release*, and *Connection*. *Connection* was later seen as a result of experiencing what happened in the group and less of a reflective function. *Beliefs* was changed to *Impact* and also placed under the EXPERIENCE OF THE MUSIC THERAPY GROUP category. *Action/Release* was later found to contain data that referred to long-term changes, and was thus re-categorized and renamed. This process resulted in a more accurate data description relating to the purpose of the study.

The final steps of Phase Two moved the data from being single units to larger units of meaning from which conclusions could be drawn. *Ranking* allows the data units to be ranked by importance or relevance to the study. *Comparing* utilized notes from the observational review to sort for background characteristics and determine whether any patterns emerge among the participants. *Combining and Weighing* pulls all the interviews back together to construct a more holistic perspective. The final step, *Integrating, Checking, and Modifying* checked for accuracy and consistency of data to support observations from the reflexive logs and observational reviews. This ended the process of data analysis (see Appendix D for a sample of the completed data set).



Bruscia (2005) suggests analyzing data as the data is collected rather than waiting until all data has been collected. Since I was both therapist and researcher, I decided to collect all the data and analyze it at the end. Any information I gained from the sessions that informed future sessions was recorded in my session logs. It also made sense to me to analyze data after completing the collection because each session was designed based on the ongoing treatment needs of the participants.

Even though only segments of participant statements were used to develop the categories, it became necessary to put the data units into context when describing the results. At this point, I consulted with my reflexive logs and the full interviews to provide a clear picture of the statements in context. This helped to make the results more meaningful and demonstrate the connection between the various experiences of the participants.

### Trustworthiness

This study built credibility through several factors. I had prolonged engagement through a four-week course of data collection, twice per week. The design of the study used multiple perspectives by including several participants and interviewing a diverse representation of all participants. I engaged in persistent observation by facilitating the sessions, reviewing the sessions on videotape, and interviewing the participants about their experience. I kept a reflexive journal to document subjective responses to the sessions and interviews, and I compared observations with interview data. This process resulted in multiple types of data to use, including the session logs, videotapes of all sessions, audio recordings of interviews, transcripts of interviews, and personal reactions to the ongoing process.

## RESULTS

The results for this study are presented by category. The quotes included in this section are extracted statements from the interview and do not include the entire statement. This is done to illustrate each theme that was developed through the data analysis. The extracted statements were considered to be significant portions of the statements and were the most meaningful to the purpose of the study. Parts of interviewee statements that were redundant or irrelevant were not included in the analysis and therefore are not included in the illustrations of the themes.

Three main categories were identified based on the data and the meaning of the data in relation to the purpose of this study. These categories are PERSONAL CONTEXT, EXPERIENCE OF THE MUSIC THERAPY GROUP, and EFFECTIVENESS. Within these categories, sub-categories were formed to more clearly define the units of data. PERSONAL CONTEXT included *History*, *Beliefs*, and *Values*. EXPERIENCE OF THE MUSIC THERAPY GROUP included *Triggers*, *Options*, *Feelings*, *Connection*, *Change*, *Impact*, and *Role of Music*. EFFECTIVENESS included *Transfer/Association*, *Affirmations*, and *Change/Shift*. Sub-categories will be examined after each category is defined below.

## Personal Context

The units of data that were categorized in PERSONAL CONTEXT revealed the participant's relationship with music and his or her motivation for treatment or involvement in the study. This category included any preconceived notions potentially affecting the experience and outcomes of the music therapy or the group process. All participants referred to their past experience with music while in the group. Those who were interviewed were asked specifically about his or her relationship with music and why he or she decided to be a part of the study. One should note that Adam, the first interviewee, was not asked specifically, as this question was added to the interview after the first interview. The first interview was intended as a pilot, I found it contained useful data.

### *History*

This sub-category contained musical background and previous experiences with music therapy. All participants easily identified how music was used in day-to-day life and the effect that music had on feelings, moods, and activities at home. All participants in the study were open to disclosing their preferred music genre. Four of the five participants interviewed indicated prior involvement with music, such as playing instruments in elementary or high school band.

Each participant has a unique background with music. Adam has not had any formal training in music, though he says he has played around on a guitar at home and enjoys listening to various kinds of music. Elaine had formal training in jazz in high school, yet she listens to a wide variety of music. She started out playing the flute in elementary school and switched to playing saxophone in junior high through high school. She has an 8 year-old daughter to whom she hopes to teach the saxophone.

Kelly relates her musical history closely with her family. She used to play the guitar, and her entire family played as well. She also told stories of singing in school choir and of her mother being very supportive of her musical pursuits as a child. Heather also sang in choir in elementary school and plays piano a little. She writes poetry and songs and has a variety of artistic interests. Lisa played the clarinet in school, though she claims that she faked playing the entire time and does not think that she has any knowledge of music aside from her preferences of listening.

### *Beliefs*

Another component of PERSONAL CONTEXT is what the participants believe about the function or purpose of the group, beliefs about the effects of music, and personal philosophies about how they function and deal with issues that have been brought to the group, such as depression, substance abuse, and relationship issues. Several participants interviewed made positive statements about the beliefs concerning the effect of music and how they relate to music. Heather stated, "It [music] makes you feel good. I love music. It makes me feel better." Similarly, Kelly associated positive thoughts with music: "Anything to do with music equals a good time, as far as I'm concerned (laughing).

Whatever mood I'm in is the type of music I'll play...it just helps me express my feelings.”

Lisa identified negative associations with music in the interview, stating, “Sometimes those songs will spark things with me, and make me want to go use [drugs].” The song Lisa chose in the first group she attended was “My Name Is” (Eminem, 1999, track 2). She chose this song to shock others in the group and behaved as though she were at a party rather than sitting in a therapy group. For the second group, participants were asked to think about a song that is meaningful to them that they would like to share with the group. Lisa then chose “Beautiful” (Perry, 2002, track 11). She related this song to her abusive relationships with her first husband and also with her current husband. She identified with the message of strength in the song and stated that this is a song she turned to in her car, which she felt gave her strength. It was the negative association to music that she referred to during the interview rather than her choice of positive message in the other song.

Other beliefs expressed by the participants include those related to what was expected in the group. Heather revealed her thoughts about joining the group and what surprised her: “I didn't think I was going to, when I first came in, I didn't think I was going to open up. I thought it would be all ‘ahhhhhhh’, but now it's ‘come on, let's go.’” Elaine expressed a similar evaluation of herself: “I didn't think I was going to enjoy the group as much as I did.”

Adam stated that teaching some basic concepts of music would have made the group better for him. This is the same participant who did not have background experience in a formal music setting, such as school band.

Finally, participants expressed beliefs about personal philosophies. Some referred to the importance of being able to enjoy an activity. Symptoms such as depression, thoughts of self-harm and anxiety were believed to be what prevents engagement in healthy activities and that it was the decrease in these symptoms that allowed them to identify areas of change. This was most apparent with Heather and Elaine, while the other participants did not discuss this as directly.

### *Values*

This sub-category refers to what the participant found to be important about the session, whether it was a result of the music or the group itself. Those who agreed to participate in the study and indicated a reason for doing so almost always stated it was to help others. This often came in the form of the desire to help me with my research. Three of the five participants interviewed stated a desire to help others by receiving help, whether it was helping me or helping a family member who was in a similar situation as the participant.

Other common values that were revealed in the analysis included being a part of something such as the music group and having a small, intimate group with which to work. A sense of belonging seemed to be valued. All participants noted the small size of the group as being conducive to treatment. Familiarity with the group members and process of the group increased as a result of a smaller group size. “It was more comfortable than me having to speak about it in front of everybody. It was a small group, I felt we would probably be able to discuss and make more of a connection” (Elaine). The

structure of the group was also valued, as Adam identifies: “I knew what to expect and we were used to it. We didn’t want to leave.”

### Experience of the Music Therapy Group

Considering the purpose of this study, the experience that the participants had in the music therapy group must be examined. This requires an evaluation of reactions to the group to understand the role that music therapy plays in the treatment of people experiencing suicidal ideations. Through identifying the data units related to each participant’s experience of the group and the interventions used, several sub-categories emerged to define this experience.

A natural flow of the sub-categories emerged upon identification of the data units that fell under the category of EXPERIENCE OF THE MUSIC THERAPY GROUP. The data are presented in the order of this flow, as it illustrates the process of the experience as identified by the participants. This section required additional analysis and attention to meaning of the units. Data units were frequently checked with the original transcript of the interview to ensure proper identification of the context in which the unit was presented.

