RESISTANCE IN MUSIC THERAPY

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Abstract

This study explores music therapists' experiences of resistance in therapy. Resistance has been defined as the direct or indirect oppositional behavior of a client due to possible reluctance to change (Newman, 2012). Though resistance has a long history being described in psychoanalytic literature, little is known about its role in music therapy outside of music psychotherapy. This study asked the following research questions: How do music therapists experience resistance in music therapy? In addition, this paper explored how music therapists utilize resistance to help people in music therapy. Eight board-certified music therapists (MT-BC) with various backgrounds of experience were interviewed to gain an understanding of clinicians experiences with resistance and how it manifests in music therapy. Interviews were transcribed and coded using Interpretative Phenomenological Analysis. Data analysis revealed nine specific themes which were categorized under three general sections - (1) Managing Resistance included three themes: building rapport, acceptance/encouragement, and consistency - (2) The Role of Music included three themes: music for expression, music for connection, and music to match and - (3) Clinicians' Reactions included three themes: personal thoughts, questioning ability, and perspective. Implications of the study, including the benefits and limitations of resistance for clinical practice are discussed.

Introduction

The topic of resistance refers to paradoxical and opposing behaviors displayed by the client in therapeutic services, related to a conscious or unconscious unwillingness to change (Ikonen, Pentti, Absetz & Kimmo, 2002). This research paper is a phenomenological study exploring music therapists' experiences of resistance within a therapeutic relationship. Interviews were completed with eight board-certified music therapists of various orientations and clinical experience for the purpose of attaining general perceptions of resistance to reveal authentic stories in current practice. With this study, readers can gain insight on the topic of resistance for a better understanding of complex therapeutic relationships. The following sections provide definitions of resistance and various conceptualizations in psychotherapy. Furthermore, forms and possible causes of the phenomenon are identified before discussing its role in music therapy.

Literature Review

Defining Resistance

Resistance is a term which describes the phenomenon of direct or indirect oppositional behaviors displayed by a client in therapeutic services due to confrontation of the therapeutic relationship and interventions offered by the therapist. It's foundations stem from psychoanalytic theory and is applicable to most populations in therapy. The founder of psychoanalysis, Sigmund Freud developed the first theory of resistance after observing avoidant behaviors of his clients in response to sensitive topics. The theory defined resistance as any attempt to avoid confrontation of suppressed or unwanted thoughts, typically in response to subconscious threat (Larsen, Randy, Buss & David, 2008). This discovery attributed to Freud's theory of repression, which states that

individuals repress or push shameful thoughts from their conscious mind of awareness into a state of unawareness, referred to as the unconscious mind. Through this, the client inadvertently avoids repressed thoughts and emotional discomfort (Bernstein, 2009).

Therapists vary in theoretical orientations, personal beliefs, and prior experiences with resistance. Nonetheless, resistive behaviors are considered by Newman (2002) as recognizable, that "therapists seem to know it when they see it" (p. 166). A client may consciously or unconsciously show resistance in attending, participating and/or engaging in interventions with a coping strategy called avoidance. If a process evokes unwanted emotions, the mind may reject it with a *defense mechanism.* Freud (1959) defined this mechanism as a psychological strategy which unconsciously manipulates, denies and distorts reality to protect the self. Therefore, resistance is considered a defense mechanism as it represses motives, fantasies and thoughts considered unacceptable by the client (Garrett, 2005). Fundamental theories of psychoanalysis influenced further research on the phenomenon, from the Freudian period to current practice.

From a later source, Pope (1979) generally defined resistance as "a process of avoiding or diminishing the self-disclosing communication requested by the interviewer because of its capacity to make the interviewee uncomfortable or anxious" (p. 74). More specifically, Messer defines interpersonal resistance as an instinctive reaction in which clients hide but also express aspects of themselves. Examples include avoiding topics, canceling appointments or forgetting to do assignments outside of therapy. Though assumed a hindrance to treatment effectiveness, resistance can be useful in therapy as it reveals information about the client.

Resistance is described as multifaceted with three dimensions; affective refers to the emotional feelings associated with change; behavioral includes the actions or inactions displayed

by the client; cognitive describes the thoughts and associations with making change (Van den Heuval, & Shalk, 2009). Another theory divides resistance into two categories of existence. State resistance refers to situational resistance, occurring for a certain period of time, whereas trait resistance is characteristic and longstanding (Van Denburg & Kiesler, 2002). As is evident by the various attempts to describe this phenomenon, resistance may require multiple definitions and perspectives due to its complex nature.

Psychologists remain divided; some define resistance as a common psychological response to threat while others argue it's the result of client temperament (Holowchak, 2012). Varying definitions have developed since the beginning of analyzing human behavior. For better understanding, foundational concepts of psychoanalysis which influenced future discoveries are identified.

History of Resistance

The first conceptualization of resistance was developed through the development of psychoanalysis, which is a set of multiple therapeutic techniques and theories evaluating the unconscious mind. In traditional psychoanalysis, the client verbally shares thoughts, dreams, and free associations as the analyst (therapist) responds, relating client's thoughts and behaviors to possible unconscious conflicts through methods of talk therapy (Milton, Polmear & Fabricius, 2011). Relative theories developed by Freud assist in understanding the earliest recognitions of resistance.

The unconscious plays a major role in the topic and includes three constructs of id, ego, and superego. The id is the primary component of personality that unconsciously seeks immediate gratification for basic urges, needs and desires. When basic needs aren't met, tension

and anxiety rise. Developed from the id, the ego controls human impulses in a social and realistic manner due to delayed gratification. The superego holds internalized moralities acquired from society and childhood, which makes up our ideals, standards and judgements (Carducci, 2009).

Freud asserted that certain memories disappear from consciousness and become unconscious material, unbeknownst to the individual as a response to threat. Current behaviors, choices and thoughts can be connected to repressed memories in the unconscious, which can be re-discovered during psychoanalysis treatment, resulting in a reduced amount of unwanted behaviors and an improved sense of control for the client. At an unconscious level, the ego relies on defense mechanisms such as resistance to decrease angst and prevent unwanted memories.

Another influential psychiatrist recognized for the development of psychoanalysis was Carl Jung. Under Freud, he studied the unconscious and established new perspectives, which became Jungian theories. To explore the roots of resistance, four Jungian theories of significance are individuation, personal unconscious, shadow, and persona. Individuation describes the process of self development which starts before birth in the unconscious. This creates personality attributes, immature psyche, life experiences and conscious memories (Jung, 1921).

The personal unconscious holds memories, thoughts and attributes that were repressed, or removed from conscious awareness for self protection (Jung, 1969). The shadow theory describes unwanted aspects of personality as an evil twin, alter ego, disowned self, or dark side. To remain hidden from themselves and others, these aspects may relegate into the personal unconscious. Jung stressed the importance of uncovering and accepting one's shadow, as "the dark side of his being, his sinister shadow...represents the true spirit of life" (Jung, 1983, pg. 262).

Jungian theories suggest that early life experience in conscious and unconscious awareness can influence future behavior (Donn, 2011). Repressed material can manifest in dream symbols, imagination/fantasies, relationship patterns and defense mechanisms including resistance. Unresolved issues continue to grow and persist, causing more unwanted behavior, and resisted aspects of personality (Snowden, 2010). This belief suggests that resistance increases when ignored, which connects us to the significance of this study for a better understanding of the phenomenon.

Resistance is an incredibly expressive tool according to Messer (2002). Many contemporary therapists emphasize working with the resistance, rather than against it for two proved reasons: to establish a positive therapeutic relationship and to gain insight on unconscious material (Beutler, Moleiro & Talebi, 2002). Client behavior can be revealing of a their overall attitude and perspective outside of therapy. Observable reactions to stimuli (verbal/non-verbal) can be indicative of a client's cognitive, emotional, and physical state, as well as limitations. For these reasons and more, the qualities which reside in resistance can be beneficial to the treatment process (Messer, 2002).

