THE EFFECTIVENESS OF GROUP MUSIC PSYCHOTHERAPY IN IMPROVING THE SELF-CONCEPT OF BREAST CANCER SURVIVORS

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Several studies have investigated the psychosocial impact of breast cancer, however, there is a paucity of research examining interventions geared towards breast cancer survivors. This study investigated the effects of group music psychotherapy on improving the self-concept of breast cancer survivors. Eleven breast cancer survivors where randomly assigned to one of two treatment groups – group music psychotherapy or a cognitive behavioral based support group. Pre and post intervention comparisons were made using the Body Image After Breast Cancer Scale and the Tennessee Self-Concept Scale on measures of identity, role performance, self-esteem, and body image. After ten weeks, results from the Wilcoxon U test indicated participants in the music psychotherapy group significantly improved on measures on identity, family role relationships, self-esteem, and body image. Furthermore, as compared to participants in the cognitive behavioral support group, participants in group music psychotherapy improved on measures of identity, role relationships, and body image. Implications and suggestions for further research are discussed.
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This dissertation is dedicated to all the survivors of cancer, their family and their friends.
What I have learned from you is invaluable, thank you for opening up and letting me be a small part of your journey.
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CHAPTER ONE
INTRODUCTION

Breast Cancer

Breast cancer is the most commonly diagnosed cancer among women in the United States, accounting for more than one in four cancers. Currently, approximately thirteen (13) percent of women, or nearly one in eight, are diagnosed with breast cancer. It is estimated that in 2008, 182,480 new cases of invasive breast cancer and another 67,770 cases of in situ breast cancer will be diagnosed in American women (American Cancer Society, 2008). But while breast cancer rates are rising in most western countries, deaths from breast cancer have decreased as a result of improved screening and treatment. According to the American Cancer Society (2008), when breast cancer is confined to the breast, the five-year survival rate is approaching 100%.

Many cancers have changed in definition from incurable diseases to chronic illnesses, and so has the definition of a cancer survivor. The National Coalition for Cancer Survivorship (NCCS) embraces a broader definition, proposing that cancer survival begins at the moment of diagnosis and proceeds along the continuum through and beyond treatment to remissions, recurrences, cure, and the final stages of life. Today, many health providers differentiate between survivors who are receiving therapy of any kind and survivors who have completed treatment (Leigh & Clark, 2002). Mullan (1985) outlined a model of life after a cancer diagnosis that consists of three stages: acute, extended, and permanent stages. The acute stage begins at the moment of diagnosis and extends through the initial treatments such as surgery, chemotherapy, and/or radiation.
Those newly diagnosed may be dealing with a fear of dying, treatment related side effects, and disruption in family and social roles (Leigh, 2005). Next is the extended stage; survivors in the extended stage may be in remission or receiving the maintenance therapy of Tamoxifen. Issues that generally arise during this stage include severing of treatment based support-systems, feelings of ambiguity related to the joy of being alive and fear of recurrence, adjusting to physical or psychosocial changes, reintegrating and reorganizing individual and family concerns, isolation secondary to external or self-imposed forces, and seeking community-based support groups (Christ, 1991; Fredette, 1995; Rowland & Massie, 1998; Leigh, 2005). Last, the permanent stage of survival represents a time of diminished probability for disease recurrence. Within breast cancer, permanent survivors may still be adapting to a number of physical and psychosocial changes not limited to lowered self-esteem, diminished social support, and workplace discrimination (Leigh, 2005). The focus of this study will be on those survivors in the extended or permanent stages of survival.

Significance of Self-Concept

Many patients and families will attest to a concern that nearly all control within their lives is lost during diagnosis and treatment for cancer. However, this loss of control may be amplified post-treatment, secondary to no longer actively doing anything to battle cancer. While many may think the last day of treatment will signal the end of a “challenge,” most women report ongoing physical and emotional issues (both intermediate and long-term) associated with breast cancer survivorship (Rowland & Massie, 1998). While one’s sense of self is normally relatively stable, cancer can cause a
woman to question her place in the world and to rethink who she is. Additionally, changes in the body (both appearance and functioning) and role performance resulting from a chronic illness can profoundly affect the sense people have of themselves. This impact may be long-term or delayed (Leigh, 1998; Moore & Hobbie, 2000). As individuals begin to deal with the physical and emotional impact of treatment, they may begin to understand that a new person has evolved with new responses and uncertainties (Shell & Kusch, 2001). Adult cancer survivors admit that to recognize and accept the “new” self, they must grieve the loss of the “old” self as they once knew it (Nessims & Ellis, 1991).

Self-concept is an individual’s conceptualization about how he or she thinks about himself or herself (Gale Encyclopedia of Psychology, 2001). It is a subjective sense of the self and a complex mixture of unconscious and conscious thoughts, attitudes, and perceptions (Potter & Perry, 2005). Furthermore, it influences thinking, talking, acting, how one sees and treats others, the ability to give and receive love, the ability to take action and change things, and the choices one makes (Potter & Perry, 2005). Self-concept provides a frame of reference that affects the management of many situations and relationships with others. In relation to illness, examples of situations that can have an effect on a person’s self-concept include hospitalization, surgery, the loss of bodily function, a decline in activity tolerance, and difficulty in managing a chronic illness (Potter & Perry, 2005). Furthermore, what individuals think and feel about themselves affects the way in which they care for themselves both physically and emotionally, as well as the way in which they are able to care for others. For example, individuals with poor self-concepts often do not feel in control of their situations and may not feel worthy

Identity involves the internal sense of individuality, wholeness, and consistency of a person over time (Potter & Perry, 2005). Aspects of identity include demographical information, beliefs, values, personality, and character as well as structural characteristics. Chryssochoou (2003) suggests that identity is a particular form of social representation that mediates the relationship between the individual and the social world. Furthermore, identity functions to inscribe the person in the social environment, to communicate positions, and to establish relationships with others (social recognition).

Being diagnosed with a chronic illness brings forth an added component to one’s identity and can cause increases in anxiety, depression, and fear. Kaiser (2008), in a qualitative study of breast cancer survivors, reports being given the identity of a “survivor” can result in substantial increases in anxiety related to fear of recurrence.

Body image issues are often associated with impaired self-concept. Body image includes one’s perceptions of shape, size, appearance, structure, and significance of one’s own body (Potter & Perry, 2005). Feelings about body image also include those related to sexuality, femininity, health, and strength. The majority of women, in general, experience some degree of body dissatisfaction, which can affect their overall self-concept. But disturbances in body image can be greatly exaggerated when a change in health status occurs. Research indicates that over fifty-percent (50%) of breast cancer survivors experience body image problems (Fobair et al., 2005; Ganz et al. 1998a,b). Physical changes may involve loss of body parts, scarring, disfigurement, weight changes, adjusting to prosthesis, and adjusting to limitations in functional ability
These changes may evoke feelings of mutilation, diminished self-worth, loss of a sense of femininity, decrease in sexual attractiveness and function, and feelings of anxiety, depression, guilt, shame, and abandonment (Shakin-Kunkel & Chen, 2003). Furthermore, studies assessing investment in Concern About Appearance (a belief that a woman must look good to feel good about herself) and Concern About Body Integrity (a belief that when something goes wrong with a person’s body that person is never really whole again) indicated that concerns about body integrity lead to emotional distress, greater loss of the sense of attractiveness and sexual desirability, greater disruption of social activities, several indicators of psychosexual disruption, concerns about further adverse outcomes from treatment, and estrangement from the self (Carver et al., 1998; Petronis et al., 2003). Last, body image is important to younger and older (Figueiredo, et al., 2005) breast cancer survivors and has lasting implications on levels of emotional distress (Carver, et al., 1998; Yurek et al., 2000; Petronis et al., 2003).

Role performance is the way in which an individual perceives his or her ability to carry out significant roles (Potter & Perry, 2005). Common feminine roles include mother, wife, daughter, employee or employer, sister, and friend. Each role involves meeting certain expectations, and fulfillment of these expectations leads to an enhanced sense of self. Difficulty or an inability to meet role expectations often contributes to an altered self-concept. Shifts in roles or family responsibilities among women and their partners and/or children are not uncommon (Walsh et al., 2005). While some families continue to maintain daily routines despite the addition of major stressors, others report a severe disruption of family life (Kuhn & Dow, 2003). Northhouse et al., (1998) and
Holmberg et al., (2001) found that couples facing breast cancer reported greater decreases in their marital and family functioning, more uncertain appraisals, and more adjustment problems; this includes adjustments in conflict resolution and less open communication associated with the illness when compared to couples with a benign diagnosis. Walsh et al., (2005) report that 61% percent of mothers report negative effects of breast cancer on their relationship with their children. This included feeling a huge loss in quality of time with their children, loss of their maternal role, and shifts within the overall family dynamic. Last, employment and insurance discrimination can force survivors to remain in the “sick” role long after they are ready to move forward with their life. Denial of a promotion, loss of a job, denial of benefits, hostility in the workplace, and difficulty obtaining health and life insurance can all be additional reminders of a cancer diagnosis (Clark, 1995).