#### *Triggers*

*Triggers* refer to the moment that the participant identified as an event or mechanism for change, advancement, movement, or progress in the session. This does not identify *when* the change happened or *what* the change was, but rather something that happened to enable movement or involvement in the therapy. For Lisa, the focused environment and lyric analysis process was the trigger. She presented as scattered with very high energy. It was difficult for her to focus in her other groups; the smaller set-up of the research group and multi-sensory experience allowed for some progress in the therapy just by slowing her down enough to take in the lyrics of the song and reflect on them. In the regular treatment group, she was usually very talkative and quick to respond with little time for self-reflection or thought. The focused intervention of lyric analysis with fewer people in the research group allowed her to process some of thoughts and feelings.

Other participants identified specific instances that allowed movement toward realizations or shifts in feelings about certain issues that were addressed in the group. Hearing others talk about depression, getting more involved in the group, adding the dimension of music to words, or even the overall experience of the research group are examples of triggers. While these instances did not bring forth a direct outcome that the participants identified or that were apparent to the researcher, they were significant for indirectly facilitating movement in thoughts, behaviors, or feelings in the participants.

#### *Options*

In the early stages of data analysis, and even before analysis began, I noted that choices were an important part of the treatment approach. This is not only true for the population in this study, but other populations as well, especially when hospitalization or institutionalization is involved. For people who are suicidal, learning to see more than

one option to solve problems is an important part of treatment (Erbacher, 2008). This theme was defined as moments when the participant perceives and chooses between two or more courses of action or expressed awareness of having options in the group.

Aside from simply having choices—such as those related to instruments and songs—participants also identified that options for forms of expression were important. Elaine identified music as a safer substitution for emotional expression: “I guess by playing I can’t hurt anybody’s feelings. I can beat on the drum hard if I’m angry, or I can tap it real soft if I’m sad...but I’m not hurting anyone with that.” Heather also found that expression came easier to her given a creative outlet: “Let your emotions come out of paper and then make a song with the words.” The participants identified instances when they felt safe enough to express themselves and had a medium through which to do so. Some participants also identified having choices as making the group more personal and allowing for more open expression and connection with others in the group.

### *Feelings*

The data identified as options led the way for the potential of feelings. This sub-category accounts for comments that were made about how the participants felt in or about the group. Half of the data units in this category were statements about positive feelings from the group. Several participants referred to emotions or feelings. Adam talked about how the music affected him: “It changes my emotion...it just felt good... It got me out of a funk, it got my mind away from everything else.” Heather highlighted her experience of writing and performing her song in the group, “I was expressing my feelings towards being abused and beaten and thoughts of hurting myself because of it and it felt good to let it out.” In these examples, music provided the opportunity for positive feelings or a release of negative feelings.

The group provided an opportunity for participants to focus on the music. Elaine talked about her experience of listening to music alone and that she often does not “hear” the words of the song. She found that the group helped her to become more receptive to the music: “Just being able to talk about our different interpretations [of the song] and the power of positive lyrics when you’re feeling down...how it can really just make you sit and think, you know, I can handle this, I can do this. That’s a good thing, it’s a good feeling.”

This may give the indication that the group was all about enjoyment, however, expression of feelings did not come easy to all participants, and “opening up” was also identified as a perceived challenge that seemed to be facilitated by having options for expression and experiencing the triggers in the group. One must also consider that the participants who were interviewed indicated a positive relationship with music, except Lisa, who correlated her musical preferences with substance abuse. Those with positive associations to music may be more inclined toward trusting the music to help with emotional expression and identification of feelings, even though some of the feelings were not positive. Music may soften the impact of emotions that are uncomfortable to feel and allow for expression, or it may serve as a way to avoid fully feeling an uncomfortable or unwelcome emotion.

### *Connection*

Of all sub-categories stemming from the data, *Connection* is the largest. All participants identified several moments of connection in the group. Support, relatedness, teamwork, feeling understood, creating bonds, and feeling empathy were all factors that participants pointed out as components of connecting with others in the group. Connections were made between participants (interpersonally), within the self (intrapersonally), and with the music.

The most common connection was with other group members. Elaine clarified her own feelings by listening to what others had to say about depression: “Some of the things they would say, it was like, wow, I’ve been feeling that but I didn’t know exactly how to express it.” She also found a connection with others through playing music, stating, “A lot of when we were playing, we were able to stay more in tune with each other and help each other out in the form of one person following another person’s beat or setting the tone for how the rhythm should be.” This shows connections with others through verbal and creative mediums.

It seemed that once the participants experienced the connection in the group and acknowledged it through the interview, they were able to attribute the connection to the group and not just within themselves. This shows how the participants were able to reach out and include others in the conceptualization of their experience in the group. Heather stated it as follows: “We all benefit from each other, we all have something that we all are connected somehow and we’ll always remember each other.” Kelly and Elaine also referred to the group effort and connection: “We’re pretty much on the same page in a lot of stuff” (Kelly), and “We all wanted the same thing, we all wanted to get something out of it, so we all put into it” (Elaine). Finding that connection with others in the group seemed to facilitate more expression of feeling, and the more that was expressed, the stronger the connections that were made.

Less prevalent but also important to note were the intrapersonal connections. These were connections that were made within oneself that seemed to let the participant experience a deeper impact of the therapy. Lisa identified a connection to herself through relating to another group member. Lisa attempted suicide and has two young children. Kelly shared her story of her father committing suicide 10 years earlier (when she was 13 years old) and the impact that this event had on her. Lisa referred to this moment several times in the interview as being an important turning point for her, but one that allowed her to look inside herself, “because of what I did [attempt suicide] and I saw her [other participant] reaction as a child, and having two children of my own really helped. It made a huge impact.” This turning point will be discussed further under the sub-category of *Change*.

The connection to music was identified. During one of the sessions in which the participants chose their own song to share with the group, which Bruscia (1998) calls *song communication*, Kelly chose a song she had not listened to in a while. This song was important to her and to her therapy because the connection to that song facilitated emotional expression and allowed her to process some of the issues that brought her into the hospital. Kelly stated, “In the beginning [of the song] it’s talking about blue eyes; my mom has blue eyes, and a lot of the lyrics I could just totally relate to what my mom

means to me.” This was a significant moment to her in the group, which was apparent in the level and intensity of the emotions evoked by the song and the way she talked about it in the interview.

### *Change*

*Change* refers to the moment of change or shift in state of mind, behavior, or feeling. These are moments that the participants identified as turning points in the session, whether they were aware of the shift during the session, or became aware by reflecting on the session in the interview. For example, Kelly chose a song to which she had a connection and one that she could relate to her mother. When she reflected on this during the interview, she noted that it was a point that shifted her perspective: “I guess seeing the lyrics to that Cranberries song.<sup>1</sup> It just gave a whole different meaning to it for me.” In the session she became tearful, and later when she processed this feeling, she did so through the song and reported how it indicated a change in feelings about her mother.

Changes or shifts in perspective or specific moments that led to a realization about a personal issue were the most frequently identified incidents among all interviewees. Adam described his change in feeling as “from bad to good, from feeling bored or lost to just gaining momentum. I can’t put it into words.” Elaine felt a change based on others in the group: “Part of it was coming here and seeing that I’m not the only one that feels this way.” Adam also pointed out the specific moment in the group when he felt a shift: “Probably 10 minutes into it where we got used to everything and just getting in a zone.”

Changes were also recognized from the events identified as *Triggers*, *Feelings*, and *Connection*. Some of the data that fell into these sub-categories also indicated change as the participant elaborated on his or her experience. For example, Lisa made a personal connection through Kelly talking about her father’s suicide. She also identified this as a moment of change. Lisa recounted, “That information coming out, that was a huge, huge turning point for me yesterday...because she’s talked about her dad before but I haven’t heard it that way,” and went on to say, “to see how much emotion that was, that was a huge thing for me, and especially what I’m going through with everything.” This was clearly a change for Lisa, observed in the change of her mood during the group and in the interview. She became serious for the first time since I had seen her in the hospital.

### *Impact*

The units of data in this sub-category refer to the effects of others in the group, interventions, or experiences in the group as identified by the participants. In a sense, this is what was meaningful for the participants. Some of this information came directly from the interview question, “what was the biggest impact of the group?” while some participants referred to specific interventions that had an impact on them. Songs were frequently identified as having some impact as Elaine states: “Especially after that first song, that was something that just told us it’s going to be okay, just spoke to each of us.” Kelly also responded to a song that was used in another session, stating, “That song has

---

<sup>1</sup> Song reference is to “Electric Blue” (Cranberries, 1996, track 9).

just such a powerful message; it was just such a perfect message for us and even the rest of the people who are here.”