Dynamics of Resistance

Identifying various forms and causes of resistance is significant for therapists due to its inevitable and ubiquitous nature (Messer, 2002). Resistance has been suggested to be a response to threat, is also a sign of therapeutic success, described as "a natural part of the change process which is to be expected" (Bovey & Hede, 2001, pg. 534). Several studies on the topic connect a higher success rate in achieving therapeutic goals with high resistance, and negative outcomes with low resistance (Bischoff & Tracey, 1995).

According to the late perspective of Freud, there are five forms of resistance: repression, transference, ego-resistance, working-through, and self-sabotage. First, repression refers to a client's ego hiding particular memories to avoid negative emotions, impulses and ideas (Laplanche & Pontalis, 1973). The second form of transference occurs when a therapist reminds a client of someone significant or personal, affecting the therapeutic relationship, particularly the clients view of the therapist (Kapelovitz, 1987). Third, ego-resistance is a form of neurotic regression, a process in which a client regresses to childlike safety to seek attention and empathy. For example, a client exaggerating medical symptoms exemplifies ego-resistance.

The fourth term entitled working-through, acknowledges the difficulties within a therapeutic process of achieving change, despite the innate human desire for consistency (Wolman, 1968). Lastly, the fifth form of self-sabotage is considered the weakest, as it refers to personal internal guilt within the client which causes self-induced punishment, and reluctance to allow positive changes (Wolman, 1968). Observable resistance may occur consciously (purposefully) or unconsciously (unknowingly) from the client as well as the therapist. Moore and Fine (1990) state:

> Resistance may take the form of attitudes, verbalizations, and actions that prevent awareness of a perception, idea, memory, feeling, or a complex of such elements that might establish a connection with earlier experiences or contribute insight into the nature of unconscious conflict (pg. 168).

Observable verbal forms may include: shouting, yelling, crying, or simply a statement. Nonverbal examples include: eye-contact avoidance, negative body language, non-participation, or lack of attendance. Nonverbal indicators of resistance can simulate reactions of a separate

factor such as a medical condition, physical pain, or stress. The cause should be analyzed and distinguished accordingly by the therapist (Mitchell, 2006).

Causes vary as each therapeutic process is individual. Overall, a variety of causes are categorized into three factors. The first is therapy and therapist factors. Examples may include: absence or lack of rapport, improper assessment or failure to recognize client needs, client reluctance to change, or ineffective interventions implemented. The second is environmental and other external factors. Examples may include: client fear of changed dynamics with family/friends/coworkers, self-sabotage with outside sources, develop unhealthy relationships, or weather cancellation of therapy. The third is client factors, which may include: lack of motivation, hidden agendas for attending therapy, disbelief in effectiveness, and a strong self-fulfilling prophecy of failure (Golden, 1983).

More specifically, five causes of resistance are categorized by Messer (2002). The first states: resistance to the recognition of feelings, fantasies, and motives. Through this, the unwanted emotions such as anxiety, guilt or shame are avoided. The second states: resistance as a way of demonstrating self-sufficiency. This relates to the autonomy of client decisions. The client can choose to resist certain topics or interventions, which can provide elements of power and control. The third is entitled: resistance to revealing feelings toward the therapist. Revealing feelings about the therapist can enhance resistance within the relationship, despite transference. Fourth is labeled: resistance as a function of failure of empathy on the part of the therapist. This refers to the lack of empathy and attunement provided by the therapist, inhibiting a decrease in change. Lastly, the fifth cause states: resistance as client reluctance to change their behavior

outside of the therapy room. The behavior and attitude presented outside the therapy room is very telling of overall progress and treatment effectiveness.

Along with verbal processing, unconscious material can be accessed through less direct methods, such as creative arts therapies. Association cortices of the brain become activated during the process of creativity and during times of rest, which is when we experience most of our uncensored thoughts (Andreason, 2011). With this knowledge, forms of creative arts therapies, such as music therapy can be extremely effective in accessing and resolving conflict.

Music Therapy

The therapeutic potential of music is wide-ranging, multifaceted and applicable to the treatment of many populations. Music is considered a human phenomenon with the potential to activate multiple areas of the brain simultaneously and improve many domains of functioning, such as physical, cognitive and emotional (Wheeler, 2014). According to the American Music Therapy Association (AMTA), music therapy is defined as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program" (AMTA, 1998-2018). Kenneth Bruscia describes the practice in his book *Defining Music Therapy* (2014) as:

> ...a reflexive process wherein the therapist helps the client to optimise the client's health, using various facets of music therapy experience and the relationships formed through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research (pg. 36)

Music therapy has evolved to accommodate various populations and settings to include such facilities as medical and psychiatric hospitals, rehabilitation facilities, outpatient clinics, schools and educational programs, special needs agencies, long-term care facilities, hospice programs, and more. Interventions used in music therapy can be active and receptive to address different needs through four methods identified by Bruscia (2014) to include: improvise, re-create, compose (active) and music listening (receptive).

Music therapists can vary in theoretical orientation and follow different models for treatment including, but not limited to: psychodynamic, cognitive, humanistic/existential, biomedical, behavioral, and holistic. Stemming from psychoanalytic theories developed by Freud and post-Freudian figures, the Psychodynamic model of music therapy aims to bring repressed material of the unconscious into a state of awareness to achieve individual outcomes. Part of the psychodynamic model, the method of Analytical music therapy (AMT) implements active interventions of improvisation and verbal processing to identify, analyze and achieve therapeutic growth.

Psychodynamic music therapy. Defined as "a form of psychotherapy with a focus on a musical, form-giving exchange between therapist and patient," (De Backer, 2014, pg. 16) psychodynamic music therapy stems from the belief that trauma may present itself through the medium of music. Emphasizing the significance of a therapeutic relationship, interventions include musical improvisation, music listening, music imaging and verbal reflection throughout. This allows for self expression through improvisation, emotional exploration through music listening, and visualizing symbols through music imaging. The therapist uses verbal processing to relate past and current behaviors (De Backer, 2004). Langenberg (2002) describes this

combination of interventions (musical, mutual and verbal) as a more efficient method for analyzing and managing therapeutic outcomes. Music is considered a medium which lies closely to where trauma, repressed thoughts, or memories reside, therefore it "reaches the deep archetypal material that we can only sometimes reach in our analytic work with patients" (Jung, 1977, p. 275).

Analytical music therapy. Developed from psychodynamic theories of music therapy, AMT follows the belief that unconscious material such as conflicts, motives, desires and impulses affect human behavior without conscious awareness. AMT was developed by the music therapist, Mary Priestley who describes the method as "the analytically-informed symbolic use of improvised music by the music therapist and client. It is used as a creative tool with which to explore the client's inner life so as to provide the way forward for growth and greater self-knowledge" (1994, pg. 3). This method includes musical improvisation (music created in the moment) to access the inner self, reveal repressed emotions, and relieve defenses. Transference and countertransference principles are elicited in the therapeutic relationship through creation and verbal analyzation of an improvisational piece.

To investigate conscious and unconscious material, Priestley (1994) developed three techniques of AMT: splitting, free association, and programmed or spontaneous regression. The technique of Splitting aims to increase projection of emotions, thoughts and intentions. During improvisation, the therapist can imitate the client musically, the client can simulate this projection and vice versa. In free-association, the client is open to improvise without limitations, expectations, or directions while the therapist can choose to reflect, mirror, or are an active listener of their music composition. When a person experiences difficulty expressing their

feelings verbally, it's evident that the technique of free-association can be useful in expressing cognitive states and feelings through the portal of music (Priestley, 1994).