Self-esteem is the emotional appraisal of self-concept. It represents the overall judgment of personal worth or value and includes self-efficacy and self-respect (Judge & Bono, 2001; Bertero, 2002). Self-esteem is an ongoing mental process and an important variable in determining how an individual functions in the world (Potter & Perry, 2005). Furthermore, the relationship between self-esteem and psychological well-being (e.g., absence of depression, social anxiety, loneliness, alienation) may be an important factor in understanding the self-esteem/health relationship (Blascovich & Tomaka, 1991). Bernard et al. (1996), in an assessment of health-related personality constructs, found high correlations among self-esteem, self-efficacy, ego strength, hardiness, optimism, and maladjustment—all were significantly related to health. Last, Pedro (2001) found self-
Esteem to be the strongest predictor of health-related quality of life for long-term survivors of cancer.

Need for Study

Given these threats to identity, body image, role performance, and self-esteem, it is not surprising to find that the growing survivorship movement is calling for greater attention to life after treatment and the rehabilitation needs of cancer patients. In 2004, the Institute of Medicine issued a report examining the psychosocial needs of women with breast cancer. This report urges professionals to focus on the psychosocial needs of breast cancer survivors and research to determine the benefits of specific interventions, along with the most effective way to deliver those interventions. While several studies have investigated the psychosocial impact of breast cancer survivors, there is a paucity of research examining interventions geared towards breast cancer survivors. A review of the literature on formal support groups for breast cancer survivors found four descriptive and eight quantitative studies. All studies call for an increase in research into the efficacy of various treatment modalities.

Music therapy is an established health care profession and a complementary therapy recognized by the American Cancer Society. Music therapy is defined as “a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change,” (Bruscia, 1998, p.20). Research on the use of music therapy has focused on the physical, emotional, and spiritual needs of cancer patients. Several articles were found on music therapy with cancer patients, including nine foundational, four quantitative, two qualitative, and five case studies. Additionally, one treatment
study on music therapy with breast cancer patients was found. These will be reviewed in the next chapter. No study examined the self-concept of breast cancer survivors.

Music therapy can be practiced in individual or group settings, depending upon patient need and the goal of therapy. Group music therapy can promote social interaction and facilitate discussions that allow members to share common experiences and support one another (Waldon, 2001; Rykov, 2006; Allen, 2008c). It can help bridge communication barriers and promote reminiscence (Bailey, 1984; Allen, 2008c). Additionally, group music therapy provides a non-threatening atmosphere, which encourages both verbal and non-verbal forms of expression by matching the experience to where the person and/or family are (Allen, 2008c). In music therapy group work with cancer patients, seven articles were found, two quantitative, three qualitative, and two descriptive studies. No research was found on music therapy-based support groups specifically for breast cancer patients or breast cancer survivors.

The present study is concerned with a group form of music therapy that is based on the Bonny Method of Guided Imagery and Music (BMGIM). BMGIM is “an individual form of psychotherapy, healing, self-actualization, or spiritual work in which the client images to specifically designed programs of classical music while in an altered state of consciousness” (Bruscia, 2000, p. 7). It is a form of therapy that allows one to imagine, explore and more fully experience possible life choices in a safe and supportive environment. In relation to music therapy, guided imagery and music is a receptive music therapy technique in which the music is used and viewed as a co-therapist (Justice & Kasayka, 1999). Sessions involve a preliminary conversation, a relaxation induction, guided music-imaging, return to an alert state, and a postlude discussion. Within this
study, Guided Imagery and Music (GIM) is an “umbrella” term encompassing all types of music therapy based on music listening and imagery. This is in comparison to the Bonny Method of Guided Imagery and Music (BMGIM), which refers to the specific method developed by Helen Bonny (Bruscia, 2000).

Several studies have examined GIM with breast cancer survivors, including two descriptive articles, two quantitative, one qualitative, one mixed study and four case studies. With the exception of the two descriptive studies, all of the above studies focused on breast cancer survivors. These studies will also be reviewed in the next chapter.

In the present study, Group Music Psychotherapy (GrMI) refers to a group format of Guided Imagery & Music where the therapist guides the imagery of members continuously while listening to selected music in a relaxed state. This method is used for groups that have a common purpose or identity (Grocke & Wigram, 2007). Note that while in GrMI, the therapist continuously guides the clients through the music imagery experience; other forms of group GIM allow the clients to image without verbal intervention by the therapist. Phases of GrMI sessions include the preliminary conversation, relaxation induction, continuously guided music imaging, and the postlude discussion. In relation to cancer, one study was found on group GIM. No studies were found on group music and imagery for breast cancer survivors.

Summary

Ultimately, breast cancer survivorship would include a renewed enthusiasm for and enjoyment of life. While several quantitative and qualitative studies have outlined and described the experience of breast cancer survivors, little attention has been focused
on meeting the needs of the growing number of breast cancer survivors. Psychotherapy-based support groups show great promise, but further research is needed to determine their efficacy. The same is true of music therapy and more specifically, group guided imagery and music; therefore, this study aims to investigate the role of music therapy in meeting the needs of breast cancer survivors. More specifically, the purpose of the present study is to examine the effectiveness of group music psychotherapy in improving the self-concept of breast cancer survivors.
In the past decade, much of the research on the psychosocial aspects of breast cancer has focused on describing the emotional experiences of women with breast cancer. As survivorship has increased, research is beginning to also focus on the identification of interventions that favorably influence survivors’ psychological and social functioning. As there is a paucity of treatment studies addressing survivor needs, this paper will first review foundational studies related to the self-concept of breast cancer survivors followed by a comprehensive review of treatment studies. Foundational studies are defined here as literature that adds to the understanding of a particular issue or approach.

Breast Cancer and Self-Concept

Once the initial crisis of diagnosis and treatment has subsided, breast cancer survivors enter a new crisis—the crisis of returning to a “normal” life. Questions and dilemmas that often arise may include identity issues (“Am I a cancer patient and/or survivor?”), changes in relationships, changes in appearance, reprioritization of daily activities, control issues, and questions of whether personality or behavior affects their health. This all occurs while the patient is living with the possibility of recurrence and death (Spira & Reed, 2003). The ultimate goal of adjustment is acceptance of the condition and its associated limitations, along with a realistic appraisal and implementation of strengths (Falvo, 2005). Integrating the cancer experience into one’s
self-concept is vital to an improved quality of life for extended and permanent survivors of cancer (Zebrack, 2000).

A limited number of studies have examined important aspects of identity in breast cancer survivors. Sulik (2005), in an exploration of survivors’ feelings of personal responsibility and guilt, suggests that women must revise their gender expectations in order to define their needs and ask for needed support. Furthermore, conceptualizations of care must be broadened to include care for the self. Naverre (2004), in a study examining survival of middle-aged women with breast cancer, described the period after initial treatment as one of regaining control. This is characterized by a discovery of one’s true “self” and the creation of one’s own personal destiny as a cancer survivor. Lastly, Clark (2007) and Politi (2007) report that adopting the identity of a breast cancer survivor and the resulting emotional acceptance can be a beneficial coping strategy.

Significantly, the removal of the breast should be understood as an amputation of a body part—a body part that symbolizes sexuality, femininity, gender, and maternal issues (Shakin-Kunkel & Chen, 2003). Research on coping with body image changes stresses the importance of acknowledging changes, mourning losses, acceptance, self-care, and open communication surrounding issues of sexuality and intimacy (Coons, 2006 & 2008).

When the demands of breast cancer are superimposed on the usual demands of family life, families must not only cope with day-to-day care of children and emerging careers, but they must also cope with a life threatening diagnosis and the effects of treatment. Walsh et al., (2005) reported the areas of greatest concern for women with breast cancer were avoidance of communication and lack of partner support.
Furthermore, breast cancer patients regard positive relations as significantly more important than their matched controls (Lampic et al., 2003). In addressing role-related changes, advocates encourage survivors to approach relationships openly, avoid blame, and stay positive so that others can have a better sense of how they are feeling (Dirken, 2005). Dirken (2005) also reports that breast cancer survivors have an important role in supporting other survivors because sharing similar experiences positively impacts self-esteem and re-adjustment to life.