Lisa pointed out that the experience of music in the group enhanced her awareness of the impact or influence of music: “I realize that [music] had an influence, but that really, really put the focus on it, by doing the music in here.” Specific interventions were identified as having an impact. For Heather, it was songwriting. She stated, “I liked the songwriting because it stimulates your mind more, you get to think about what you think and put it down.” For Kelly, it was song communication: “It was more in-depth.” For Lisa, it was in listening to others’ music selections: “Opening doors to other music that I can use as an outlet, that could be more of a positive than more of a drug dealing song, especially with the addiction that I have.”

The participants used a variety of ways to identify the biggest impact of the group. For Adam, it was “Everybody playing together.” The biggest impact for Lisa was “Focusing and doing the music in here [the group].” Elaine found that it is “easier to connect when it is a smaller group.” The impact seemed to come from various sources, such as music, group size, and function of the group.

### *Role of Music*

This sub-category was also defined late in the analysis process when I discovered that many of the units that fell under other sub-categories referred more closely to the role the music played in the group and in the treatment. The participant identified the way in which music influenced his or her experience of the intervention or session. While several factors accounted for meaningful experiences in the group—such as group size, personal connections, similar experiences, and opportunities for choices—, music played a unique role and must be accounted for.

Music facilitated connection, as identified by Heather: “It brought me closer to you guys [sharing the song].” Heather also pointed out that music allowed for expression of thoughts and memories, stating, “Writing that song. Just to think about what to put on the paper, and what was in my head. It was just a bunch of words then I summed it down to that little paragraph and that was challenging.” Adam indicated that after a short while in the group, music improved mood. He said, “It got me out of a funk. It got me, my mind away from everything else. Just kind of concentrating on the music.” He also talked about how music enabled him to focus: “Your mind’s not racing, cause you’re actually trying to achieve something, the songs, playing something, and at the end of the group, you do.” Elaine described her inability to hear positive messages from others in the midst of depression. For her, music provided a message: “Especially after that first song, that was something that just told us it’s going to be ok, just spoke to each of us. And then the last one was up-beat song, a happy song just to leave us on a good note.” Finally, music relieved stress and provided an outlet for Heather: “It helps you release some stress, too. Music relieves stress. And it brings out things.”

This is also reflective of the participants’ beliefs about music and likely based on the role that music had played in their lives before being admitted to the hospital. The participants defined these roles out of questions in the interview and general comments that they made about the session. The many roles of music identified by the participants send a clear message about the importance of this component in the therapy.



## Effectiveness

Data in the category EFFECTIVENESS revealed events or experiences identified by the participants as producing a strong impression or response. Since the interview took place after the participants had attended the research group(s) and just before discharge, it allowed for reflection on the groups and clarification of what the participants got out of the group. It is difficult to say how much impact the research group had on overall treatment, since only those in the study were interviewed. The intention was not to measure effectiveness of the sessions, but to recognize factors that may have contributed to the effectiveness of the session.

### *Transfer/Association*

Since the context of the person comes in to play when he or she engages in any familiar experience, such as with music, it seemed important to recognize when participants were able to relate experiences or encounters in the group with outside experiences or encounters. This sub-category identified associations that the participant made between past experiences and current experiences, or those experiences that happened in the group. They may be positive or negative, happen through the music or through interaction with others in the group.

Participants often answered questions about the group by talking about a similar experience at home or interaction with family members. Heather connected her experience of using songs in the session to an enjoyable time in her life: "It just reminded me when it was good, when my parents were kind of, cool parents, and cared." Kelly chose a song that she had not listened to in many years. She was going through a difficult time with her mother when she was admitted to the hospital. She related her song to her mother and how her relationship with her has changed over the years: "I had my mom listen to that song one time and I was telling her about it and I made her listen to it, but now it just totally has a different meaning, I'm glad I did play that song for my mom."

There were other ways of relating the experience within the group to real-life situations. Adam compared how he functioned in the music therapy group with areas of life that provided a similar opportunity and produced a similar effect: "It's [the group] just more structured, so you what, the same thing at work; my boss expects me to do this, so I go to work and I do that (referring to when he is not feeling depressed and suicidal)." Heather also found the group to appeal to her desire to try new things in life: "It's fun; I like to interact with things and it gives me something to do, keep my mind off; I'll do everything, try new things like working on cars, and art and music." Elaine had a clear connection between playing music in the group and memories of playing in school band, which was important to her: "When we were all playing in the group... it took me back to when I was in school playing, which I enjoyed, so that was a happy time for me, so I guess the correlation between the happy time made me be able to relax."

The relatedness of each participant with experiences outside of the group may have contributed to the effectiveness of the group.

### *Affirmations*

One must not help but wonder if things that are liked are more effective. Several of the participants gave me compliments and made positive statements about their experience in the group. Because of the frequency of this type of data found, they were included under the sub-category of *Affirmations*. This includes any positive comments made by the participant about their experience. Adam said, referring to the group, “It was cool, a good time.” Kelly said the group was “perfect,” and when asked what made it perfect, she stated, “just the fact that everyone was having a good time together.” Heather had many positive statements about the use of music in the groups and she felt that “the music was cool.”

The participants also gave me feedback, though it was not solicited. This could also reflect the level of comfort the participants had in the group since it seemed that I was able to build rapport with them. Heather complimented me by telling me, “You’re awesome, it’s been real good”, and Kelly stated, “You’re good at what you do. I definitely think that this seems like your niche.” Admittedly, it was nice to hear, but I think this also demonstrates how the therapist may have had some influence on how the group was experienced.

### *Change/Shift*

This category refers to an identified moment or event of change in thought or feeling that lasted beyond the group and into the interview. While change for many participants was noted as part of the experience of the group, it is also important to consider which changes each person identified as having a lasting effect. These are statements that indicate a movement toward the future, statements of goals, or long-term impacts that the group had on the participant.

For Heather, it came in the form of resolution and looking toward the future:

I let go. I forgive him [ex-boyfriend]. I won’t forget it, but I forgive him. He’s sick too, and people who hit and beat on other people just for self-gain, they’re sick... So I feel good about myself, I need to set my standards different than what I was setting.

She went on later in the interview to say,

There’s more to life and just drugs and sex and alcohol and stupid depression and anxiety. There’s more out there. I have a lot more goals now. I’m actually going to try to pursue my art instead of just putting it off.

She demonstrates a clear shift toward the future and a change in her self-image.

Kelly talked about her overall experience in the hospital, stating that it made her stronger. She also referred to her experience in the music therapy group: “It just broadens your horizons, opens your eyes to different things, like if someone likes one kind of

music and you listen to something else, you're like, hey, there really is something else out there for me." Similarly, Lisa talked about her experience of hearing music she never listened to before, "So to have other songs and other people that was introduced like Johnny Cash, something so simple, it might just be that a tweak of things might help with other parts of my life." This is important for Lisa since she had such strong connections with music that supported her drug habits.

## DISCUSSION

The results of this study yielded several findings related to the purpose of this study. The original research questions have been consulted through the analysis process and have remained steady throughout. While some are more directly answered by the data than others, the questions that may not be answered have been explored. This gives way to future implications for research and clinical practice, as well as the professional development of the researcher in this process.

### The Role of Music Therapy in Treating People with Suicidal Ideation

The role of music was identified as a sub-category in the data that were broken down into six distinct areas, four of which are expanded upon. This helped to clarify the participants' view of the music in the group and what they felt its role was in treatment. An expanded version of this approach can be seen in the application of songs in the treatment of oncology patients. Dileo (1999) outlines several reasons songs are appropriate for oncology patients and summarizes the role of songs in life. Similarly, the sub-category *Role of Music* helps to answer this question through expanding on the roles identified by the participants.

In this treatment setting, an important role that music plays is the facilitation of connection. The risk factors for suicide are often addressed in the literature and in treatment settings; however, it is also necessary to consider protective factors since these help to decrease the risk factors, and connection is considered a protective factor and necessary component of suicidal treatment (Erbacher, 2008). The participants also identified connection as an important component of the music therapy research group. Connections were often identified through the music, thereby giving music the role of facilitating connection.

Music also played a role in improving mood. Since most of the participants were diagnosed with depression or some type of depressive disorder, improvement of mood was a clinical goal for them. Many participants identified a shift in mood from the beginning of the session to the end. I observed this in their behavior during the session. It became especially apparent for the people who attended two sessions, as their mood seemed to improve more quickly in the second session than the first. This could be due to familiarity with the group and the process involved. Many reported the research group as something they looked forward to.

As a therapist, it is often not in our best interest to tell clients what we think they need to hear. In fact, we want clients to discover for themselves what will help in healing. The role of music here is to provide a message. The experience of interacting in groups often results in some insight triggered by another group member. In the case of music

therapy, the music can also trigger the insight. Participants who listened to lyrics of songs or engaged in improvisation were able to pick out some aspect that spoke to them personally. This was identified in the interviews and also observed in the sessions. The music enabled the participants to hear the message, which allowed me to be a sounding board and to support the processing of the message.