It is a strong belief of psychoanalysis that crucial relationships with our environments and caregivers are established within one to three years of life. During these early years, details of traumatic events or relationships may be repressed or forgotten, but arise during relevant situations later in life (Priestley, 1975). In programmed or spontaneous regression, the client revisits the traumatic event and feelings and then resolves it within the safety of musical improvisation and support provided by a therapeutic relationship (Priestley, 1994). In AMT, the therapeutic relationship plays a significant role in the treatment process (Priestley, 1994). The therapist prompts the client to access repressed, uncomfortable emotions through mutually active interventions of musical improvisation and conversational processing.

Resistance in Music Therapy

Resistive behaviors can manifest in any form of therapy at any phase of treatment for various reasons. Forms of resistance can be observed in AMT as verbal or musical. For example, a client may verbally show resistance by talking throughout the session to avoid accessing emotions through engagement in music. A musical example could be purposeful avoidance of instruments/voice, or fixation on one musical idea (Schieby, 2005). The uniqueness of each therapeutic process signifies that resistance is dependent of many causes. With prior knowledge of common causes and factors, simple strategies for preventing resistance can be enforced by clinicians.

Resistance is figuratively described as a wall built for emotional security/protection. To achieve deeper goals, that wall can be explored for client disclosure and expression (Watson,

2006). Exploring the perspectives of clinicians can provide foundational information for contemporary and further research. Theories have developed to explore the phenomenon, however, more information is needed in contemporary practice.

The purpose of this study is to explore music therapists' experiences with resistance from various theoretical orientations. Through this, multiple opinions of definitions, causes, and forms of resistance are gathered in interview responses. Previous literature identifies client resistance, however this study conducts interviews to gather perspectives from music therapists themselves. Collective responses provide authentic experiences which are coded into results on a topic of limited resources: the role of resistance in music therapy. The following research questions are addressed: How do music therapists experience resistance in music therapy? Furthermore, how do music therapists utilize resistance to help people in music therapy?

Methods

Epoche

As a music therapist, I developed a particular interest in this topic as I struggled with initial resistance from clients throughout internship as well as the early stages of my clinical career. Through supervision and research, I was better able to identify these behaviors and recognized the potential of resistance as a natural part of the therapeutic process. It appeared that many clients who presented initial resistance made the most progress in achieving therapeutic goals. This outcome was fascinating to me, and led to the question: why and how those who were reluctant to attend music therapy showed the most improvement toward their clinical goals?

My stance on the subject comes from a personal experience receiving verbal resistance from a client who later exceeded therapeutic goals. As a music therapy intern at a treatment

facility for traumatic brain injuries, I struggled to engage with a client, whom will be referred to as Emma. After suffering a substance-induced stroke, the young adult experienced rapid changes in her life including vision loss and left sided hemiplegia, and was referred to music therapy due to agitation towards staff. Upon our first meeting, Emma stopped in the office at random and engaged in general dialogue. After this, my attempts to schedule a session were verbally declined. Respecting her declinations, I did not reflect until we had an interesting verbal encounter.

MT: Hey Emma, how are you? Would you like to come by the music office today?

Emma: No I'm just not ready for music.

MT: Okay no problem, but we don't have to play music. If you just want to talk, I'm around!

Emma attended her first of many music therapy session later that day. Through reflection and supervision, realizations were made regarding my response that may have contributed this change: accepting her declinations and matching her mood. Sessions consisted of guided meditation, song listening and verbal dialogue with the use of counseling skills (Appendix C). Song listening led to lyric analysis and discussions which revealed many personal aspects.

Independent exploration was encouraged outside of therapy using a binder, CD's of preferred songs, and printed lyrics. Emma wrote poems with recurring themes of anger and rage due to her accident. The goals for the treatment plan were to increase self-expression, develop coping skills and reduce depressive symptoms. By the tenth session, a pivotal moment occurred when Emma wrote a poem about the beauty of life. Composing poetry became an outlet for expressing her emotions, which lowered agitation towards staff in other treatment modalities.

Towards the end of treatment, Emma viewed her binder of poems as a book of knowledge. With a new sense of autonomy, she organized an 'open mic' program at the facility where she shared her poetry with others.

Resistant to attend music therapy initially, this client exceeded treatment goals over the course of a fourteen session treatment process. Music therapy interventions developed naturally within the relationship. It is my belief that matching her mood and accepting her choices initially decreased resistance, allowing for the progression of building rapport while slowly incorporating client preferred music into the sessions was highly effective in achieving goals. The purpose of this study is to provide insight to resistance by interviewing music therapists who reveal their personal experiences. Many also share techniques to work through resistance in groups and individual practice.

Participants

Eight board-certified music therapists participated in this study by responding to ten interview questions in person, over the phone, or via email. A collective list of professionals and renowned clinicians located in the United States was provided to the researcher by clinical supervisors and local colleagues. Participants were selected following four specific criteria for this study: professional reputation, current position, populational experience, and expertise. For professional reputation, practitioners included have a history of experience working with a number of populations, who can share multiple experiences with resistance.

The current position of participants was considered, choosing those who are credentialed and currently practicing. Their backgrounds of experience with populations was another aspect, ranging from music therapy with all ages: children, adolescents, young/middle aged adults, older

adults. Multiple populational experience include: individuals with disabilities/various special needs, medically fragile conditions, substance abuse and memory impairment. Lastly, clinicians chosen have areas of expertise in active and receptive methods of including Nordoff-Robbins, Analytical Music Therapy, and the behavioral model.

An invitation letter, consent form and proposed interview questions were provided to each individual via email to describe the purpose of study, interview length, steps involved, risks and benefits of participation. By technologically signing the consent form, eight music therapists agreed to participate. In the following sections, clinicians are labeled anonymously from A-H for confidentiality purposes, however populational experience is provided for consideration (see Appendix A). Demographics of participants is provided below (see Table 1). All aspects of this research study have been reviewed and approved by the SUNY New Paltz Human Research Ethics Board.

Table 1
Demographic Characteristics of Participants

Characteristic	Number	%
Gender		
Male	3	37.5
Female	5	62.5
Age		
20-29	2	25
30-39	1	12.5
40-49	2	25
50-59	3	37.5
Education		
MA	6	75
Ph D.	2	25
Main Populational Experience		
Medical Setting	2	25
Rehabilitative Setting	2	25
Geriatric Facility	2	25
Intellectual Disabilities	2	25

Design

Qualitative research studies aim to discuss, question, and understand a problem, conflict or theme. As described by Forinash (1995), this approach "allows the research to examine experience as it is lived" (p. 368). This study reveals if resistance manifests within a music therapeutic relationship and develops into further questions regarding many aspects of the experience. Phenomenology is used as it describes lived experiences of a phenomenon (Smith, Flowers & Larkin, 2009).

The design of qualitative research is derivative of social constructivism, the sociological belief that humans gain knowledge from interactions with each other. Therefore, a phenomenological, constructivist approach is necessary to address the research questions. According to Malterud (2001) qualitative methods "are founded on an understanding of research as a systematic and reflective process for development of knowledge that can somehow be contested and shared" (page 483). Therefore, trustworthiness of qualitative studies relies on reflexive and critical humanism, particularly the ability to relate through stories. Useful information is embedded within substantive stories/experiences shared in clinician interviews (Malterud, 2001).

Protocols were established throughout the research process to meet criteria of trustworthiness: credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). Several techniques were implemented to establish reliability and trustworthiness. All protocols and techniques implemented in this study were documented, including dates and times of action. Trustworthiness criteria was met through the technique of journaling. The researcher recorded significant activity throughout the research process for organization and documentation.