Women deemed to be optimal survivors of breast cancer have reported an increased self-awareness and appraisal of self that includes an exploration of their past, present, and future life (Pelushi, 1997). Dirksen & Erickson (2002) report a significant relationship between resourcefulness and self-esteem suggesting that greater resourcefulness positively impacts feelings of self-worth and is an important factor in maintaining a sense of self. Dirksen (2002) demonstrated social support to be the strongest predictor of higher self-esteem in breast cancer survivors. Moreover, it is theorized that support from significant others strengthens a person’s self-evaluation through feelings of being appreciated, respected and loved (Bertero, 2002; Dirksen, 2000).

**Therapy for Breast Cancer Survivors**

The therapeutic goals for extended and permanent breast cancer survival include developing and implementing active, emotion-oriented coping strategies; reexamining life values, beliefs and priorities; mediating the expectations of others; offering support to others; and confronting mortality (Carter, 1993; Pelusi, 1997; Spira & Reed, 2003; Westbrook, 2006). Group psychosocial interventions are the most widely available and
applied methods of support for cancer patients. Furthermore, group therapies, given their
reduced cost and combined with research suggesting they are as or more effective than
individual therapy, are the preferred method for treating distress in cancer patients
(Carlson & Bultz, 2004). Research indicates that these groups substantially reduce the
emotional distress associated with cancer, provide important social support, and enhance
adaptive coping skills (Burke & Kissane, 1998; Fawzy et al., 1995; Meyer and Mark,
1995; Michalec, 2005).

Formal support groups are available in a variety of settings and are based on the
assertion that patients with breast cancer benefit from contact with other cancer patients
through mutual social support. Interventions generally incorporate cognitive-behavioral
approaches with group social support and education; the results of these groups have
been mixed. Samarel et al., (1997) reported no significant differences in symptom
distress, emotional distress, or functional status among women who participated for eight
weeks in social support and education groups and women who did not participate in any
groups. Helgesen et al., (1999 & 2001) in a comparison of an education group, education
plus peer discussion, and peer discussion without education, concluded the education
group enhanced vitality, mental health, social functioning, role functioning, and reduced
body pain; however, the effects dissipated over time. No benefits were found in the peer
discussion group. Targ & Levine (2002), in a study comparing a psychoeducational
group with a mind-body-spirit group, concluded that both methods improved measures of
health-related quality of life and psychosocial functioning. Additionally, the mind-body-
spirit group improved spiritual integration and satisfaction. Improved mood, vigor, and
fighting spirit were reported by Fukui (2000) in a one-group study investigating
cognitive-behavioral group therapy with relaxation and guided imagery. Antoni (2001), in a study investigating the effects of structured group cognitive-behavioral therapy, reported no overall effects; however, there was a reduced prevalence of moderate depression and increased benefit finding and optimism. Lastly Samarel et al., (1998) interviewed participants in a social support group. Content analysis, based on the Roy Adaptation Model, revealed physiological, self-concept, role function, and interdependence mode changes (Samarel et al., 1998). All of the above reviewed studies focused on women newly diagnosed with breast cancer, and they were still in an active treatment stage. Furthermore, only one of the studies had control group comparisons. Last, no studies were found that investigated the effects of support groups on extended stage or permanent survivors of breast cancer.

Group Psychotherapy

Group therapy, incorporating psychotherapeutic interventions designed for people with medical illness, can be a powerful intervention (Spira, 1997; Meyer & Mark, 1995). Yalom (1995), an authority on group therapy, described three curative factors in the group setting that contribute to improvement: universality, altruism, and hope. Universality is the opportunity for group members to feel that they are not alone; being part of a group offers a sense of community that diminishes feelings of alienation and isolation. Altruism provides members a sense of purpose through lending support and guidance to others. Finally, group members have the opportunity to see that others experience similar emotions, cope with similar situations, and still find meaning in life—this instills hope.
Group psychotherapy is intended to reduce distress while allowing group members to live as fully and authentically as possible. Spira & Reed (2003) describe the essence of group psychotherapy for women with breast cancer as openly addressing issues related to breast cancer and the impact of this experience on their lives. Additional goal areas include self-expression, drawing on the emotional support and understanding of others, finding ways to become actively involved with difficulties one is facing, and using the cancer crises as an opportunity for growth. Typical themes discussed in cancer patient groups include relationships with family, friends, and coworkers; coping with the effects of the disease; group dynamics; adjusting to living with a cancer diagnosis; fear of dying; shifting priorities; and self-image (Spira, 1991; Spira & Spiegel, 1993; Spira & Reed 2003). Simpson et al. (2001) conducted a six-week investigation on the effects of structured group psychotherapy with early breast cancer survivors. Results indicated that group psychotherapy reduced depression and severity of psychiatric symptoms while enhancing mood and health-related quality of life. No control group comparison was made.

Supportive expressive group therapy is an approach developed and practiced by David Speigel (Classen et al., 1993; Spiegel, Bloom, & Yalom, 1981; Spiegel & Spira, 1991). The goal of this therapy is to create an environment in which participants receive support from one another and can freely express feelings and concerns. Furthermore, this approach is existentially-based with the goal of helping the patient live life more fully in the face of a life-threatening illness. To accomplish this, the therapist must help the patient adjust her internalized view of self to one that more accurately reflects present capabilities. Randomized clinical trials demonstrate that supportive, expressive group
therapy significantly improves mood and coping skills (Spiegel et al., 1981), reduces phobic responses and the pain experience (Spiegel & Bloom, 1983), and significantly increases survival time (Spiegel et al., 1989). Finally, Spiegel et al., (1999) in an investigation of group psychotherapy for recently diagnosed breast cancer patients, reported significant decreases in the distress of breast cancer patients. Of these studies, only one focused exclusively on (early) breast cancer survivors (Spiegel et al., 1999).

Experiential expressive supportive groups use movement, relaxation, art and imagery to work with issues of fear, body image, mood, and spirituality (Serlin et al., 2000). Also developed out of Yalom’s (1995) work, the goals include accepting new bodies and integrating them into healthy positive views of self, improving communication, enhancing quality of life, and being clear about values and life goals. Serlin et al., (2000) describe two such groups—a Dance/Movement therapy group for women with breast cancer and the Healing Stories group. While detailed descriptions of these groups are available, research on the effectiveness of such interventions on stated goal areas was not found. Furthermore, the descriptions do not focus exclusively on breast cancer, survivors, or survivors of breast cancer.

Music Therapy

A review of the literature on music therapy with cancer patients reveals several potential goal areas including procedural support, physical and emotional needs, and end of life care. While earlier studies focused on comparing the benefits of live versus recorded music, later studies focused on specific music therapy techniques (e.g., singing) or on comparing active and receptive methods. The following review will begin with
foundational studies followed by individual music therapy interventions, music therapy group interventions, and the practice of guided imagery and music.

Early literature on music therapy with cancer patients focused on the efficacy of music therapy as a treatment modality and potential goal areas. Cook (1985) describes numerous practices for music therapy as an adjunct to traditional treatment methods for pain management, insomnia, and anxiety in oncology settings. Furthermore, she discusses the effectiveness of music therapy in increasing communication and serving as an outlet for emotions. Porchet-Munro (1995) states that music therapy may address coping, withdrawal, expression, anger, anxiety, fear, anguish, extreme physical tension, confusion, boredom, loneliness, and a search for meaning in cancer patients. Last, Magill (2001) provides an overview of the practice of music therapy for advanced cancer pain. Case examples are provided to demonstrate how music therapy sessions offer patients moments of release, reflection and renewal.

Several studies were found describing specific music therapy techniques used with cancer patients. Bailey (1984) describes the beneficial qualities of the use of songs in providing support, acting as a tool for change, and in reducing suffering related to cancer. VonHodenberg (1995) provides several case examples to show the diversity of music therapy approaches practiced with patients undergoing radiation and chemotherapy. Turry & Turry (1999) describe the practice of creative song improvisations with children and adults with cancer. Last, Burns et al., (2005) in an investigation of cancer patients’ interest and preference for music therapy, reported a large majority of cancer patients were interested in music listening versus active music making.
In addition to the above studies, two theoretical articles were found. Aldridge & Aldridge (1999) proposed, through case examples and research, the theory that creatively improvising music can lead to renewed health in individuals facing life-threatening illness. Dileo (1999) presents stages of a potential music therapy process from a biopsychosocial perspective. Research and clinical examples are provided to encourage songs in direct relationship to those factors promoting survival from cancer.