Another significant role that the music played inside and outside the group was as a stress reliever. Some participants defined the group as being relaxing, even though we did not specifically engage in relaxation techniques or address the need for stress management. Risk factors for suicide include recent traumas and external pressures (Erbacher, 2008). These can naturally lead to high levels of stress, which need to be curtailed to allow for healing. Since the participants identified music as a useful means for expression and stress management in their everyday lives, it makes sense that the music continue this role in the treatment process.

## The Experience of the Music Therapy Group

Participants were asked a question that was formed while conceptualizing the study: “What is it like to be a part of a music therapy group?” While this question was not a driving force for the study, I felt it should be considered. When the participants were asked, they often responded with feeling words, such as *relaxing*, or descriptive words, such as *helpful*. This does not speak specifically to the music, but rather to the group itself. It seems impossible to separate the group experience from the musical experience, as one influences the other.

Based on the data collected from the interviews and my perspective from the research groups, it appears that this was a positive experience for the participants. The smaller groups offered a more intimate setting that allowed a more personalized approach in treatment. The participants responded to this frequently in the interviews, and the group size was often referred to as allowing for connection and change to occur. It also seemed that this intimacy provided opportunities that the regular, large treatment groups did not. It may be difficult to feel heard and understood in a group of 12-15 patients, which was the typical group size to which the participants were accustomed.

In addition to the importance of intimacy in enhancing participants’ session experiences, I also recognized the importance of the role that I played in treatment. The impact that I had on the participants is likely to make a mark on the participants’ experience of the groups since I was leading them. Aside from the rapport I had with the participants, I acknowledged the fact that the participants seemed satisfied with their treatment. This is important for psychiatric patients who are suicidal, as they tend to be more dissatisfied with their therapist and frequently wish to change therapists (Hintikka, et. al., 1998).

## How Music Therapy Impacts Overall Treatment

The question of how or if music therapy affected overall treatment of the participants can be inferred from sources other than the patient’s own opinion. This question cannot be answered based on the data collected in this study, but I considered it for future research in this area. To answer this question, one could follow-up after discharge with the

participants, collect data on readmission following treatment, or interview other professionals who work with the participants.

This question remains relevant to the present study because participants did identify long-term effects of the group and often referred to influences outside of the research groups, such as psychiatrists and social workers. For some, it was the supportive environment in the hospital that made a difference to their treatment. Therefore, it is important for the music therapy to support and complement other treatment modalities. The participant who identified long-term goals, such as pursuing her artwork and returning to school, expressed these goals being supported within the music therapy research group as well as within other treatment groups that she attended. For others, there was no mention of incorporating the research group experience into their overall treatment. One participant used the experience in music therapy to contradict the effectiveness of other treatment modalities, since she did not have the same experience in both groups. For this individual, it seems that the music therapy groups may have polarized her treatment and created an attitude that left her less receptive to other modes of treatment from which she may have benefited. The impact of music therapy on treatment can only be speculated given the data from this study.

## Interventions of Music Therapy and Consideration of Suicidal Ideation

Since so many music therapy interventions are available, I was curious if some were more effective or appropriate for this population than others. Given this study alone, I cannot draw any conclusions about this. A variety of interventions were used in this study, depending on the needs of the client. Prior to each group, I designed a rough session plan, which took into consideration my assessment of the participant through the regular unit music therapy groups. I also gave participants the opportunity to choose types of interventions in the beginning of their first session. The second session was usually a follow-up or continuation of the first, since many issues were left unaddressed and the participants anticipated a second session.

It is inconclusive whether one intervention is superior to another. What is conclusive is that participants were responsive to the types of interventions used as well as the creativity required within those interventions. Whether song writing, engaging in lyric analysis, improvising, or re-creating songs through singing and playing instruments, the participants were noticeably motivated to put energy into the intervention and expose parts of themselves normally hidden in the regular unit treatment groups. It became apparent to me as therapist and researcher that the interventions were enhanced through the intimacy in the research groups.

## Indications and Contraindications for the Use of Music

The use of music is indicated for patients who are suicidal similarly to any other clinical population. During the initial periods of this study, I wondered if there would be any reason specifically related to suicidal ideation that would be indicated or contraindicated for music therapy. The data suggest that contraindications were revealed on an individual basis and did not show any consistency from one participant to the next. These are not

specific to patients with suicidal ideation, but were concluded from the data and my experience as therapist.

There were two instances where music may have been contraindicated. The first happened with Adam. He presented as anxious in the sessions and had difficulty sitting still in his chair, making decisions, and interacting with others. By the second session, he was more relaxed and interactive with the other group members. He seemed more confident and comfortable with the music. While he made this significant transformation, it seemed that he used the music to avoid issues and never got to the point where he felt comfortable talking about himself. This may speak more to his needs in therapy and that he would benefit from a longer treatment; however, as a short-term therapy, the music therapist should consider whether this is effective.

The second instance of potential contraindication occurred with Lisa. She chose music that reminded her of drug-dealing and using drugs. She also identified these as stressful, negative habits that contributed to her depression and suicide attempt. In the second session, she chose a song that had a positive message and one that she felt supported by. A music listening intervention should always be done with caution, as we do not know what will trigger negative feelings or memories in a client. We also may not know the client's intention for choosing certain songs. Lisa did not reveal her intention behind choosing the drug-dealing song until the interview. She talked about it in the group, but since it occurred during the first session, she appeared to be more superficial in her discussions.

While these may not be clear contraindications for the use of music, it may help to consider counter-therapeutic possibilities when treating patients in a short-term setting. In therapy, there is often a period of working through the superficial layer to get to more meaningful substance with a client. Depending on the patient, the therapy may not move beyond the superficial layer in an acute inpatient setting. The limited time frame does not allow for in-depth treatment; rather, treatment usually comes down to stabilizing the patient for discharge. This is when using the music to enhance protective factors to counteract suicidal ideation may be indicated.

### Theoretical Integration: Transactional Analysis

While several theories were considered in the approach of therapy as I designed and led the music therapy sessions, a particular theoretical orientation was absent in the interpretation of the data. My clinical orientation is generally grounded in humanistic psychology, although I sometimes use psychodynamic and cognitive-behavioral approaches. This generally depends on the client and the situation. In working with a population such as this, I maintained a humanistic approach during treatment.

However, the data did not seem best conceptualized by humanistic theory. Suicidal ideation was expressed so differently in all of the participants, yet seemed to bring them all to the same place. While personalities varied, many characteristics were similar across participants. After closely examining the results, I began to recognize meaningful outcomes. These were not inherent in a single theoretical orientation. One way I viewed the outcomes of the participants' behaviors and states of being was through the lens of Transactional Analysis.

Transactional Analysis (TA) is a form of psychotherapy that “makes extensive use of the interpersonal interactions between therapist and client within sessions” (Klerman & Weissman, 2007, p. 215). It is not in the interest of this paper to explain the details of TA, therefore only a few key components will be introduced. Eric Berne (1910-1970) is the founder of TA and first came upon this approach by observing his clients using states of relating to others: Child, Parent, or Adult. The Child ego state is impulsive, stimulus-bound, irresponsible, but also the source of spontaneity, creativity, and fun. The Parent ego state is also carried over from childhood and includes behaviors and attitudes that imitate parent or authority figure behavior. The Adult ego state is the rational and logical ego state that is not bound by emotion. This ego state is developed over many years of interacting with the physical and social environment.

Games are another well-known part of Berne’s work. A game is “a complex series of ulterior transactions that progress to a psychological *payoff*—a feeling such as guilt, depression, or anger” (Klerman & Weissman, p. 217). It would be interesting to examine the types of games that were played in the research, though it takes considerable training in the this area to become skillful at identifying, understanding, and working with games.

Another key component to consider in TA is the use of strokes. Strokes are any interpersonal form of recognition, whether positive or negative. Berne’s theory includes strokes as a necessary part of healthy development and continued mental and emotional health. If people do not receive positive strokes, they will play games to receive even negative strokes. Based on an informal reflection of transactions that occurred in the research groups, the participants demonstrated a generous amount of stroking through the music and on account of musical engagement and creativity. This also may have led to more positive experiences as described by the participants.