Dates/times of clinician interviews and supervision meetings were recorded as well as revisions and developments of themes. The journal provides an overview of the process from start to finish, including the obstacles faced and progressions made which led to valid themes.

Specifically, this research is a qualitative, phenomenological interview study in which ten open-ended questions were asked to capture the essence of an experience. As interpreted by each clinician, experiences with resistance are derivative of various factors. Phenomenology was chosen as the research methodology in order to describe the lived experiences by the clinicians. The researcher distilled themes through a coding process using interpretive phenomenological analysis (IPA), an approach of qualitative research that focuses on the experience of a given phenomenon. Themes are distilled from coding and use evidence from interview responses to identify causes, forms, and appropriate responses to resistance. With an idiographic focus, IPA was used in this study because results revealed experiences of participants gaining insight on the phenomenon of resistance.

Data Generation

The data collection procedure used for this interview study involved six steps of analyzing data, specific to phenomenological inquiry (Forinash and Grocke, 2005). Throughout data collection procedures, I consulted with my research advisor to confirm trustworthiness and credibility of the steps.

(1) After transcribing the interviews and printing copies, each interview was read for an overall understanding of the position, language, and view of the clinician.

(2) I re-read the interviews and began identifying significant quotes by circling them with black ink, which revealed similarities in responses from multiple clinicians.

(3) I examined the circled statements to understand their meanings, as well as their significance to this topic.

(4) I condensed these meanings into three general sections categorized as: managing resistance; the role of music; clinicians' reactions. The three sections are general to categorize more specific themes developed.

(5) Returning to the interviews, I re-evaluated the text to ensure that circled quotes could be placed under the three general sections.

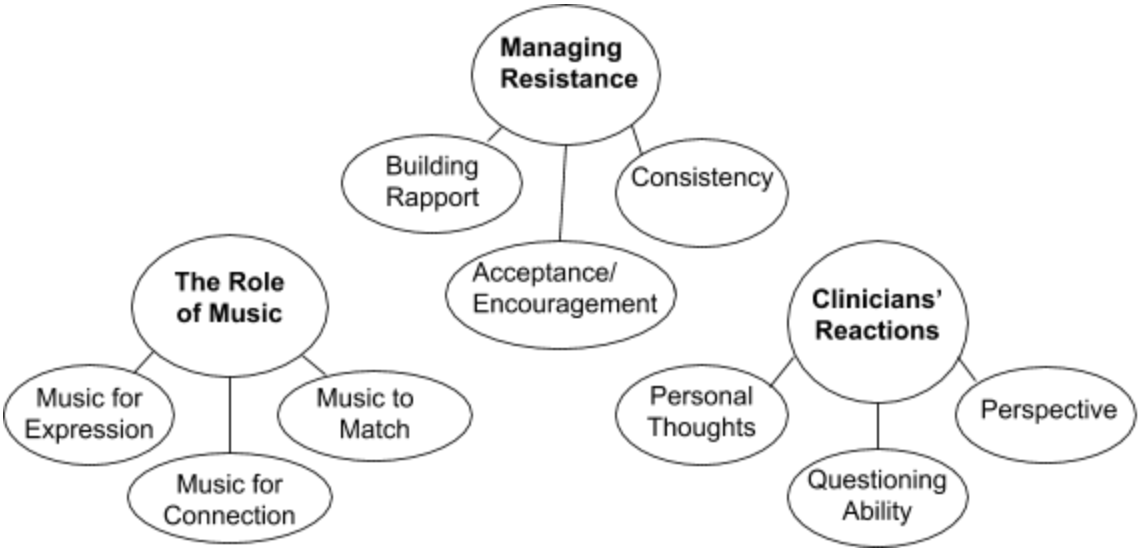
(6) I developed specific themes by re-examining circled quotes in the interviews (step two). While considering all material, I underlined similar responses and recurring statements across clinicians using different colored ink to represent different themes.

After underlining similar quotes with colors, I categorized nine specific themes into three broad sections (see Appendix B). Following IPA, this last step utilizes direct quotes of narrative experiences to support themes while providing insight of the experience (Smith, Flowers, Larkin, 2009). Connections were made between clinicians' responses from experiences and personal reactions shared within the interviews, and then categorized into results of our research question.

Results

Results reveal three categories with nine themes which address the question: How do music therapists experience resistance in music therapy? Furthermore, themes present strategies and techniques for managing client resistance. Each general category includes three specific themes which support the belief that resistance manifests within a music therapeutic relationship (see Table 2).

Table 2
Categories & Themes



Managing Resistance

There were three consistently mentioned methods used to prevent and resolve client resistance. These methods are to build rapport, to embody acceptance and encouragement of the client, and to maintain consistency in the therapeutic process and relationship.

Building rapport. The most common method used to prevent and reduce resistance was building rapport. Rapport refers to the development of a therapeutic relationship to instill trust, safety, and communication. The music therapist can initially build rapport by asking open-ended questions and making small connections. The importance of establishing rapport was noted by every participant (see Table 3).

Table 3
Building Rapport

Participant	Supporting Quotations

Clinician A	How can I connect with this person? Not fix them... not having the agenda of fixing or getting particular responses. How can I provide a relationship which this person may use for their own personal growth?
Clinician B	If my response is to try and build rapport, that will eventually make the client comfortable.
Clinician H	It is all about building a rapport with your client and learning how to foster interests and facilitate an intervention to address their needs. Over time, the therapist can connect a clients interests to a music therapy intervention, which can target specific goals for healing.
Clinician E	I usually try to gain the person's trust without pushing. I try to learn what makes each individual tick... and in the case of resistance I ask myself, how can I slowly add music to their therapy without scaring them away? I wanted to help this patient succeed, but I had to wait until he was ready to participate in his own treatment.

Clinician A emphasizes the importance of building connections within the therapeutic relationship for effective therapy. The benefit of building rapport to acquire client likes and dislikes enhances individualized treatment planning and may prevent resistance according to Clinician H. Incorporating a clients interests/hobbies into an intervention can increase participation and engagement. Clinician E learns about her client through building rapport before implementing music therapy interventions. The therapist is able to incorporate interventions at a comfortable pace, and recognize client limitations. For example, observing when to provide

space. Building rapport is beneficial as it provides insight about a client from what is communicated through verbal engagement, and what is observable in behavior. Through comprehension and recognition of resistive behavior, the therapist deciphers possible causes, and discovers resolutions.

Acceptance and encouragement. The second theme refers to the psychological desire to be accepted, as well as the intrinsic motivation to improve. Combined, the two terms represent a many techniques discussed in interview responses (see Table 4). The concept of accepting the client includes the acceptance of resistance.

Table 4
Acceptance/Encouragement

Participant	Supporting Quotation
Clinician A	Resistance means that the person is in some way coming up against their boundaries, their limitations, their comfort zone. And of course that is the whole essence of therapy, to move someone outside of that. So there can be no therapy without resistance. My response is to stay patient, and whatever the client did or didn't do was okay.
Clinician C	Some may take a longer amount of time than others, but all responses are accepted, while encouragement from me continues.
Clinician B	This process of making choices is really drawn out. If you push her, it becomes less from her and more from me. She can make these decisions and find what the choices are but then we make little progress. Then, I think there's a fear inside her that we're going to finish this, and she pulls back, which could be a fear of completing something.
Clinician E	I was now in the physical place of resistance. I was able to show her that I would be with

	her no matter what, that I respect her. Within a few moments, she was singing through the music at the top of her lungs in the sunshine with the cigarette forgotten on the ground.
Clinician A	I allowed these individuals the space to just attend. After letting them sit there for 3-4 weeks, all of a sudden they started to do something with me. I believe this is from accepting their need for space. I don't believe everyone responds with the same timeline or the same degree.
Clinician H	Unsure of what to do, I encouraged him to try the first activity of the drum group, and I placed a lap drum in front of his seat... He played the entire time! At the end, he said he felt better than he did before and smiled like a child when playing. I told the group that feeling childish can be a good thing!
Clinician D	I provided verbal and nonverbal encouragement, but I felt that this client was in charge and she needed to have that authority.
Clinician C	Allowing them to vent, then validating their experiences and encouraging them to move on can be a helpful technique. We must be open to inspire our patients and families to see things as they are. In this way, we can meet in the therapeutic middle and have a chance for true healing.