Several quantitative studies investigating the effects of music therapy on cancer patients were found. One of the earliest studies examined the effects of live versus tape-recorded music in reducing tension and anxiety in hospitalized cancer patients (Bailey, 1983). Results indicated that live music was significantly more successful than taped music in reducing tension and anxiety as well as in alleviating physical discomfort and negative affect. This was followed by a study investigating the effects of music therapy and guided visual imagery on chemotherapy-induced nausea and vomiting (Frank, 1985). Results indicated that state anxiety, length of nausea and vomiting, and perceived severity of vomiting were all significantly reduced. Last, Ferrer (2007) examined the effects of live, familiar music on decreasing anxiety in patients undergoing chemotherapy. Results indicated statistically significant improvement for the experimental group in measures of anxiety, fear, fatigue, relaxation, and diastolic blood pressure.

In relation to breast cancer, one quantitative study was found. Hanser et al., (2005) investigated the effects of music therapy interventions for women with metastatic breast cancer. Results showed a significant improvement in the music therapy group after each session on measures of relaxation, comfort, happiness, and decreased heart rate.
as compared to the control condition. Furthermore, the music therapy group reported greater satisfaction and frequent use of music to cope with cancer.

A few qualitative studies on music therapy with cancer patients were found. In a study exploring the relevance of music therapy for hospitalized cancer patients, O’Callaghan & McDermott (2004) report that music therapy allowed patients to revisit significant memories as well as experience new feelings and thoughts; allowed patients to reflect more on personal affective experiences; and affirmed and heightened many people’s “sense of aliveness.” Furthermore, live familiar music was comparable to song writing as both allowed patients to reflect on emotions and concerns, memories, and significant others as well as experience imagery and spiritual awareness. Last, a number of sessions were not necessarily related to the significance of the experience, as some single sessions had a profound impact (O’Callaghan & Hiscock, 2007).

A number of case studies on music therapy with cancer patients were found. Bunt & Marston-Wyld (1995) present several case studies demonstrating the active nature of music therapy that allows patients to access and express emotions in a very direct and immediate way. Logis & Turry (1999) describe the process of improvisational music therapy sessions from the perspective of the patient. Sessions began when Logis was newly diagnosed with cancer and the resulting narrative takes the reader through her stages of acceptance, fear, despair, trust, and healing. Last, Allen (2008a) describes in-patient music therapy sessions from a biopsychosocial approach. Recurrent sessions over a seven-month period highlight the treatment process aimed at increasing self-expression, validating religious and spiritual beliefs, and decreasing pain and anxiety.
Jackson (1995) describes the process and benefits of music therapy with a palliative care patient who has breast cancer. Jackson states that sessions improved quality of life, provided a means for self-expression, and provided an opportunity for the patient to further explore her spirituality. Last, Aldridge (1996) describes the development of melodic expression in a breast cancer patient under the premise that self-expression is important for breast cancer patients, and melody is an important form of musical expression.

Group music therapy is another approach used to meet the needs of cancer patients. The following is a review of quantitative, qualitative, and descriptive group music therapy studies. Waldon (2001) investigated the effects of group music therapy on mood states and cohesiveness in adult oncology patients. Results indicated significant improvements in self-reported mood states for both the active and receptive-based music therapy groups. In a pilot study comparing the effects of group music listening in a relaxed state with group improvisation within the context of a music therapy group setting, results indicated that group music listening resulted in increased well-being, relaxation and less tension, and group improvisation resulted in increased well-being, energy and less tension (Burns, et al., 2001). Additionally, both groups experienced increased levels of sIgA and decreased levels of cortisol (Burns et al., 2001). No quantitative studies were found that investigated group music therapy with breast cancer survivors.

Several qualitative studies have described the experience of group music therapy within cancer care. In a qualitative study evaluating the contribution of music therapy at a cancer care center, Bunt & Marston-Wyld (1995) report that group music therapy
enhanced the experience of communication, induced a shift from passive feelings to more active experience, temporarily relieved pre-occupations with pain, illness, and life problems while also helping the patient to discover hidden talents. Furthermore, many group members reported that they found themselves in contact with feelings they had not been able to identify or express. Rykov (2002) explored the ability of a brief, time limited, closed music therapy support group to provide psycho-spiritual existential support through active participation in music and related creative experiences. Rykov concludes that emerging themes related to cancer and the music provided an experiential learning experience whereby individuals came to know themselves. Last, Daykin et al., (2007) qualitatively examined the experience of group music therapy. The authors note themes of choice and enrichment countered themes of limitation and restriction commonly experienced when diagnosed and treated for cancer. Again, no studies were found that focused exclusively on group music therapy for breast cancer survivors.

Two studies were found that described particular models of music therapy. O’Brien (2006) describes the process before, during, and after creating and performing an opera with cancer patients. Overall themes that arose included anger, fear, humor, suffering, and peace; therefore, O’Brien concluded that Opera Therapy was a transformative method for self-expression. Last, Rykov (2008) describes a music therapy support group model based on her previous research. According to Rykov, music therapy-based support groups for cancer patients allow participants to talk about feelings of loneliness and isolation while feeling a profound, non-verbal connection to themselves, others, and something larger. Furthermore, the experience of improvisation was particularly empowering as it provided opportunities for experiencing feelings of
control during a time of loss of control inflicted by the experience of illness. Last, the results are long lasting and something many participants did not think themselves capable. No articles on music therapy-based support groups for breast cancer patients were found.

Guided Imagery and Music

Working with individuals who have a chronic illness is one of the primary applications for Guided Imagery and Music (Bruscia, 2000). Short (2002) suggests that guided imagery and music with medical patients typically includes ventilation of emotions, insight into problem relations or negative patterns of behaviors, symbolic transformation of body parts, and increased feelings of physical, and mental health in addition to emotional reactions related to self-concept. She identifies many advantages of group GIM work including the exertion of less energy, the diffusion of fears about the nature of therapy, and the opportunity to connect to others with similar medical problems. This, in turn, may enhance therapeutic development (Short, 2002). The following is a review of the applications of Guided Imagery and Music within cancer care.

In relation to cancer care, two descriptive studies were found. Logan (1998) in a study investigating music-evoked imagery in cancer patients concluded that this combination could be useful in promoting insight and healing. Additionally, because the client generates imagery based on his or her needs and desires, music-evoked imagery can provide comfort, a sense of control, a means of self-expression, and reduced anxiety. Allen (2008b) examined the application of music and imagery in the management of advanced cancer pain. Results from case examples indicated that music and imagery
could decrease pain perception and address the captioned emotional components of the pain experience.

Two quantitative studies were found in relation to guided imagery and music with cancer patients. Burns (2001) investigated the effects of individual guided imagery and music on mood and quality of life indicators in female cancer patients (all but one had breast cancer) who had completed active treatment. Participants who received ten weekly individual guided imagery and music sessions had better mood, improvement in tension, fatigue and confusion and also experienced changes in depression and anger. Furthermore, at six-weeks post-follow-up, the guided imagery and music group continued to have a better quality of life in comparison to the wait-list control.

Clark and McKinney (2003) investigated the effectiveness of six BMGIM sessions on distress, life quality, and relevant endocrine markers in women recovering from treatment for non-metastatic breast cancer. The results demonstrated that BMGIM sessions significantly reduced levels of depressed mood and total mood disturbance, increased emotional and social well-being and well-being associated with breast cancer concerns, and decreased intrusive thoughts and avoidance behaviors related to cancer. But in contrast to Burns’ study, the observed changes in depressed mood and total mood disturbance were not sustained through the six-week follow-up. While the results of these studies are promising, additional research is needed to determine the efficacy of guided imagery and music in meeting the needs of cancer survivors.

One qualitative study was found in relation to guided imagery and music with cancer patients. Bonde (2007), based on previous research with breast cancer patients in the rehabilitation process, examined how clients experienced the BMGIM process and
how they perceived the outcome of their therapy. Additionally, the author documented how the music-listening periods of the sessions could be described as an experiential process of narrative configuration. Based upon the analysis of the above, a grounded theory of developmental steps in the therapeutic BMGIM process and of image configuration types in the music listening periods was presented.

Last, one mixed study was found. Bonde (2005) explored the influence of music therapy on mood and quality of life of cancer survivors. Results indicated that after ten individual music therapy sessions, participants had improved mood and quality of life scores. Furthermore, a qualitative analysis indicated that imagery within the sessions was not cancer specific; instead, participant directed imagery focused on general issues of self-understanding and coping during periods of transition. Bonde concludes that BMGIM is especially well suited to stimulate the capacity to “wish…a necessary precondition for mobilizing the will.”