The observation of ego states in clients who are suicidal is interesting to note. Berne suggests that the decision to commit suicide is “a lonely and agonizing and apparently autonomous one” (1972, p. 296). The Child and Parent ego states generally lead to suicidal thinking as a method of problem solving. Orten (1974) expanded on this notion, stating that it is the Child ego state that is feeling despair and hopelessness. He suggests engaging the Adult ego state to gain control over the suicidal thinking. Lester (1994) then took this a step further to suggest for the therapist to ask questions that are non-threatening and unrelated to the problems causing the suicidal ideation. Lester states, “this is the most effective method of getting the client’s adult ego state to take control” (p. 69).

This information is helpful for the music therapist, and it seems that music therapy can work well within this framework with suicidal patients. As I looked back on how I navigated this study, I see many parallels between my approach through music therapy in working with suicidal patients and the approach through TA in working with suicidal patients. Music seems to appeal to the Child ego states of the clients, as they can identify a relationship with music as far back as they can remember. However, the practical nature of music therapy—which involves problem solving, critical thinking, and recognizing emotions rather than acting on them—helps to put the clients in their Adult ego states.

TA has a meager presence in the music therapy literature. Arnold (1975) integrated TA with music listening to structure the session using Berne’s six ways of structuring time. He also incorporated several theoretical constructs in discussing this

approach, such as stroking the Child ego state, awareness, intimacy, and time-structuring. Wheeler (1981) briefly mentioned TA in an article discussing music therapy and psychotherapy, in which she highlighted articles that describe the use of music therapy to activate various ego states. Bruscia (1987) described the use of TA in “metaphoric improvisation,” which applies a combination of Gestalt therapy, TA, and developmental theory.

When one decides that suicide is a viable option to solve a problem, the person has a sense of autonomy (Berne, 1972). In a situation that seems out of control, the suicidal client may have some relief in this decision. Autonomy is not only an important component for the healthy person, but also for the person in treatment. Autonomy is “the release or recovery of three capacities: awareness, spontaneity, and intimacy” (Berne, 1964, p. 158). These three capacities are reflective of the findings in this study and also became the impetus for conceptualizing the conclusions of the data. I found myself asking the same question again and again after discussing the results: What do my findings mean to me?

Upon exploring the desired outcomes of TA, I found that these mirrored the outcomes of this study. Though my outcomes were not intentionally aimed toward TA, they were a result of a naturally unfolding process that seemed to lead to some principles of TA. Even though the therapy was brief, the clients were able to balance ego states, and it could be argued that the music facilitated the components needed for some autonomy (recovery) and feelings of improvement.

Each component of autonomy, as defined by Berne, can be seen in the results of this study. “Awareness requires living in the here and now, and not in the elsewhere, the past or the future” (Berne, 1964, p. 158). During a music therapy session, when the client is engaged in some act of making music, he or she is in the here and now. Insights that the participants gained from the music therapy interventions in this study came out of engaging in the music and interacting with others in the group. While this is not to be accomplished in a single session, or even in a few sessions, it seems to be a good place to start. It appears that the participants who had some form of insight in the therapy were able to talk more openly about their present state of being.

Berne (1964) writes, “Spontaneity means option, the freedom to choose and express one’s feelings from the assortment available (Parent feelings, Adult feelings and Child feelings)” (p. 160). Options, freedom to choose, and the expression of feelings were all outcomes identified in the data from this study. This is not necessarily unique to people who feel suicidal, but it was an important aspect of the sessions for the participants. The use of music in the treatment groups allowed the participants to explore options, make choices, and try different roles. This type of experience inherent in music therapy supports Berne’s concept of spontaneity. Berne also states, “Intimacy means the spontaneous, game-free candidness of an aware person, the liberation of the eidetically perceptive, uncorrupted Child in all its naïveté living in the here and now” (p. 160). Several of the participants talked about the experience of being close to the other group members and feeling open to share thoughts and feelings with the group. The size of the group enabled this, though the music also played an important role. This also builds on one of the protective factors against suicide: connection. This was an important theme that developed into a category of data and carried through as a key implication for this study.



Although the categories that emerged from the data analysis built a solid case toward answering the research question, applying an existing theory to the results helped me to expand my understanding of this topic. Several theories could have been used to explain the findings in the data. It seemed to me that TA complimented key findings. This only touched on concepts of TA with the possibility of paving the way for further investigation.

## CONCLUSION

This study employed the naturalistic inquiry method of qualitative research. This method allowed me to openly investigate an unfamiliar area of treatment. It also allowed me to take on the dual role of researcher and therapist, as one role constantly informed the other throughout the entire process. The data collected were based on a natural setting, though unique to this study since participants were screened and the treatment groups were much smaller than traditional treatment groups in a psychiatric facility. This resulted in a manageable amount of data that I could analyze. The results also served as yet another open door that yielded more room to explore through discussion and theoretical integration.

Based on the results of this study, it seems music therapy lends itself to enhancing protective factors in clients with suicidal ideation. This was explained in the discussion of the results. Protective factors include feeling connected, being cognitively flexible, being willing to obtain treatment, being hopeful, and having coping strategies (Erbacher, 2008). The results from this study imply that these factors are supported through music therapy. This is important to consider when working with such clients, as stabilization and the identification of coping skills are often key goals associated with psychiatric treatment.

Through exploring how the findings from this study relate to TA, it seems that music therapy supports the process of building autonomy. While there are many other components of this approach to treatment, this study coincides with only a portion of TA theory. This refers to Berne's (1964) attainment of autonomy, a key goal of therapy in TA. Autonomy is characterized by the recovery of awareness, spontaneity, and intimacy. The results of this study compliment these capacities as a movement toward healing and improved functioning.

### Researcher Perspective

If I could go back to the data collection, I would change three things. First, I would focus more on specific treatment issues in the sessions. I allowed the participants to bring up issues as they felt necessary. For some of the participants, this worked well; for others it enabled them to avoid the very issues that brought them into the hospital. I noticed this with the first two participants, who were re-admitted before I completed the study. Although greater direction in my research may not have prevented re-admission, I believe that some participants would have benefited from more structure. As the study progressed, I found myself more focused on issues rather than circumventing them through the music.

Second, I would approach the data analysis process differently. The data analysis process was overwhelming. It took several attempts to organize the data in a useful and

efficient way. Even with guidelines from experts in data analysis, it was difficult to take my own data and organize them in a way that I could manage. In a qualitative study, I found that experience was the best teacher. Having never organized this type of data before, it became a trial and error approach. I would allow more time to think about how I want to use the data and the purpose of organizing them before settling on an approach for analysis. This also illustrates a potential problem with qualitative analysis: It can become a never-ending process.

Finally, I would change my approach to the interviews. I would ask more direct questions about what I wanted to know. I found that the participants seemed to talk with ease, and at no time did they appear uncomfortable with the questions I asked. People seem to be open to talking about personal issues in an intimate setting when the conversation partner is someone with whom they are comfortable. I attempted to set up a comfortable environment, and I approached the interview in a relaxed manner. This was helpful, though I feel I could have done more to elicit deeper answers from the participants.

Overall, this study enabled me to become aware of the nuances involved in research and how to apply this to future projects or studies. By reflecting on my own process, I hope that it gives others some things to consider when taking on a dual role and engaging in a learning process that obviously influences the overall study.

### Implications for Music Therapy

The approach to treatment does not have to be drastically altered to accommodate for suicidal thinking, though understanding of how it affects a patient is helpful. Many music therapists possess the knowledge and ability to work with such a population and do so on a daily basis. Regardless of one's familiarity with this population, it may be of help to consider the factors examined in this study. It may also help to understand the role that music plays with the suicidal patient. This can be emphasized, depending on the intervention and how the client responds to it. In an ideal world, we would have smaller groups and dedicated space for working with this population, however the feelings of suicide can often be lost in the crowd of the typical treatment group.

Understanding the positive effect music can have on this population would benefit professionals of other disciplines who work with this population. This underscores how useful music therapy is with suicidal patients and the potential for treatment in this area.

### Implications for Future Research

This study can be expanded on in many ways, given the results. One way is to examine the use of games in music therapy to expand on the connection of TA with music therapy. Qualitative research revealed findings that may not have emerged had the design been more structured. I think this form of research is useful in this area of inquiry because of the loosely established relationship between TA and music therapy. This may lead to a theory that can guide therapists and increase understanding of suicidal ideation and the purpose it serves for people who resort to it.

Further research might also examine more specifically the role of music. The present study only scratches the surface of the importance of music as a treatment

modality for addressing suicidal ideation in treatment. This could also lead to a protocol for treatment for music therapists to consider. Issues that are specific to suicidal ideation could be explored through more extensive music psychotherapy or adapted music therapy approaches based in cognitive-behavioral therapy. Engaging in such research adds to the base of knowledge in the field and expands one's own understanding of these phenomena.