Accepting client responses and behaviors is a way of validating their present selves, while decreasing fear and vulnerability. Clinician B shared an experience working with a client who made progress in interventions/projects, but then chose not to complete them. Though the

clinician admitted personal frustration, he showed full acceptance of her decisions, which he believed led to further discoveries about this client.

Clinician E described a situation working with a young woman who consistently asked to leave to smoke a cigarette during their sessions, which became a convenient object of resistance. In an effort to show acceptance, the therapist began to join and continue the music intervention outside. Clinician A shared an experience leading group music therapy in a mental illness program. Though all clients were mandated to attend, some chose not to participate. Instead of reinforcing, the clinician found success by accepting this need for initially.

Acceptance without motivation to improve may hinder the process of change. While leading a drum circle with adults, Clinician G shared an experience of a client laughing at her as she distributed instruments, stating that the group was childish. The short line of encouragement was effective in resolving initial resistance. Leaving the drum conveyed encouragement to participant, but that whatever he chose would be accepted. Clinician D shared an experience evaluating the clients needs at that time in her life while simultaneously encouraging her through verbal and nonverbal cues. Clinician C shared that being honest can be helpful for the client and/or family members, along with validation and encouragement to move forward.

Consistency. The regularity of music therapy sessions was mentioned by many clinicians (see Table 5). Consistency may lead to predictability which leads to security and safety within the therapeutic relationship.

Table 5
Consistency

Participant	Supporting Quotation

Clinician B	I decided that staying with the client regardless was the right move, even if there was no music going on. Even just the consistency of the sessions is effective in itself.
Clinician A	I would try and take him to the drum kit, knowing it wasn't going to work. However, that doesn't mean I ever gave up. This week, he sat down and played at the drum kit for at least 20 minutes. He sat there and he played! Amazingly enough, at the end of that session, he mumbled what sounded like goodbye. This from a boy who has never spoken in his entire life. I remember working with him since the age of 5, when the speech therapist said he would never speak. Maybe it was a matter of trust in me or himself, or a matter of trust in music as something fulfilling rather than threatening. I continuously stayed in the game. I kept persistence! Low and behold, something would happen.
Clinician B	I'm used to a lot of waiting and consistently trying with my clients, constantly operating under that. It takes time either way!
Clinician D	Trying non-music approaches such as conversation about various topics that the client may have shown interest in. Trying different kinds of music, not just the known preferences of client.

After struggling with client resistance, clinician B considered termination in an individual session. Through supervision, he made the realization that consistency was valuable. The ability to rely on music therapy sessions could be affecting the client more than expected. This theme

was verified by clinician A, who shared his experience working with a young man consistently for eight years, experiencing chronic resistance throughout. Along with consistency, a similar term to point out is persistence. After eight years of consistent sessions but little progress observed, he witnessed a pivotal moment after making persistent efforts to connect. Through reflection, he attributes this moment to the trust and consistency established. The clinician explained that most parents give up on music therapy when results are not observable, or easily attained. Part of consistency and persistence, is the ability to try various approaches, as noted by clinicians B and D. Each client may react differently than another. Continuous attempts and perseverance may attribute to the final establishment of connection.

The Role of Music

Interviewing music therapists revealed unique qualities of music that can aid in three goal areas: expressing emotions, building connections, and matching client mood. Each factor contributes to the overall therapeutic process and may lead to positive change.

Music for expression. Inherent in music therapy practice, music is often used for clients to express themselves. There are multiple music therapy methods to encourage emotional expression and are adaptable for varying populations. Interview responses mentioned such expressive qualities of music as a potential method of reducing resistive behavior (see Table 6).

Table 6
Music for expression

Participant	Supporting Quotation
Clinician B	Take the resistance and use music to express it! Then you can redirect it and shift the mood.

	This clients form of expressing himself in any way, was almost painful. Everything I tried, he said no. Even if I did the opposite, it was a bigger no, however it was easy to support expression with music. I started singing a popular song that the whole group would know that included the word no continuously. I left out the word and cued this client to fill it in. It went from this uncomfortable situation affecting the group to a musical automatic response.
Clinician F	If a child with emotional disturbance is experiencing resistance as anger toward you, you could write a song about feeling angry, play a song that sounds like anger, or sing a song with angry lyrics. If a child with developmental delays is expressing resistance by throwing their mallets, you might leave the mallets on the floor and offer a hand drum to better express the frustration.
Clinician E	Resistance can be used with music to help a client push past their main issues. When you realize that there is almost always something causing the patient to be resistant, you use music to uncover the source and work through it to express this with them.

When resistance manifests in observable behavior, music can support underlying emotional causes and fears in the moment. In an experience leading a group session, one client expressed verbal opposition continuously. Clinician B found success in choosing music that enables his client to express this vocally and feel the support of music to channel that energy. The oppositional behavior turned into an effective intervention for building rapport, expressing emotions and sustaining engagement.

As clinician F suggested, emotional responses can be expressed and processed through interventions such as songwriting, instrumental playing, improvisation, therapeutic singing, and more. The root of the behavior may be observable and resolved in the moment. For example, clinician F referred to a simple switch of instrument, allowing for the release of emotions through instrumental playing. The complexity of resistance may be difficult to express with words. Clinician E shared that resistance is always caused by something, which can be discovered and resolved through the musical expression.

Music for connection. Music has the ability to reach individuals of various backgrounds, ages and cultures according to interview responses (see Table 7). Though each individual has a unique relationship with music, it's an agent which naturally builds relationships with others.

Table 7
Music for Connection

Participant	Supporting Quotation
Clinician C	I had a patient who could no longer speak as a result of his illness. I knew he was a lover of classical music. When I first visited him, I asked if there was anything I could do for him, to which he responded by pointing toward the door! I kept coming back to visit, sometimes just to sit with him as he slept. Eventually, he let me play my flute for him, something I had not done in years. My technique was a little rough, and he often shook his head to say no when asked if he liked the music, but he did so with a smile.
Clinician E	When a particular patient saw his peers/other patients participating in music therapy to strengthen their hands and arms, he decided to give it a try. At first he played the drum while another patient played a melodic instrument. This gave us a chance to build therapeutic trust and connections in a relaxed atmosphere

	before starting to work individually and focus on his functional goals.
Clinician F	I can create a session that is respectful of her individuality while showing her that no matter how our sessions look, there will be opportunities for creativity, self-expression, focused joint participation, and the aesthetic beauty of connection.
Clinician A	When I stopped trying to get him to do a specific action, I found that I was able to feel a real connection, especially through music, which is doing something way more meaningful.

Clinician C made continuous efforts to connect with a client in hospice care who was reluctant to music therapy at first. Eventually, a connection was made between music, specifically when the music therapist played her flute imperfectly. Over time, the therapeutic relationship grew, and led to the inclusion of his wife. The clinician performed at his funeral and remains in contact with his wife.