In addition to the above studies, several case studies were found describing the effects of guided imagery and music with breast cancer survivors. Hale (1992) describes twenty-six (26) individual GIM sessions with a women physically and emotionally recovering from a mastectomy. The GIM process resulted in the women finding their inherent beauty and the ability to trust, a more positive self-image, and the fear of cancer no longer dominating her life. Burns (1999) described BMGIM sessions with a woman five-year post double radical mastectomy that also continued to experience poor self-image. Following a series of sessions, a process evolved whereby a confident woman willing to take risks and allow herself to live her live without the fear of recurrence emerged.
Additional case studies were found in relation to GIM with breast cancer patients at end of life. Cadrin (2005-2006) examined the process of BMGIM in addressing the psychosocial, spiritual and existential issues of a palliative care breast cancer survivor. The process of GIM allowed the patient to move towards her goal of re-claiming her identity. At the end of a series of sessions, the patient was able to be at peace. Lastly, Marr (1998-1999) highlights the ability of GIM to enhance spirituality, express strong emotions, and re-evaluate identity with a fifty-four (54)-year old with advanced breast cancer.

In relation to group GIM, one study was located. Pienta (1998) examined the effects of group music and imagery on the self-esteem and well-being of breast cancer survivors. After six group sessions, results indicated an increase in self-esteem in three out of four subjects and an overall increase in well-being for all subjects. The author calls for additional studies to determine the efficacy of group music and imagery in addressing self-esteem issues in cancer patients.

Music therapy literature in relation to cancer care continues to evolve. While beginning research was focused on the efficacy of music therapy as a treatment modality, more recent studies have described and researched therapeutic goal areas, compared techniques, and begun investigation of several treatment sessions. Despite the promising impact of music therapy, research is still needed to determine the efficacy of this modality in meeting not only the needs of cancer patients, but cancer survivors, and specifically, breast cancer survivors.

The purpose of the present study was to examine the effectiveness of group music psychotherapy (i.e., group music and imagery) in improving the self-concept of breast...
cancer survivors. More specifically, does group music psychotherapy (GrMI) have an effect on adapting to changes in identity, body image, role performance, or self-esteem? These questions will be answered by comparing an experimental group that receives group music psychotherapy (GrMI) with a control group participating in a cognitive-behavioral support group. Comparisons will be made using The Body Image After Breast Cancer Scale and the Tennessee Self-Concept Scale. Subordinate questions include:

1. Will breast cancer survivors in the music psychotherapy group improve social self-concept scores significantly more than breast cancer survivors in the cognitive-behavioral group? Null hypothesis: After treatment, there will be no significant difference between groups on the social sub-score of the Tennessee Self-Concept Scale (TSCS-2).

2. Will breast cancer survivors in the music psychotherapy group improve their identity supplemental scores significantly more than breast cancer survivors in the cognitive-behavioral group? Null hypothesis: After treatment, there will be no significant differences between groups on the identity supplemental score of the Tennessee Self-Concept Scale (TSCS-2).

3. Will breast cancer survivors in the music psychotherapy group improve academic/work self-concept scores significantly more than breast cancer survivors in the cognitive-behavioral group? Null hypothesis: After treatment, there will be no significant difference between groups on the academic/work sub-score of the Tennessee Self-Concept Scale (TSCS-2).
4. Will breast cancer survivors in the music psychotherapy group improve on family self-concept scores significantly more than participants in the cognitive-behavioral group? Null hypothesis: After treatment, there will be no significant difference between groups on family sub-score of the TSCS-2.

5. Will breast cancer survivors in the music psychotherapy group improve their self-esteem significantly more than participants in the cognitive-behavioral group? Null hypothesis: After treatment, there will be no significant difference between groups on the personal sub-scale of the TSCS-2.

6. Will breast cancer survivors in the music psychotherapy group improve their body image significantly more than breast cancer survivors in the cognitive-behavioral group? Null hypothesis: After treatment, there will be no significant differences between groups on the Body Image After Breast Cancer Questionnaire (BIBCQ).
CHAPTER THREE

METHOD

Design

A pretest-posttest control group design was applied. The experimental group consisted of a music psychotherapy based support group. The control group consisted of a cognitive-behavioral based support group, considered standard care in most cancer settings. Both groups ran for ten consecutive weeks. The dependent variables were changes in identity, body image, role functioning, and self-esteem as measured by the Tennessee Self-Concept Scale and the Body Image After Breast Cancer Questionnaire.

This study was reviewed and approved by the Institutional Review Board at Trident Medical Center and the Institutional Review Board at Temple University.

Participants

Subjects were recruited from the greater Charleston, SC area. The researcher visited local breast cancer support groups and posted flyers in area cancer centers, informing potential participants of the study. The researcher then independently met with potential participants to inform them about the study and to ensure they met study criteria. The researcher did not exclude any potential subject who met the study criteria and wished to participate. Participants were eligible to participate if they 1) Were over 18 years of age; 2) Were able to read and speak English; 3) Had normal hearing; 4) Were able to engage in conversations; 5) Had completed initial treatment for breast cancer and were currently in remission or receiving maintenance therapy; 6) and were female. Once informed consent was obtained, participants were randomly assigned to either the
experimental or the control condition. Random assignment was achieved by having participants select a sealed envelope. Inside of the envelope was a sheet of paper listing either the control or the experimental group.

Five individuals participated in the experimental group. The average age of participants was 61 and all with diagnosed with invasive carcinoma. The average number of months post diagnosis was 34.8. All participants in the experimental group had undergone surgical treatment, and all were currently on hormonal treatment. Additionally, two of the five individuals had undergone radiation treatment, two had undergone radiation and chemotherapy, and one had undergone chemotherapy.

Six individuals participated in the control group. The average age of participants was 60.3, and the average number of months post diagnosis was 38.3. Like the experimental group, all members of the control group were diagnosed with invasive carcinoma and had undergone surgical treatment. Additionally, all members were currently on hormonal treatment. Lastly, three members had undergone chemotherapy, two had undergone radiation and chemotherapy, and one had undergone radiation.

Given the limited availability of breast cancer survivors in one location, and the length of the treatment involved in the study, it was not be possible to recruit and treat the required sample size of 102 (51 for each group) for a one-tailed test at a p level of .05.

*Measures*

Data for this study was collected using: 1) Researcher-developed intake forms to record demographic and background information on each participant; 2) The Body Image
After Breast Cancer Questionnaire (BIBCQ); 3) The Tennessee Self-concept Scale (TSCS); 4) and a researcher developed well-being questionnaire.

*The Body Image after Breast Cancer Questionnaire (BIBCQ)* was specifically designed to measure the long-term impact of breast cancer on body image in a multidimensional way (Baxter, 1998). The final version of the BIBCQ is a self-report measure with forty-five (45) common items, six optional items specific to women with two breasts, and two optional items specific to women missing one or both breasts. There are six scales, corresponding to six domains of body image found to be independent in factor analysis; these are vulnerability, body stigma, limitations, body concerns, transparency, and arm concerns.

Two types of statements and responses are applied. Respondents are asked to report how each statement pertains to them personally using a five-point scale ranging from strongly disagree to strongly agree for type one statements. Type two statements ask respondents to report how true each statement is using a five-point scale ranging from never to always. The measure is quantifiable and has been shown to have good reliability (0.77-0.87) and convergent validity (Baxter et al., 2006).

*The Tennessee Self-Concept Scale (TSCS)* is a self-report measure consisting of six self-concept scales (physical, moral, personal, social and academic/work) that yields a total summary score for total self-concept and conflict (Fitts & Warren, 1996). Respondents are asked to report how accurate each statement is in describing them, using a five-point scale ranging from completely false to completely true. Negatively worded items are reverse scored. The TSCS has been reported to be sound from a psychometric
perspective, with an internal consistency reliability of 0.84 and a correlation of 0.94 with the total self-concept scale of the full measure (Fitts & Warren, 1996).

*The Well-being Questionnaire* is a researcher designed self-report measure consisting of four statements. It is a visual analogue scale (VAS) whereby respondents are asked to specify their level of agreement to a statement by indicating a position along a continuous line between two end-points. See Appendix D.

**Procedures**

*Participant Recruitment.* The researcher attended area breast cancer support groups held at local cancer centers in order to describe the study to those in attendance. Additionally, the researcher posted flyers at local oncology offices and on-line with the Komen foundation. Interested parties were invited to meet individually with the researcher to learn more about the study, and to determine if they met inclusion criteria for participation. If criteria were met, the researcher reviewed the consent form, the schedule of group sessions and answered any and all questions. Volunteers who agreed to participate in the study and who meet all inclusion criteria were then asked to sign the consent form. Once informed consent had been obtained, the participant was randomly assigned to one of two treatment groups. At the first group meeting, all pretests were completed. The pretests were administered by an independent party not connected with the study.

*Group Music Psychotherapy* (Experimental Condition). Participants assigned to the GrMI attended ten consecutive weekly sessions, led by the researcher, each lasting approximately sixty (60) minutes. The format for each session was: 1) Preliminary
Conversation; 2) Relaxation Induction; 3) Music imaging experience; 4) Return to alert state; and 5) Postlude Discussion. See Appendix F.