## REFERENCES

- American Psychiatric Association. (2003). *Practice guidelines for the assessment and treatment of patients with suicidal behavior*. Retrieved November 5, 2007, from <http://www.psych.org>
- Apter, A., Horesh, D., Gothelf, D., Graffi, H., & Lepkifker, E. (2001). Relationship between self-disclosure and serious suicidal behavior. *Comprehensive Psychiatry*, *42*, 70–75.
- Arnold, M. (1975). Music therapy in a transactional analysis setting. *Journal of Music Therapy*, *12*, 104–120.
- Berne, E. (1964). *Games people play*. New York: Grove.
- Berne, E. (1972). *What do you say after you say hello?* New York: Grove.
- Blumenthal, S. J. (1988). A guide to risk factors, assessment, and treatment of suicidal patients. *Medical Clinic of North America*, *72*, 937–971.
- Bright, R. (1999). Music therapy as a facilitator in grief counseling. In T. Wigram, B. Saperston, & R. West (Eds.), *The art and science of music therapy: A handbook* (pp. 309–323). The Netherlands: Harwood Academic Publishers.
- Brooks, D. M. (1989). Music therapy enhances treatment with adolescents. *Music Therapy Perspectives*, *6*, 37–39.
- Bruscia, K. E. (1987). Metaphoric improvisation therapy. In *Improvisational models of music therapy* (pp. 319–334). Springfield, IL: Charles C. Thomas Publisher.
- Bruscia, K. E. (1998). *Defining music therapy*. Gilsum, NH: Barcelona.
- Bruscia, K. E. (2005). Data analysis in qualitative research. In B. Wheeler (Ed.), *Music therapy research* (2nd ed.) (pp. 179–186). Gilsum, NH: Barcelona.
- Comtois, K., Russo, J., Roy-Byrne, P., & Reis, R. (2004). Clinicians' assessments of bipolar disorder and substance abuse as predictors of suicidal behavior in acutely hospitalized psychiatric inpatients. *Biological Psychiatry*, *56*(10), 757–763.
- Comtois, K. A., & Linehan, M. M. (2008). Psychosocial treatments of suicidal behaviors: A practice-friendly review. *Journal of Clinical Psychology: In Session*, *62*(2), 161–170.
- Cranberries (1996). Electric blue. On *To the faithful departed* [CD]. London: Polygram Records.
- Dalton, E. J., Cate-Carter, T. D., Mundo, E., Parikh, S. V., & Kennedy, J. L. (2003). Suicide risk in bipolar patients: The role of co-morbid substance use disorders. *Bipolar Disorder*, *5*, 58–61.
- Dalton, T. A. & Krout, R. E. (2006). The grief song-writing process with bereaved adolescents: An integrated grief model and music therapy protocol. *Music Therapy Perspectives*, *24*(2), 94–107.
- De Backer, J. & Van Camp, J. (2003). The case of Marianne: Repetition and musical form in psychosis. In S. Hadley (Ed.), *Psychodynamic music therapy: Case studies* (pp. 273–297). Gilsum, NH: Barcelona.
- de l'Etoile, S. K. (2002). The effectiveness of music therapy in group psychotherapy for adults with mental illness. *The Arts in Psychotherapy*, *29*, 69–78.
- Dileo, C. (1999). Songs for living: The use of songs in the treatment of oncology patients. In C. Dileo (Ed.), *Music therapy and medicine: Theoretical and clinical*

- applications* (pp. 151–166). Silver Spring, MD: American Music Therapy Association.
- Drake, R. E. & Sederer, L. I. (1986). Inpatient psychosocial treatment of chronic schizophrenia: Negative effects and current guidelines. *Hospital and Community Psychiatry*, 37, 897–901.
- Dyck, R. J. (1995). Guidelines for the development and organization of suicide prevention programs. In R. F. W. Diekstra, W. Gulbinat, I. Keinhorst, & D. de Leo (Eds.), *Preventive strategies on suicide* (pp. 51–75). Leiden, The Netherlands: E. J. Brill.
- Eddy, D. M., Wolpert, R. L., & Rosenberg, M. L. (1987). Estimating the effectiveness of interventions to prevent youth suicides. *Medical Care Supplement*, 25(12), 57–65.
- Eminem (1999). My name is. On *The slim shady LP* [CD]. Santa Monica, CA: Interscope Records.
- Erbacher, T. (2008, November). *A comprehensive understanding of suicidal risk assessment*. Paper presented at the Princeton Health Care Systems Psychiatry Grand Rounds, Princeton, NJ.
- Freed, B. S. (1987). Songwriting with the chemically dependent. *Music Therapy Perspectives*, 4, 13–18.
- Fristad, M. A., & Shaver, A. E. (2001). Psychosocial interventions for suicidal children and adolescents. *Depression and Anxiety*, 14, 192–197.
- Gfeller, K. E., & Thaut, M. H. (1999). Music therapy in the treatment of mental disorders. In W. B. Davis, K. E. Gfeller, & M. H. Thaut (Eds.), *An introduction of music therapy: Theory and practice* (2nd ed., pp. 89–117), New York: McGraw-Hill.
- Gliatto, M. F. & Rai, A. K. (1999, March 15). Evaluation and treatment of patients with suicidal ideation. *American Family Physician*. Retrieved November 5, 2007, from <http://www.aafp.org/afp/990315ap/1500.html>
- Goldeberg, F. S. (1989). Music psychotherapy in acute psychiatric inpatient and private practice settings. *Music Therapy Perspectives*, 6, 40–43.
- Granello, D. H., & Granello, P. F. (2007). *Suicide: An essential guide for helping professionals & educators*. Boston, MA: Pearson Education.
- Heaney, C. J. (1992). Evaluation of music therapy and other treatment modalities by adult psychiatric inpatients. *Journal of Music Therapy*, 29(2), 70–86.
- Hintikka, J., Viinamaki, H., Koivumaa-Honkanen, H. T., Saarinen, P., Tanskanen, A., & Lehtonen, J. (1998). Risk factors for suicidal ideation in psychiatric patients. *Social Psychiatry and Psychiatric Epidemiology*, 33 (5), 235–240.
- Indin, B. M. (1966). The crisis club: A group experience for suicidal patients. *Mental Hygiene*, 50, 280–290.
- Jones, J. D. (2005). A comparison of songwriting and lyric analysis techniques to evoke emotional change in a single session with people who are chemically dependent. *Journal of Music Therapy*, 42,(2), 94–110.
- Katz, P. (1995). The psychotherapeutic treatment of suicidal adolescents. *Adolescent Psychiatry*, 20, 325–341.
- Kerkhof, A. J. F. M., & Diekstra, R. F. W. (1995). How to evaluate and deal with acute suicidal risk: Guidelines for health care workers. In R. F. W. Diekstra, W.

- Gulbinat, I. Keinhorst, & D. de Leo (Eds.), *Preventive strategies on suicide* (pp. 97–128). Leiden, The Netherlands: E. J. Brill.
- Kleespies, P. M., Deleppo, J. D., Gallagher, P. L., & Niles, B. L. (1999). Managing suicidal emergencies: Recommendations for the practitioner. *Professional Psychology: Research & Practice*, *30*(5), 454–463.
- Klerman, G. & Weissman, M. (2007). Interpersonal therapies. In J. O. Prochaska & J. C. Norcross (Eds.), *Systems of psychotherapy: A transtheoretical analysis* (6th ed., pp. 203–228). Belmont, CA: Thomson Brooks/Cole.
- Kroll, J. (2000). Use of no-suicide contracts by psychiatrists in Minnesota. *American Journal of Psychiatry*, *157*, 1684–1686.
- Leenaars, A. (1990). Psychological perspectives on suicide. In D. Lester (Ed.), *Current concepts in suicide* (pp. 159–167). Philadelphia, PA: The Charles Press.
- Lester, D. (1994). Psychotherapy for suicidal clients. *Death Studies*, *18*, 361–374.
- Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *48*, 1060–1064.
- Litman, R. E. (1995). Suicide prevention in a treatment setting. *Suicide and Life-Threatening Behavior*, *25*, 134–142.
- Luetje, V. M. (1989). Music therapy in crisis intervention. *Music Therapy Perspectives*, *7*, 35–39.
- Malone, K. M., Haas, G. L., Sweeney, J. A., & Mann, J. J. (1995). Major depression and the risk of attempted suicide. *Journal of Affective Disorders*, *34*, 173–185.
- Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... Hendin, H. (2005). Suicide prevention strategies: A systematic review. *Journal of American Medical Association*, *294*(16), 2064–2074.
- Mann, J. J., Waternaux, C., Haas, G. L., & Malone, K. M. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *American Journal of Psychiatry*, *156*(2), 181–189.
- Nolan, P. (1994). The therapeutic response in improvisational music therapy: What goes on inside? *Music Therapy Perspectives*, *12*(2), 84–91.
- Nolan, P. (2003). Through music to therapeutic attachment: Psychodynamic music psychotherapy with a musician with dysthymic disorder. In S. Hadley (Ed.), *Psychodynamic music therapy: Case studies* (pp. 317–338). Gilsum, NH: Barcelona.
- O’Callaghan, C. C. (1997). Therapeutic opportunities associated with the music when using song writing in palliative care. *Music Therapy Perspectives*, *15*, 32–38.
- O’Callaghan, C. C. (1996). Lyrical themes in songs written by palliative care patients. *Journal of Music Therapy*, *33*(2), 74–92.
- Orten, J. D. (1974). A transactional approach to suicide prevention. *Clinical Social Work Journal*, *2*, 57–63.
- Perry, L. (2002). Beautiful [Recorded by Christina Aguilera]. On *Stripped* [CD]. New York: RCA.
- Placidi, G. P., Oquendo, M. A., Malone, K. M., Brodsky, B., Ellis, S. P., & Mann, J. J. (2000). Anxiety in major depression: Relationship to suicide attempts. *American Journal of Psychiatry*, *157*, 1614–1618.