In the example provided by Clinician E, a client refused to attend sessions due to physical impairments and a stated disbelief in music therapy. The resistance was resolved as the client witnessed peers achieving similar physical goals through instrumental playing, leading to his engagement with the group and individual sessions. Connections were built between group members as well as the therapist. Clinician F stated that each session contains opportunities for therapeutic growth, and most importantly, connection. The last supporting quotation by clinician A exemplifies the significance of connection within a therapeutic relationship, achieved through the flow of music rather than expected outcomes.

Music to match. The clinicians synonymously stated the importance of incorporating music therapy interventions which presently match the client (see Table 8). Matching the client's mood for example could include mirroring vocal tone, body language or facial affect.

Table 8
Music to Match

Participant	Supporting Quotation
Clinician F	What I had to remember was that just being together was important. It showed her I could meet her at her energy level on an unconscious level and that she was not disappointing me.
Clinician B	A client may not do something because they just can't and that's different from they simply don't want to.
Clinician A	I realized I have to communicate on his level. I had to work with who he was and communicate with only my face and eyes.
Clinician F	A client was sleeping when I arrived and didn't want to sit upright or open her eyes. I had walked into the session with some ideas of what I wanted to work on with her, but when I saw her energy level, mood, and affect, I had to throw all of my ideas out the window. I wanted her to know that I was satisfied just to be present with her.

Clinician F stated effectiveness in being present and matching the client's energy level. Session plans may be altered momentarily to meet the client where they are physically, cognitively and emotionally. When the therapist does not meet the client where they are presently, the therapeutic intervention may lose effectiveness, and the client may feel

misunderstood. Clinician B pointed out that physical impairments/disabilities may also influence behaviors of resistance. Being aware of the clients present state and initial assessment may assist in appropriate interventions and accommodations.

In a session with a client diagnosed with a severe brain injury at three years old, Clinician A quickly adapted his original plan of instrumental playing when he observed the client's inability to move limbs or sit up independently. The clinician matched his clients abilities by communicating through eye contact and facial affect, before building upon skills over time. Clinician F evaluated the present state of her client and adapted the session plan from an active intervention of instrumental playing to a receptive intervention of meditative guitar picking, which matched the current energy level and mood.

Clinicians' Reactions

The last section includes three themes regarding clinicians' feelings, reactions and emotional responses to resistance. Interview responses revealed personal thoughts, doubts in professional ability, and positive beliefs associated with the phenomenon.

Personal thoughts. Each clinician shared personal thoughts, opinions and definitions of resistance (see Table 9). Despite professional background, clinicians can experience a variety of natural thoughts, which are significant to observe and be aware of.

Table 9
Personal Thoughts

Participant	Supporting Quotation
Clinician A	It means that the person is in some way coming up against their boundaries, their limitations, their comfort zone. Of course that is the whole essence of therapy, to move

	someone outside of that zone. So really, there can be no therapy without resistance.
Clinician F	I believe the therapeutic relationship can act as a blank slate, and a client may project psychic material onto the therapist in an attempt to deal with or express resistance to change. Because the therapist exists as an advocate of the therapy as an agent of change, the client may feel the psychic discomfort of impending change more acutely, and therefore act out against it more obviously.
Clinician C	Resistance to music therapy can often mask deeper issues, such as resistance to letting go of abilities, loved ones, or life itself.
Clinician E	When someone resists the idea of music as therapy I want to pull out my soapbox and preach about the scientific facts. I know that that is not the solution, so instead, I usually try to gain the person's trust without pushing.
Clinician B	I was asking myself things like: what is he really saying no to? Can I withstand it? Are there other things I could be doing? Is it me? Or I'd think, maybe someone else would have better luck.
Clinician C	It brought up issues of countertransference for me since my mother had died a few years earlier, and I feared that as I got closer with the patient, it would feel as if I were losing my mother all over again. I feel that my initial discomfort and willingness to stay in that uncomfortable place helped make me a better clinician and more open to difficult exchanges.

Clinician A shared his belief that resistive behavior is a natural aspect of therapy, as it is used to avoid change. Furthermore, clinician F points out the representation of change associated

with the therapist and therapeutic sessions, increasing the likelihood of resistance manifesting in that relationship. Varying opinions including definitions and causes of this phenomenon were often based on clinians' primary population of expertise. Clinician C discussed resistance in hospice care, possibly representing resistance to the end of one's life.

Clinician E stated the personal desire to advocate for music therapy, however she emphasized gaining trust by building a therapeutic relationship at a comfortable pace as more effective. Though common to experience exasperation when receiving minimal energy/responses, it's important to recognize that it has nothing to do with the individual or therapist personally. As the therapist, there is responsibility to make countless therapeutic decisions throughout a session which may lead to self blame as stated by Clinician B.

Clinician C experienced countertransference while seeing a client in hospice care who reminded her strongly of her mother. The Freudian concept of countertransference occurs when a therapist experiences personal associations or feelings in relation to their client. As the appropriate response, the clinician met with a bereavement counselor to discuss these feelings associated with her loss and work through the countertransference in her own personal growth process.

Questioning Ability. Personal thoughts and evaluations as the therapist may occur if the cause of resistance is unknown. Questioning capability of skills as a music therapist emerged as another common concern amongst interview responses (see Table 10).

Table 10
Questioning Ability

Participant	Supporting Quotation

Clinician C	It was very challenging for me. Knowing how quickly she would decline physically, and how much the music therapy meant to her, it was frustrating not to be able to be present for her more often. I questioned my effect on her, and why she only wanted sessions once a month.
Clinician D	I can recall feeling inept in my clinical skills when I felt I was not breaking through resistance. With experience, I no longer feel that way and allow whatever time is needed.
Clinician F	Whenever a client is resisting treatment, there is usually a moment where I doubt my own effectiveness. I might wonder whether music therapy really is an effective modality for this person, if I am the right fit as their therapist, or whether there is something I am missing.
Clinician A	I've learned by now to not take it personally or get insecure because I've realized that resistance is only disconnect, and that each case is different. There will always be a time of connection.

When a client in hospice care requested music therapy only once a month despite her positive reactions in sessions, clinician C expressed personal difficulties accepting this decision. Despite her professional opinion of weekly sessions, she respected the client's wishes. Clinician D questioned her abilities at times, but stated that clinical experience diminished this thought due to prior experiences with more populations. Clinician F has questioned her skills, as well as the effectiveness of music therapy.

Inferred from similar responses, resistive behavior from a client can cause the therapist to shift focus from the client, to personal feelings and realizations. From an opposing view,

clinician A stated professional growth from experiencing resistance, which decreased his insecurities of professional abilities.

Perspective. Despite negative connotations, clinicians discussed the positive aspects of resistance (see Table 11). Therapeutic opportunities may develop from client resistance. Observing behaviors of avoidance in therapy can be indicative of client reactions to stimuli/situations outside of therapy.

Table 11
Perspective

Participant	Supporting Quotation
Clinician H	I was able to break through resistance with a client when I changed my approach to positive instead of negative.
Clinician F	If a certain approach reaches a client, the therapist can observe the positive response and utilize a similar approach in future sessions.
Clinician G	For your consideration, therapists don't break through resistance, clients break through resistance.
Clinician A	Resistance is a term of psychotherapy that is to expected. It's not something that means the therapy is going wrong or that as a therapist you are doing anything wrong. The concept of therapy is to do work, when you are the therapist, not a recreational aid.

Resistive behavior can be revealing of personality traits, responses to emotions, and even unconscious stimuli. Clinician E points out that there is usually a cause of resistance which may be uncovered within the therapeutic process. Clinician H states that changing their approach

worked positively to breaking through resistance. Similarly, clinician F explained the phenomenon as a learning experience; if an approach worked previously, it may be successful again in future scenarios. The therapeutic relationship may be one of the few situations for a client to relay discomfort of change, even with strong desire to reach goals.