The preliminary conversation served to identify the goal, concern, theme, and/or conflict that was relevant to the group or any of its members for that session. This might have been determined by the therapist, based on assessment of group needs or wants or based on what members presented in the opening discussion. Alternatively, group members may have determined the theme based on a group discussion of concerns. Once the overall theme was decided upon, the type of listening experience, the interactional format of the imaging, the induction and focus, and the music was selected.

The purpose of the relaxation induction was to prepare group members physically and emotionally for the group music psychotherapy experience. The type of induction for each session was based on the nature of the group, theme and music selection. Inductions may have included breathing exercises, progressive body stretches, autogenics (repeating verbal phrases focused on a particular effect to facilitate a deeper state of relaxation), and/or directed imagery (e.g., ball of energy massaging each part of your body). The induction was concluded with the therapist providing a starting image based on the theme and chosen music.

During the music imaging experience, group members imaged while listening to music in a relaxed state, assisted by verbal interventions by the therapist, all aimed at helping each individual explore and work through the selected theme. Based on the preliminary conversation, group members may have interacted within the imagery independently, as a group, or within subgroups. Additionally, the image may have been directed (participants image what the therapist presents so the entire group has a very
similar inner experience), unguided (each participant images to music separate from one another and without direction from the therapist), progressive (each participant takes a turn in contributing to an evolving image or story) and/or interactive (therapists guides as participants co-image to music), (Bruscia, 2004). As the music imaging experience came to a close, the therapist then helped members return to the here-now and the session transitioned into the postlude discussion.

The purpose of the postlude was to process, work through and/or consolidate the music-imaging experience. The therapist worked with the group to process and reflect on the experience in an effort to find connections and meaning. Alternatively, the therapist explored the experience even further or consolidated the experience to closure. The specific approach taken during the postlude was based on the overall direction of the session as decided on in the prelude.

_Cognitive-behavioral based support group (Control condition)._ Participants assigned to the control condition attended ten consecutive weekly sessions, led by the researcher, each lasting approximately sixty (60) minutes. The researcher had facilitated this type group in the past. The format for each session was: 1) An introduction; 2) A group discussion; 3) Education; and 4) A discussion of personal commitment statements.

During the introduction, the therapist reviewed the previous weeks personal commitment statements and identified the goal or theme of the particular group session based on an assessment of group needs, or based on general concerns often experienced by breast cancer survivors.
During the group discussion, the therapist facilitated participant interaction around the chosen theme. The therapist emphasized participants speaking from a personal, specific, and emotional way while supporting one another.

During the education phase, participants were presented with various resources and experiences to highlight coping strategies related to the chosen theme. The focus was on teaching skills and reflecting on problems that occur in daily life. Exercises (including worksheets and dyads) were applied to emphasize self-guided discovery.

Prior to the end of the group session, participants were asked to create a personal commitment statement based on the overall theme of the group and captioned coping strategies. This personal commitment statement was designed to hold participants accountable for change.

Prior to and at the end of each group, participants completed the well-being questionnaire. Pre/post data were then analyzed to determine any significance. At the end of ten consecutive weeks, both the experimental and control group completed all dependent measures. Pre/post data was then be analyzed to determine any significance. Additionally, all sessions were audio taped and reviewed by an independent party to determine if the researcher followed stated session protocols.

Data Analysis

Since hypotheses were adopted, a p level of .05 was used. The Statistical Package for the Social Sciences (SPSS) Version 16 was used to calculate all statistical tests. Given the sample size, nonparametric statistics was used. Specifically, the Mann-Whitney U was used to compare pre-tests of each group on all measures, and to compare post-tests
of each group on all measures. Additionally, the Wilcoxon was used to determine within-group significance.
CHAPTER 4

RESULTS

To prepare for hypothesis testing, pre and posttests on the Tennessee Self-Concept Scale (TSCS-2), and the Body Image After Breast Cancer Questionnaire (BIBCQ) were scored for both the experimental and control groups. On the TSCS-2, $T$-scores were obtained by tallying the raw scores from the social, identity, academic/work, and personal subscales and finding their respective/corresponding $T$-scores on the Profile sheet. $T$ – scores are standard scores with a mean of 50, and a standard deviation of 10. On the BIBCQ, sub-scores were tallied and added together to determine a total BIBCQ score. Mean scores pre and post test for both treatment groups can be found in Table I.

Table I: Mean Scores

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Music Psychotherapy (GrMI)</td>
<td>Cognitive Behavioral</td>
</tr>
<tr>
<td>Mean $T$ Scores</td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Social</td>
<td>47.4$T$</td>
<td>54.0$T$</td>
</tr>
<tr>
<td>Identity</td>
<td>54.8$T$</td>
<td>45.4$T$</td>
</tr>
<tr>
<td>Academic/Work</td>
<td>47.20$T$</td>
<td>48.8$T$</td>
</tr>
<tr>
<td>Family</td>
<td>44.0$T$</td>
<td>52.6$T$</td>
</tr>
<tr>
<td>Personal</td>
<td>48.0$T$</td>
<td>53.4$T$</td>
</tr>
<tr>
<td>BIBCQ</td>
<td>147.4</td>
<td>114</td>
</tr>
</tbody>
</table>

Pre and posttest scores on all measures were compared using the Wilcoxon Rank Sum Test to determine differences between pre and post test scores for each group. Reporting of this data is broken down by subordinate questions related to identity, role performance, self-esteem, and body image in the following paragraphs.
Next, pre-test comparisons were made between groups using the Mann-Whitney U to determine if the experimental and control groups were equal on the dependent variables (TSCS and BIBCA) prior to treatment. Results of the Mann-Whitney U indicated no significant differences on TSCS-2 pre-test scores between experimental and control groups on social (U = 10.50, z = -8.25, p = .429); identity (U = 12.00, z = .555, p = .662); family (U = 10.50, z = -.833, p = .429); academic/work (U = 12.50, z = -.480, p = .662); and personal subscales (U = 14.00, z = -.184, p = .931), of the TSCS: 2. Results of the Mann-Whitney comparing pre-test scores on the BIBCQ indicated no significant differences between experimental and control groups (U = 9.00, z = -1.095, p = .329).

As results of the Mann-Whitney U pre-test group comparisons indicated score distributions were non-significant between groups, post-test scores between groups were then compared for hypothesis testing. Reporting of these data is broken down by subordinate questions related to identity, role performance, self-esteem and body image, in the following paragraphs.

Identity: Social Subscale and Identity Supplemental Score

The Wilcoxon Rank Sum Test was used to compare pre and post test social subscale T scores for the experimental and the control groups to determine possible differences for each group. Results indicated no significant differences between pre and post test scores for the experimental (z = -1.826, p = .068, r = -0.82) or the control group (z = .000, p = 1.00, r = 0).

The Mann Whitney U Test was used to compare post test T scores of the social subscale between the experimental (GrMI) group and the control (cognitive behavioral) group. Results indicated no significant differences between groups on post-test social
sub-scores of the TSCS-2, \( U = 10.5, z = -.841, p = .429, r = -0.25 \). In relation to the first subordinate question: Will breast cancer survivors in the GrMI group improve significantly more than the cognitive-behavioral group on post test social scale self-concept scores, the null hypothesis is accepted. Neither group improved significantly, nor there were no significant differences in improvement between the experimental and control groups.

In relation to the identity supplemental scale, an analysis of pre and post test differences using the Wilcoxon indicated significant differences for the experimental group \( (z = -2.032, p = .042, r = -0.91) \) and the control group \( (z = -2.226, p = .026, r = -0.91) \). Both groups made significant gains on this measure.

A Mann Whitney U Test was used to compare post test T scores of the identity supplemental subscale of the TSCS between the experimental and control groups. Results indicated significant differences between groups \( (U = 3.50, z = -2.119, p = .030, r = -0.64) \), favoring the experimental group. In relation to the second subordinate question: will breast cancer survivors in the experimental group improve their identity significantly more than the control group, the null hypothesis is rejected, as post test identity scores between the GrMI and the cognitive-behavioral group were significantly different. The experimental group improved significantly more than the control group.

**Role Performance: Academic/Work, and Family Subscales**

Role performance was measured using the academic/work and family subscales of the TSCS: 2. A within group analysis using the Wilcoxon Rank Sum Test indicated significant differences between pre to post test academic/work scores for the
experimental group \( (z = -1.89, p = .059, r = -0.84) \), but not the control group \( (z = -1.342, p = .180, r = -0.55) \).