- Potash, J. B., Kane, H. S., Chiu, Y., Simpson, S. G., MacKinnon, D. G., McInnis, M. G., ...DePaulo, J.R. (2000). Attempted suicide and alcoholism in bipolar disorder, clinical and familial relationships. *American Journal of Psychiatry*, *157*, 2048–2050.
- Pretzel, P. (1972). *Understanding and counseling the suicidal person*. Nashville, TN: Abingdon Press.
- Priestley, M. (1985). *Music therapy in action* (2nd ed.). St. Louis, MO: MMB Music, Inc.
- Reiss, D. (1968). The suicide six: Observations on suicidal behavior and group function. *International Journal of Social Psychiatry*, *14*, 201–212.
- Richman, J. & Eyman, J. (1990). Psychotherapy of suicide: Individual, group, & family approaches. In D. Lester (Ed.), *Current concepts of suicide* (pp. 139–158). Philadelphia, PA: The Charles Press.
- Rogers, J. R. (2001). Theoretical grounding: The “missing link” in suicide research. *Journal of Counseling & Development*, *79*, 16–25.
- Rubin, H. J. & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). Newbury Park, CA: Sage.
- Rucci, P., Frank, E., Kostelnik, B., Fagiolini, A., Mallinger, A. G., Swartz, H. A., ... Kupfer, D. J. (2002). Suicide attempts in patients with bipolar I disorder during acute and maintenance phases of intensive treatment with pharmacotherapy and adjunctive psychotherapy. *American Journal of Psychiatry*, *159*, 1160–1164.
- Sanchez, L. E., & Le, T. L. (2001). Suicide in mood disorders. *Depression and Anxiety*, *14*, 177–182.
- Sharry, J., Darmody, M., & Madden, B. (2002). A solution-focused approach to working with clients who are suicidal. *British Journal of Guidance and Counseling*, *30*, 383–399.
- Shneidman, E.S. (1981). Psychotherapy with suicidal patients. *Suicide and Life-Threatening Behavior*, *11*, 341–359.
- Silverman, M. J. & Marcionetti, M. J. (2004). Immediate effects of a single music therapy intervention with persons who are severely mentally ill. *The Arts in Psychotherapy*, *31*, 291–301.
- Slotoroff, C. (1994). Drumming techniques for assertiveness and anger management in the short-term psychiatric setting for adult and adolescent survivors of trauma. *Music Therapy Perspectives*, *12*, 111–116.
- Smeijsters, H. & Cleven, G. (2005). The treatment of aggression using arts therapies in forensic psychiatry: Results of qualitative inquiry. *The Arts in Psychotherapy*, *33*, 37–58.
- Smith, D., Fisher, L., & Goldney, R. (2002). Do suicidal ideation and behaviour influence duration of psychiatric hospitalization? *International Journal of Mental Health Nursing*, *11*, 220–224.
- Suicide: Understanding causes, signs and prevention*. (n.d.). Retrieved November 5, 2007, from <http://www.mayoclinic.com/print/suicide/MH0053/METHOD=print>
- Thaut, M. H. (1989). The influence of music therapy interventions on self-rated changes in relaxation, affect, and thought in psychiatric prisoner-patients. *Journal of Music Therapy*, *26*(3), 155–166.
- Unkefer, R., Ed. (1990). *Music therapy in the treatment of adults with mental disorders*. New York: Schirmer.

- Wadson, H. (1975). Suicide: Expression in images. *American Journal of Art Therapy*, *14*, 75–82.
- Weyrauch, K. F., Roy-Byrne, P., Katon, W., & Wilson, L. (2001). Stressful life events and impulsiveness in failed suicide. *Suicide and Life-Threatening Behavior*, *31*(3), 311–319.
- Wheeler, B. (1981). The relationship between music therapy and theories of psychotherapy. *Music Therapy*, *1*(1), 9–16.



## APPENDIX A

### SAMPLE OF GENERAL INTERVIEW QUESTIONS\*

	<b>Question</b>	<b>Participant</b>
1.	Can you tell me about your experience with music in your life, just how you use it day to day?	Kelly, Elaine
2.	What made you agree to be a part of this study?	Heather, Lisa, Elaine
3.	What were your expectations going in to the group?	Elaine, Adam, Kelly, Lisa
4.	What was the group like for you?	Kelly, Adam, Elaine
5.	What kinds of things did you learn from being a part of this group?	Heather, Adam
6.	How did you relate to the people in the group?	Kelly, Elaine, Lisa
7.	What was the most valuable experience that you got out of the group?	Heather, Kelly, Adam
8.	Did anything surprise you in the group?	Kelly, Elaine, Lisa
9.	What was the most challenging thing for you to do in the group?	Kelly, Elaine
10.	Is there anything you would change about the group or the sessions?	Kelly, Adam, Lisa
11.	What about the experiences in the group, how would you compare the first day to the second day?	Heather, Adam
12.	Would you have changed anything about the groups?	Heather
13.	What part of the group had the biggest impact on you?	Adam
14.	Did you feel safe opening up here?	Elaine
15.	Did you express feelings through your playing, and how was that different from doing it verbally?	Elaine
16.	What was the most helpful thing in the group?	Lisa

\*This sample does not include follow-up questions or questions that were asked about specific experiences in the group.

## APPENDIX B

### SAMPLE EXCERPT FROM INTERVIEW

Erin: Alright, so I'm just going to ask you a few questions about the music groups and your experience. You can answer whatever questions you want and say whatever you feel comfortable saying.

Heather: Okay.

Erin: Let's get started with your past experience with music. I know you play the piano...

Heather: I play the piano, um I was in chorus from elementary school through high school (oh, ok). But, I did it cuz like all my friends were doing it, I thought it was pretty cool, cuz we did, um the Sound of Music in, I think, like 5th or 6th grade. Or, no, Welcome to Broadway. That's what we did when we were kids. I like, I called my friend last night just to listen to music because that's just the highlight. I love music. It makes me feel better.

Erin: Yeah, and you said you like country?

Heather: Uh, some, cuz my mom listens to country, so it's like I have to hear it. And I hung out with my mom. I'm more of, I like electronica, reggeton, reggae, hiphop, R&B, stuff toward rhythm and blues and bass and drum. Stuff like that.

Erin: Mmm hmmm. So it sounds like you've been involved in music and you like to use music in your day-to-day life.

Heather: Yeah, it makes you feel good. Like I like driving in the car and just listening to old school, like Motown stuff, I'll drive anywhere and you can just lose yourself. Just listen to music and drive. Yep, yep. (Laughs) That's what I like to do.

Erin: Ok, nice (slight pause) What made you agree to be a part of this study?

Heather: Cuz it helps you and it helps other people to.. You know, you learn from different things. So I figured it could be helpful for somebody else. Or, and I'm learning from it.

Erin: Okay.

Heather: I learned that it helps you release some stress too. Music releaves stress. And it brings out things.

Erin: So what kind of things, you said you learned something from it.

Heather: I learned how to let things go. Like music brings you back to some things and, you know, reminds you of stuff. Like my parents used to listen to old school rock and roll, like you have on the thing and it just reminded me when it was good. When my parents were kind of, cool parents, and cared. That's what it reminded me of.

Erin: Good times?

Heather: Yeah.

Erin: And you said it helped you release stress.

Heather: Yeah, relieve stress. It just lifts you up. Music always does. (pause) I liked it, it just relieved my stress, I don't know. I don't know how to explain it. But it just does.

Erin: So would you say there was a difference between when you walked into the group from when you walked out of the group?