Having a positive perspective can lead to improved therapeutic outcomes which affects the client and the therapist. Clinician A shared his personal thoughts, stating that resistance is inevitable as therapeutic growth may require the client to move outside of their comfort zone. This quotation views resistance as a positive phenomenon as a result of growth.

Discussion

The research question of this study examined the phenomenological experiences of music therapists with client resistance. It is evident that the psychoanalytic term can occur frequently at any time of treatment for many reasons. Theories developed define resistance as a defense mechanism portrayed in conscious and unconscious forms. A method of music therapy called Analytical Music Therapy involves specific training to implement interventions which may reveal unconscious conflict. Through improvisation and verbal reflection, these conflicts are resolved in the conscious mind.

Resistance reveals many facets of the client's overall attitude and perspective. Interviews conducted with current music therapists provided client examples, effective approaches to managing resistance and clinicians' personal responses to client resistance. Participants were chosen for their differing philosophical views of music therapy and from populational experience. The aim of this paper was to gather the experiences from multiple music therapy

methods for wider variety of relativity. After exploring the information provided by these clinicians, results were coded to identify themes in relation to the phenomenon.

Three main categories and nine specific themes of resistance were identified through analysis of the data. Based on the informative responses derived from clinician interviews, the three main categories are: managing resistance, the role of music, and clinicians' reactions.

Managing Resistance

Managing resistance includes three themes of: building rapport, acceptance/encouragement, and consistency. Therapeutic relationship typically requires comfort and established trust before disclosure begins, which is called building rapport. Engaging with a client and showing genuine interest, especially during the initial assessment phase may increase client comfortability throughout. Rather than constant reinforcement, clinicians reported positive results with leaving space, allowing for the client to make decisions and participate at their pace. Learning about the client and addressing their needs allows for the client to respond in their own way and make individual progress (Wheeler, 2014). Most clinicians agreed that building a connection effective in achieving therapeutic goals. Establishing, developing, and maintaining rapport is described as a fundamental aspect of effective therapy (Grocke & Wigram, 2007).

Another aspect of trust was showing acceptance of the client and their responses, even resistive behaviors. Accepting the client's present mood along with providing encouragement to move forward can be achieved through verbal and nonverbal methods. Acceptance and encouragement were combined as the second most reported strategy for resistance management. If a client does not participate in an intervention, the therapist can show acceptance of this

choice, which validates client autonomy and separates therapist's expectations from client's wants (Otani, 1989).

Barbara Wheeler discusses the power between resistance and music, stating: "some of the most trusted working music therapy relationships have been initiated through numerous attempts met with allowance and acceptance of resistance" (2014, pg. 432). In the third and final theme, the value of consistent music therapy sessions is described as a sense of safety and security for the client. To establish routine, meeting with a client at the same time weekly is a beneficial method of preventing and diminishing resistance.

The Role of Music

The second category discussed three significant qualities of music as reported by multiple clinicians as effective in music therapy treatment. Resistance is often an unconscious response, used to avoid difficult emotions or memories. Using music as a tool to promote emotional expression could decrease this type of avoidance. Music is described as a medium of experience through which clients can identify issues and discover methods for resolution (Bruscia, 2014). The connection between music and human emotion is commonly understood, and also explored by various research studies. To promote expression of feelings, thoughts, and beliefs, music therapists implement interventions such as vocal/instrumental improvisation, instrumental playing, songwriting, song listening or lyric analysis.

Clinicians with years of experience reported that engagement through music can lead to increased attention, awareness, organization, and flexibility of the client. The therapist engages their client through the familiar, and commonly loved modality of music, building connections throughout. Musical stimuli, particularly client preferred music captures the attention and focus

of an individual, which may decrease levels of physical pain and negative thoughts. Music has the potential to replace negative thoughts with positive associations from musical stimuli. Playing an instrument, singing, or listening to client preferred music captures the clients attention and interest. This may lead to further discussion about musical preferences and further self-disclosure overall while diminishing resistive behavior.

Using the resistive behavior by incorporating it into the intervention can alter overall mood. Examples provided by clinicians indicated that validating all client responses whether positive or negative, can enhance the therapeutic relationship as the clinician does not dismiss or ignore. Instead, they may incorporate the client's response into an intervention to work through the conflict together. The last theme of matching the client relates to the importance of observing, assessing, and then meeting your client where they are physically, emotionally and/or mentally. In some cases, session plans are altered momentarily to match client mood. Then, the energy or mood may shift as the session progresses. This signifies the necessity to have a live music therapist to observe and adapt to match their client. Overall, this was reported by multiple clinicians as a method which shows acceptance and understanding of the client.

Clinicians' Reactions

The last category presents therapists responses and experiences with resistance. Most clinicians reported personal discouragement when experiencing resistance, comparing it to rejection. Countertransference was another common aspect of clinician experiences, occurring when a client reminds the therapist of someone else, typically with a personal connection. This affects the therapeutic relationship as the clinician has associations of this person outside of therapy. Introspection is essential for a clinician, especially in the resolution of

countertransference phenomena (Gelso & Hayes, 1998). As reported by clinicians, appropriate therapy sessions may continue through supervision, session notes, or personal counseling.

When exploring clinicians' personal thoughts about resistance, there was a common response of questioning professional abilities, asking themselves if they have the ability to help their clients. Clinicians reacted with professional and personal uncertainty, as well as doubting the effectiveness of music therapy. Self-awareness is beneficial for both the therapist and the therapeutic process (Norcross, 2000). It's important to observe and process these doubts through supervision and session notes. During edirect focus to the client and present moment.

The last theme of this section, labeled perspective, described resistance as a positive phenomenon. Incorporating resistive behavior into the music therapy intervention is an effective method to validate the client. From a positive outlook, resistance can certainly be effective in treatment and revealing of client aspects otherwise unnoticed. Messer (2002) stated:

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

Resistance can be very telling of the client. Some examples include: client response to interventions implying physical, emotional, and cognitive limitations; discussion topics which evoke emotional responses implying sensitivity; avoidance of particular interventions implying client disclosure comfortability. This results section has many purposes; to help define this complex phenomenon, explore its many facets throughout history and current practice, and to ultimately improve therapeutic outcomes.

Stance of the Researcher

My perspective on the term resistance has evolved tremendously throughout the research process. Ultimately, I believe that resistance manifests in various forms of therapy and can be caused by innumerable factors, varying with each individual as conscious or unconscious tactics of avoidance. As I researched this phenomenon for the literature review, it became a personal belief that we all exhibit resistive behaviors in different areas of life. It's significant to study historic and contemporary views to form an individual opinion. Overall, my perspective on resistance has shifted as a positive reaction, revealing many personality traits and characteristics of a client/group, allowing for effective assessment and treatment implementation. After reviewing literature, conducting interviews and coding data into themes, I have gained therapeutic knowledge on the psychoanalytic term, as well as appropriate methods of management.

At the start of this research, I was a music therapy student who experienced client resistance throughout internship which affected my therapeutic presence, security, and professionality. By the end, I have more confidence in my clinical abilities due to a general understanding of resistance. I gained knowledge of multiple methods of prevention and redirection, as well as the ability to empathize and comprehend the phenomenon on a personal level. Clinicians have provided authentic experiences which become therapeutic tools of knowledge for future experiences and effective treatment.

Evaluations and Limitations

Despite thorough preparation and planning, there are several limitations of this study to consider. Out of the fifteen clinicians invited to participate, this study includes results from eight

interviews. The small sample size was primarily due to varying schedules between the researcher and participants which limited time and ability to travel to meet in person. Purposive sampling was used as the music therapists were selected from a personal/referred mutual contact list and chosen for their populational experiences and reputation. An expanded sample size would have provided a wider range of perspectives, more reliability, and validity in the results.