In order to determine if breast cancer survivors in the experimental group improved their role performance significantly more than participants in the control group, post test scores on the academic/work and family subscales were compared using a Mann Whitney U test. Results of the academic/work scores indicated no significant difference between groups \( U = 12.5, z = -.468, p = .662, r = -0.14 \). The null hypothesis was accepted as no significant difference between groups on the academic/work subscale was found.

Within group analysis using the Wilcoxon indicated significant differences between pre and post test scores on the family subscale for the GrMI \( (z = -2.23, p = .043, r = -0.99) \) and the cognitive behavioral group \( (z = -2.207, p = .027, r = -0.90) \). Both groups improved significantly on this measure.

Post test scores on the family subscale on the GrMI and the control group were compared using the Mann-Whitney. Results indicated a significant difference between groups, \( U = 4.00, z = .042, p = .052, r = 0.01 \), favoring the experimental group. The null hypothesis was therefore rejected as a significant difference between groups on the family sub-score was found. The experimental group (GrMI) improved significantly more than the control group (cognitive-behavioral).

Self-esteem: Personal sub-scale

Self-esteem was measured using the personal sub-scale of the TSCS: 2. Within group analysis indicated a significant difference between pre and post test scores for the experimental group \( (z = -2.023, p = .043, r = -0.90) \), but not the control group \( (z = -.526, \)
p = .599, r = -0.21). The experimental group made significant improvements in self-esteem; the control group did not.

To determine if breast cancer survivors in the experimental group improved their self-esteem significantly more than participants in the control group, post test scores of the personal sub-scale of the TSCS-2 were compared using the Mann-Whitney U test. Results indicated no significant difference between groups, U (11) = 6.00, z = -1.654, p = .126, r = -0.50. The null hypothesis was therefore accepted, as there was no significant difference between groups on the personal sub-scale of the TSCS. Improvements in the experimental group were not significantly greater than improvements in the control group.

Body Image

Changes in body image were measured using the Body Image After Breast Cancer Questionnaire. Within group analysis revealed significant differences for the experimental (z = -2.023, p = .043, r = -0.90) and control group (z = -2.21, p = .028, r = -0.90). Both experimental and control groups improved significantly in body image.

A Mann Whitney U test was conducted on the post test scores on the BIBCQ. Results indicated a significant difference between groups, (U = 3.5, z = -2.109, p = .030, r = -0.64). With regard to body image, the null hypothesis was therefore rejected as the experimental group improved significantly more than the control group.

Summary

A comparison of pre and post test scores across all variables for the experimental group indicated significant improvements for the identity supplemental scale (p = .042, family (p = .043) and personal (p = .043) subscales as well as in body image (p = 0.43).
No significant differences between pre and post test scores for the GrMI group were found on the social (p = .068) or the academic/work (p = .059) subscales. These results indicate that the GrMI had a significant effect on breast cancer survivors’ identity, role performance, self-esteem and body image, but not social or academic/work self-concepts.

Within group comparisons of pre and post test scores for the cognitive-behavioral control group were also made using the Wilcoxon Rank Sum Test. Results indicated a significant difference between pre and post test identity supplemental scores (p = .026), family sub-score (p = .027) and body image (p = .028). No significant differences were found between pre and post scores on social (p = 1.00) academic/work (p = .180) or the personal (p = .599) sub-scores. This indicates that the cognitive-behavioral group had significant improvements in identity, role performance, and body image but not self-esteem.

Results of between group comparisons using the Mann Whitney U Test indicated that breast cancer survivors in the GrMI experimental group improved significantly more than the cognitive-behavioral control group on identity supplemental scores (p = .030), family sub-scores (p = .052), and body image (p = .028). In relation to self-concept, subjects in the experimental group improved significantly more on measures of identity, role performance, and body image, as compared to the control group.

Additional Data

In an effort to determine the impact of each group on general well being, all participants in the experimental and control groups completed pre and post test questionnaires for each session. The General Well-Being Questionnaire consisted of five statements: I feel in control; I feel empowered; I feel good about myself; I feel connected.
to others in the group; and this session helped me access a part of myself that I need at this time (post-session only). Subjects were asked to rate their level of agreement with each statement by marking an “X” along a solid line. Each scale was measured with a ruler to determine a numerical value. Numerical values were then averaged according to question, session, group, and pre and post session responses. Results are presented in Table 2 and will be reported according to session number and group.

Results of the General Well-being Questionnaire were analyzed to determine any significant overall differences over the course of treatment. Within group results were analyzed using the Wilcoxon Rank Sum Test and between group results were analyzed using the Mann Whitney U Test. These results are presented in Table 3.

<table>
<thead>
<tr>
<th>Session Two</th>
<th>Session Three</th>
<th>Session Four</th>
<th>Session Five</th>
<th>Session Six</th>
<th>Session Seven</th>
<th>Session Eight</th>
<th>Session Nine</th>
<th>Session Ten</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Pre/Post</td>
<td>3.64/3.83</td>
<td>3.63/3.78</td>
<td>3.89/4.12</td>
<td>3.66/3.89</td>
<td>4.05/4.16</td>
<td>4.12/4.54</td>
<td>4.18/4.45</td>
</tr>
<tr>
<td>I feel empowered</td>
<td>Experiment</td>
<td>Pre/Post</td>
<td>3.4/4.33</td>
<td>4.66/4.42</td>
<td>3.88/4.16</td>
<td>4.22/4.66</td>
<td>4.18/4.43</td>
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<td>I feel good about myself</td>
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<td>Pre/Post</td>
<td>2.68/2.83</td>
<td>3.65/3.12</td>
<td>3.45/3.87</td>
<td>3.66/3.63</td>
<td>3.89/4.13</td>
<td>4.28/4.33</td>
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<tr>
<td>I feel connected to others in the group</td>
<td>Experiment</td>
<td>Pre/Post</td>
<td>4.23/5.21</td>
<td>3.37/3.88</td>
<td>4.10/4.18</td>
<td>3.86/4.18</td>
<td>4.22/4.53</td>
<td>4.18/4.44</td>
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This session helped me access a part of myself that I need at this time.

Table III: General Well-being Questionnaire Overall Significance

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<th>Experimental Group</th>
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<td>p = .038</td>
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<td>I feel good about myself</td>
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<td>p = .002</td>
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<td>a part of myself that I need at</td>
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<table>
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CHAPTER FIVE
DISCUSSION

The purpose of this study was to determine the effectiveness of group music psychotherapy on the self-concept of breast cancer survivors. Eleven breast cancer survivors where randomly assigned to one of two groups – music psychotherapy (experimental group) or cognitive-behavior based support group (control group). Pre data was collected, and after ten weeks of treatment, post data was collected using the Tennessee Self-Concept Scale and the Body Image After Breast Cancer Questionnaire. Components of self-concept studied included identity, role performance, self-esteem and body image.

Previous studies with breast cancer survivors have indicated important psychosocial benefits of group participation, including improved mood, enhanced coping, reduced phobias, enhanced quality of life, enhanced spiritual integration, enhanced vitality, and increased social and role functioning (Hewitt, Herdman, & Holland, 2004). No studies were found that investigated the effects of group interventions on self-concept, despite the overwhelming research indicating the detrimental effects of breast cancer on a women’s self-concept and the role of self-concept in enhancing transcendence of the illness. Results of the present study indicated group music psychotherapy significantly improved cancer survivors’ identity, family relationships, self-esteem and body image. Furthermore, in comparison to the control group, group music psychotherapy showed significantly greater improvements on measures of identity, role performance, self-esteem, and body image. The purpose of this chapter is to
contextualize the findings of this study within existing literature and to explain possible reasons for the present findings.

Effects on Identity

Identity involves the internal sense of individuality, wholeness, and consistency of a person over time (Potter & Perry, 2005). It functions to inscribe the person in the social environment, to communicate positions, and to establish relationships with others. The Social Self-Concept Subscale and the Identity Supplemental Sub-score of the TSCS-2 (Fitts & Warren, 1996) were used to measure identity. On the TSCS-2, $T$ scores range from $\leq 20$ to $>80$, with an average of 49-51, for test norms.

The Social Self-Concept (SSC) subscale is a measure of how the self is perceived in relation to others. It is a reflection of an individual’s sense of adequacy and worth in social interactions with other people (Fitts & Warren, 1996). Individuals with a high SSC score ($\geq 60$ $T$) are usually viewed by themselves and others as being friendly, easy to be with, and extroverted. Persons with low SSC scores ($\leq 40$ $T$) often feel isolated, but are hesitant to take social risks involved in relieving their isolation. Additionally, SSC scores are likely to be low for depressed individuals for whom loss is a primary issue (Fitts & Warren, 1996).