Heather: Yes, big difference, yeah. You're like, music, ahhhh (smiles) (pause).

Erin: And you also said you wanted to help me out.

Heather: Yeah (enthusiastically) Cuz it's fun, I like to interact with things and gives me something to do, keep my mind off, I like to things, I'll do everything, try new things like by myself, like cars, working on cars, and art, and music and I try everything, at least once to say I did it (laughs).

Erin: Yeah, so is this your first time in music therapy?

Heather: Yes.

Erin: What were the groups like for you? I know you've been in both the big groups and the small groups, but what were the small groups like?

Heather: The small groups, um, it's more intimate. And, um, everybody talks bout more in the smaller groups. Um, and you feel closer with the people, and you can open up more, that's what... you feel safer in the small groups. That's my opinion.

Erin: And what about the experiences in the groups? The first day we did singing, and the second day was songwriting.

Heather: Yeah that was awesome (excited, smiling) I thought that was cool.

Erin: You liked the songwriting?

Heather: Yeah, I liked the songwriting (pause) cuz it stimulates your mind more, you get to think about what you think and put down, let your emotions come out on paper and then do a song with the words.

Erin: What was it like putting the sounds to your song?

Heather: It was neat. I thought it was neat. I like it, um... it was like sound effects in my head that I heard. Like to the words like with the beating of the drums and the... the thing what's it called... With the...(motions with hands).

Erin: The cabasa?

Heather: Yeah, that was cool, for the wrists. Like different tones for different things.

Erin: What did that do for you to hear those sounds in your song?

Heather: It just reminds you of what things can be, like it's weird to explain, I don't know. Yeah, um... (pause, thinking).

Erin: So when you were doing that, how did it feel having other people in the group experiencing that with you?

Heather: Like, it brought me closer to you guys cuz I was expressing my feelings towards, you know being abused and beaten and thoughts of hurting myself because of it and (pause) just, I felt good to let it out.

Erin: Did you feel safe in that situation?

Heather: Yeah.

Erin: And how did it help you to let it out?

Heather: I let go. I forgive him. I won't forget it, but I forgive him. He's sick too. And people who hit and beat on other people just for self gain, their sick. They need help. And now I know, I realize that I don't need that type of person (pause) So I feel good about myself. I need to set my standards different that what I was setting. I would just pick any guy, anybody who would love me. And then they turn out to be real scum bags.

Erin: You say you forgive him and I'm wondering about yourself because you also talked about harming yourself in that song.

Heather: I'll never do it. I'll never think of that again. I let that go too, I really did. I don't have no thoughts of hurting myself, I have more self-worth than that.

Erin: You feel like you've been able to build up your self-esteem?

Heather: Yes, I have a lot more goals now. I'm actually going to try to pursue my art instead of just I'll do, I'll do it and just putting it off. I want to put my artwork out, I'm going to start going back to High street in Vineland and sell my artwork and get myself straight. And go to school. That's what I was planning on doing, going to college to do art. So, that's what I want to do.

Erin: Alright, what was the most valuable thing about the small group?

Heather: The most valuable? The Closeness. Being close to everybody and being able to open up.

Erin: (pause) and what would you say was the most challenging thing for you to do in group?

Heather: Writing that song. Just to think about what to put on the paper, and what was in my head. Cuz it was a bunch of words and then I summed it down to that little paragraph and that was challenging.

Erin: Is it usually challenging for you to write your poetry?

Heather: To get it out, like I don't know, I guess I'm not educated to writing things, certain words down. I'm not very smart when it comes to writing words down and stuff. I'm still learning, though. I'm more of a colors and lines and stuff.

Erin: Well, you know, you didn't have a lot of time to do it in, and so given the amount of time, it was pretty amazing.

Heather: Thank you, I enjoyed it. I thought it was cool, Me and X talk about it all the time. She's like (enthusiastically) let's make another song! Oh my God, no, I want to go to sleep (laughing).

Erin: It sounds like the intimacy in the group was helpful to you.

Heather: Yeah.

*Interview continues*

## APPENDIX C

### SAMPLE EXCERPT OF CODED DATA

<b>Interview with Heather Coded 3/13/2008</b>	Profiles	Beliefs	Values	Options/Choices	Feelings/Emotions	Change/Shift	Distancing	Action/Release	Transfer/Association	Connection	Affirmations	Beliefs	Change/Shift L/T	Action/Release L/T
I learned that it helps you release some stress too. Music relieves stress. And it brings out things.														
So what kind of things, you said you learned something from it.														
I learned how to let things go. Like music brings you back to some things and, you know, reminds you of stuff. Like my parents used to listen to old school rock and roll, like you have on the thing and it just reminded me when it was good. When my parents were kind of, cool parents, and cared. That's what it reminded me of,														
Good times														
Yeah														
And you said it helped you release stress														
Yeah, relieve stress. IT just lifts you up. Music always does. (pause)I liked it, it just relieved my stress, I don't know. I don't know how to explain it. But it just does.														
So ...														
Yes, big difference, yeah. You're like, music, ahhhh														
And you also wanted to help me out														
Yeah (enthusiastically) Cuz it's fun, I like to interact with things and gives me something to do, keep my mind off, I like to things, I'll do everything, try new things like by myself, like cars, working on cars, and art, and music and I try everything, at least once to say I did it (laughs)														
Yeah, so is this your first time in music therapy?														
Yes														
And what were the groups like for you? I know you've been in both the big groups and the small groups, but what were the small groups like?														
The small groups, um, it's more intimate. And, um, everybody talks bout more in the smaller groups. Um, and you feel closer with the people, and you can open up more, that's what... you feel safer in the small groups. That's my opinion.														
And ...														
Yeah ...														
You liked the songwriting														
Yeah, I liked the songwriting. (pause) cuz it stimulates your mind more, you get to think about what you think and put down, let your emotions come out on paper and then do a song with the words.														

APPENDIX D

SAMPLE OF COMBINED SORTED DATA

Who	Code	Data Unit
L	C-B	You know that would have been a completely different class because we would have just been goofing off the whole time. You saw how goofy we were when we were together.
L	C-B	Sometimes those songs will spark things with me, you know, will make me want to use.
K	C-B	A good time, anything to do with music equals a good time as far as I'm concerned (laughing)
E	C-B	I listen to it in the car to soothe me after a long day at work, so different reasons
H	C-B	It makes you feel good (music).
K	C-B	I think music to me, it's a big part of my life and I believe that music should be and can be a big part in everybody's life. There's just so many good things you can get out of music.
K	C-B	Whatever mood I'm in is the type of music I'll play,... it just helps me express my feelings
H	C-B	I love music. It makes me feel better.
H	C-B	It just lifts you up. Music always does.
L	C-B	I just know I was like, argh, I hope we aren't playing those instruments, cause I can't play them.
K	C-B	I really did not see (participant) as a hip hop, rap person
E	C-B	I don't think I was expecting to enjoy the group as much as I did.
H	C-B	I didn't think I was going to, when I first came in. I didn't think I was going to open up. I thought it would be all <i>ahhhh</i> , but now it's, <i>come on, lets go</i> .
A	C-B	You could teach somebody how to play a certain instrument. Not like the guitar, that's going to take weeks and weeks (to improve the experience)
L	C-B	To be able to help somebody out with that is cool. And I didn't have to do anything for, really. You know, I just had to be me.
E	C-B	I feel vulnerable and I don't like leaving myself open, completely vulnerable to certain people (okay), but if it's in a smaller group it's okay (talking about the big vs. small group)
H	C-B	There's more to life than just drugs and sex and alcohol and stupid depression and anxiety. There's more out there.
E	C-B	Positive thoughts can help to lead to a more positive attitude.
H	C-B	To get it out, like, I don't know, I guess I'm not educated to writing things, certain words down. I'm not very smart when it comes to writing words down and stuff. I'm still learning, though. I'm more a colors and lines and stuff.
H	C-B	I'll do everything, try new things like by myself, like cars, working on cars, and art, and music and I try everything, at least once to say I did it (laughs).
E	C-B	Sad you're feeling, cuz sometimes you can't find the good in anything (talking about her depression) But it you're so far in to it and it's like, nothing is helping, nothing will help, you're not going to be able to pull that message out.
E	C-B	When I zone out it's usually like, if I'm watching tv, it will appear that I'm watching tv, but I'm not really watching it, my mind is just racing a million different ways.
H	C-B	I'll never do it. I'll never think of that again. I let that go too, I really did. I don't have no thoughts of hurting myself. I have more self-worth than that now.
E	C-B	I'm a person that I hold on to everything until it overflows, so that's why it was hard for me, cuz I'm not used to expressing myself with words.