The interviews were completed in person, via phone call or through email. Another limitation was the technological methods of collecting interview responses. Only three/eight clinicians responded to the interviews in person. Another three responded via phone call, and the remaining two via email. The methods of phone call and email lack humanistic qualities. Meeting with each participant in person would have likely produced clear responses, as the interviewer can rephrase questions, explain further meanings, and/or observe physiological responses; i.e.facial affect, body language. The study should have mandated the interviews to be conducted in person.

Scheduling the interviews at a mutually available time was difficult to accommodate due to separate work schedules and prior commitments on both ends. The interviews conducted via phone call seemed compared to in person or email responses. Two clinicians responded via phone call during work breaks, resulting in a time restraint. The last limitations to observe is that I, the researcher, conducted all interviews and coded responses into themes. Being the researcher as well as the coder could have led to unintended in interpretation. This study aimed to answer my research question with my decision making strategies to distill certain themes. The interviews conducted and coded by the same individual should be a consideration when observing results. Improvements to the reliability of this study would be to include a larger sample size of

participants and conduct all interviews in person only. Including a secondary source to review the results would have increased validity.

Implications of the Study for Clinical Practice

Resistance, manifesting frequently in music therapy can be revealing of client perspective both inside and outside of therapy. As research on this topic is limited, this study aims to provide relatable information for current and future therapists/general public. The themes presented as results are valuable tools for preventing and decreasing client oppositional behavior, leading to an enhanced therapeutic process. Along with their professional judgement, therapists can refer to results to guide clients away from resistance and towards goal oriented progress, as well as exploring their own personal reactions.

Most clinicians agreed that building a connection is extremely effective in achieving therapeutic goals. Showing acceptance of client behaviors as well as encouraging improvement throughout therapy is another tactic for preventing resistance. Consistent therapeutic presence and efforts is the third technique presented. We can infer that music plays a significant role in achieving a beneficial therapeutic relationship as it is used for expression, connection and matching purposes. Another implication of the study is evident in clinicians' personal responses. Readers may resonate with personal thoughts, questioning abilities as a clinician when receiving resistance, and with the final positive perception. Resistance can be utilized in therapy for effective treatment when understood and recognizable.

Recommendations for Future Research

Through phenomenological measures, readers of this study gain insight from true experiences discussed in their entirety. The effectiveness of the results varies as each clinical

situation is complex and individual. Future research on the topic can extend these findings through a wider range of participants and particular interview questions on the themes presented in this study.

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Appendix A

Clinician Code	Populations
Clinician A	Adults with substance abuse disorders; children and adults with disabilities; Adults with acute and chronic mental illness; severely abused children; adults with traumatic brain injury; older adults with dementia.
Clinician B	Medical setting with medically complex children residing in a pediatric hospital.
Clinician C	Hospice and palliative care; older adults, dementia and medical settings.
Clinician D	Elderly; wellness; cognitive or physical impairment and hospice in senior day centers, day care, assisted living, skilled nursing and private homes.
Clinician E	Children with emotional and developmental disabilities; adults in outpatient psychiatric treatment; elderly clients in long-term care; adults in neuro-rehabilitation.
Clinician F	Infants in daycare setting; early intervention/pre-k and kindergarten-aged children with special needs; birth - 21 in palliative care; children, teens, and young adults with special needs in co-occurring psychosocial-medical conditions; adults with developmental delays, typical adults in bereavement, depressions, anxiety, personality disorder; older adults in assisted living and alzheimer's disease.
Clinician G	Hospitalized psychiatric patients; children,

	adolescents, and adults with a wide range of needs, abilities, and disabilities: autism spectrum disorders (ASD), behavioral disorders, developmental delays, sensory impairments, multiple handicaps, and psychiatric disorders.
Clinician H	Children, adolescents and adults with various special needs; adults with traumatic brain injury; adults in rehabilitative facility; older adults with alzheimer's disease/dementia in assisted living.

Appendix B

Color-Coding example (Clinician A)

Pale Blue	Personal Thoughts
Pale Green	Music to match
Pink	Acceptance
Orange	Consistency
Purple	Acceptance
Bright Green	Music for Expression
Red	Perspective
Green	Encouragement

3. If so, does this resistance tend to occur towards the beginning, middle, or end of treatment?

"It doesn't matter. Resistance means that the person is in some way coming up against their boundaries, their limitations, their comfort zone. And of course that is the whole essence of therapy….. to move someone outside of that. So there can be no therapy without resistance."

4. Describe a time when a client resisted music therapy (include population and age range).

"I have an interesting case now in my private clinical studio working with a 13 year old boy with serious Autism. He is nonverbal, and has always been so difficult to connect with. His parents, for whatever reason, never stopped….since the client was 5 years old and began working with

me. This client will leave you and walk to another part of the room during an intervention. At one point, he was throwing things…. drum sticks, or whatever. And you would try to get him to play something, and he wouldn't play! And it just goes to show, there's no timeline with this. It was years of this 'resistance' or inability to do anything that felt like we were connecting or anything productive besides a very short period of time. And then one day, probably around 2013, all of a sudden he somehow decided somewhere inside, that 'I like this...I don't want to get away from it." Maybe it was a matter of trust in me or himself, or a matter of interest in music as something fulfilling rather than threatening. Maybe he was seeking self expression. Resistance is a response to a threat. Something turned where, okay…. now he's moving towards music rather that away from it. And that took a few years. His parents never gave up and most people do."

"I worked once with a little boy who had a severe brain injury at 3/4 years old and he couldn't sit up. He couldn't do anything with his limbs. I kept trying to figure out... what can I do with him? But I realized I have to communicate on his level….taking his hand and making him play a drum has no meaning for him because he can't use his hand. I had to work with who he was and communicated with only face and eyes. When I stopped trying to get him to hit an instrument or do a specific action….I found that I was able to feel a connection...which is doing something more meaningful for him."

5. During this experience, what was your initial response to the client's verbal and/or non-verbal resistance to music therapy?

"My response was to stay persistent with similar interventions with this client, and not give up. I had been working with this client from the age of 5, to now 13 and am just starting to see some response. My response was to stay patient, and whatever the client did or didn't do...was okay."

6. What were your personal reactions/thoughts to the resistance?

"It doesn't bother me, I don't really care... how difficult someone might seem to be, I think it is part of the whole thing. I don't get frustrated and I don't take it personally or get insecure. It's more about figuring out how to connect with this person. I don't know if I made this up or someone else, but I'd say: there's no such thing as resistance, only disconnect. Each case is different. There is always going to be a time during the treatment, where all of a sudden, it connects." Part of the resistance could be the level of disability. If someone had a stroke and they can't move their left side so they can't walk, the physical therapist isn't going to blame resistance."

7. Did the music therapy treatment

continue or terminate?

"Yes, music therapy has continued for eight years and will continue to occur once a week, so long as his parents continue to bring him. They haven't given up yet. With any of my clients, I would never say to terminate. I've told parents what was happening in the session…. if the child was running away or something, but I would never say: this isn't working. Some decide on their own it's not working and they stop coming."

Appendix C

Counseling Skills

Open ended questions: questions which require more than a simple 'yes" or "no" response. These types of questions will evoke self expression, encouraging the client to share more information with the therapist.

Mirroring: occurs when the therapist reflects back to the client whether word for word, or in their own words, the idea or sentence just stated by the client.

Self disclosure: a technique that should be used carefully, as if used improperly, could break professional boundaries. It is a technique in which the therapist can briefly share a personal story or experience that connects with the client. This may build rapport and trust within the therapeutic relationship, help the client to not feel alone, and increase the genuinity of the clinician.