For the music psychotherapy group, the pre-intervention mean SSC score was 47.4$T$, and the post-intervention SSC mean was 54.0$T$. Based on the TSCS-2 test norms, individuals in the group music psychotherapy group SSC scores went from the 38th percentile to the 81st percentile of test norms. This further indicates that after group music psychotherapy, participants had a more favorable view of themselves in relation to their interactions with others than 81% of the general population. While specific studies
investigating social self-concept were not found in the literature, these findings do support the work of Clark & McKinney (2003), who found that Guided Imagery and Music increases social well-being.

It is important to note, however, the Wilcoxon Rank Sum Test revealed that this improvement was not statistically significant \((p = .068)\). Participants in the experimental group did not improve significantly in social self-concept, as measured by the TSCS-2. However, when taking effect size into account, results indicated a large effect size \((r = .082)\). This indicates that post-test scores, while not statistically significant, are clinically significant. Future research with a larger sample size is needed to further investigate the effectiveness of group music psychotherapy on measures of social self-concept.

In the control group, the pre-intervention SSC mean was 49.67. The post-intervention SSC mean was 49.6. Participants’ mean SSC scores remained between the 46-50th percentiles of TSCS-2 norms. No significant differences \((p = 1.00)\) were found between the pre- and post-test scores on the SSC, indicating that the control group did not improve significantly in social self-concept, as measured by the TSCS-2. In relation to effect size, results also indicated no clinical significance between pre and posttest SSC scores in the control group, as a small effect size was found \((r = 0)\).

Results of the Wilcoxon U Test indicated no significant difference between the experimental and control group on post-test scores \((p = .329)\). However, the effect size was small \((r = 0.25)\), indicating there was not enough power in the statistical analysis.

Previous literature on support groups has found anecdotal evidence that support groups can increase social wellbeing (Samarel, N., Fawcett, J., & Krippendorf, K., et al., 1998; Montazeri, A., Jarvendi, S., & Haghhighat, S., et al., 2001). However, in a study
investigating a comprehensive post-treatment recovery program for breast cancer, results indicated improved social functioning within the treatment group post-intervention; however, these results were not significant in comparison to the no-treatment control group (Hockett, 2005). This suggests that while participants in support groups perceive benefits to overall social well-being, research indicates that these benefits are not statistically significant, and more research is needed. Furthermore, given the clinical significance of group music psychotherapy on social-self-concept, future research is warranted not only to further support the effectiveness of music psychotherapy on social self-concept but to also determine if it is more effective than traditional support group formats.

In relation to the first subordinate question – will breast cancer survivors in the experimental group have significantly higher post-test social self-concept scores as compared to the control group the null hypothesis is accepted. However, while neither group had statistically significantly improvements in social self-concept, participants in the music psychotherapy group did have clinically significant improvements in social well-being.

The identity supplemental score (IDN) conveys the message “This is who I am, and this is how I identify myself.” It is an indication of a desire to change as well as the stability of one’s sense of self and its vulnerability to situational factors (Fitts and Warren, 1996). IDN T scores range from 27. If the IDN score is above 70T, it may indicate inflexibility that could impede the process of change and personal growth. When the IDN score is below 40T, it is an indication of an actively negative self-view. So when IDN scores are high, a decrease in scores is desirable; when IDN scores are low, an
increase in scores is desirable. It is important to note that both the music psychotherapy group and the cognitive-behavioral support group started off with identity scores that were above average. This is thought to be the result of their strong identification of themselves as breast cancer survivors; however, as the support group treatment unfolded, it was clear that all were struggling with what being a breast cancer survivor meant as well as where to go from there. Given the high pre-test IDN scores, a decrease in IDN scores was desirable.

Within the music psychotherapy group, the pre-intervention IDN mean score was 54.80T. The post-intervention IDN mean was 45.4T. Since pre-intervention T scores were high, this decrease was desirable. In relation to TSCS norms, individuals in the music psychotherapy group went from 67th percentile (above average) to the 41st percentile (slightly below average) in relation to personal identity. Again, since pre-intervention scores were high, a decrease in scores was desirable. According to the Wilcoxon U test, this decrease in IDN scores was a statistically significant improvement in identity. Furthermore, these results are clinically significant, as a large effect size was obtained (r = 0.91).

The significant decrease in identity scores in the music psychotherapy groups was related to the process of re-evaluating and reclaiming one’s personal identity. At the beginning of the process, several of the group member’s imagery indicated feeling “stuck.” Participant images included: standing on a rock, wanting to go in the water but afraid to do so, inability to see beyond the face of a grandchild, afraid to leave the shore, needing and yelling for help and reassurance, and recurring color patterns. Imagery in subsequent sessions indicated an active exploration of self. Participants began to revisit
and reclaim significant persons from the past; became open to allowing other aspects of self in; reclaimed a part of old self; explored inner beauty; and found the courage to explore new opportunities. At the end of the 10-weeks, some participants expressed and identified with a newly found self, and some indicated continued search of self, moving towards transformation. These results support previous findings regarding the ability of Guided Imagery and Music to help breast cancer survivors re-evaluate and reclaim identity. (Marr, 1998-1999; Cadrin, 2005-2006).

In the control group, the pre-intervention IDN mean was 55.83. The post-intervention IDN mean was 51.17. This decrease in IDN scores was desirable, as pre-intervention scores were overly high. This indicates that participants went from the 69th percentile to the 53rd percentile of test norms on IDN scores. Based on the Wilcoxon Rank Sum Test, this decrease in IDN scores was a statistically significant improvement in identity from pre- to post-intervention (p = .026). Furthermore, this improvement is clinically significant, based on a large effect size (r = 0.91). This finding adds to the literature, as previous treatment studies investigating the effectiveness of cognitive-behavioral based support groups were not found.

While no comparison studies are available, like the music psychotherapy group, it is felt that participants in this group were actively moving toward reclaiming a personal identity that integrated their illness, but no longer was defined by their illness. However, unlike the music psychotherapy group, participants in this group were just beginning the process of reclaiming and/or creating a new identity. Many participants expressed a desire to explore new opportunities, but no participants actually succeeded in engaging in
identified opportunities of interest. Furthermore, many participants expressed a continued struggle in reclaiming loss parts of self.

In relation to the second subordinate question – will breast cancer survivors in the music psychotherapy group improve their identity significantly more than the cognitive-behavioral group, the null hypothesis is rejected as post-test identity scores between the music psychotherapy and the cognitive-behavioral group were significantly different (p = .30). The experimental group improved significantly more than the control group on IDN measures. Furthermore, these results are clinically significant, as a large effect size was obtained (r = 0.64).

Effects on Role Performance

Role performance is the way in which an individual perceives his or her ability to carry out significant roles (Potter & Perry, 2005). Each role involves meeting certain expectations. Difficulty or an inability to meet role expectations often contributes to an altered self-concept. The Academic/Work Subscale and the Family Subscale of the TSCS-2 were used to measure changes in role performance. On the TSCS-2, T scores range from ≤ 20 to >80, with an average of 49-51, for test norms.

The Academic/Work (ACA) scale is a measure of how people perceive themselves in school and work settings, and how they believe others see them in those settings. Individuals with high ACA scores (≥ 60 T) feel confident and competent in learning and work environments. They are comfortable approaching new tasks and are not affected by the early failures that usually accompany new learning or creative activity (Fitts and Warren, 1996). Individuals with low ACA scores (≤ 40 T) have expressed difficulty performing in work or school settings. This difficulty may be related to actual
performance levels or it may indicate the presence of unrealistic expectations. These individuals are cautious about accepting new tasks or responsibilities and interpret early failures as indications that they are not competent to complete the task at hand (Fitts and Warren, 1996).

Within the music psychotherapy group, the pre-intervention mean for the ACA was 47.20. The post-intervention mean was 48.8. This indicates that subjects in the music psychotherapy group went from the 38 percentile of test norms to the 48 percent of norms, an increase in their positive view of their academic/work self. Results of the Wilcoxon Rank Sum Test indicated that this change in academic/work self in the music psychotherapy group was statistically significant (p = .059). Additionally, clinical significance was obtained, as a large effect size was present (r = 0.84). This finding adds to the music therapy literature, as no treatment studies were found investigating the effectiveness of music therapy on academic/work self-concept.

In the control group, the pre-intervention ACA mean score was 48.0. The post-intervention ACA mean score was 49.8. Participants in the control group went from the 42 percentile of test norms to the 46th percentile post-treatment in relation to academic/work self-concept. The results of the Wilcoxon Rank Sum Test indicated this change in pre and post test scores was not statistically significant (p = .180). As a large effect size was obtained (r = 0.55) these changes, while not statistically significant, may be clinically significant if a larger sample size was available. Future research investigating the effect of cognitive-behavioral based support groups on academic/work setting self-concept with a larger sample size is warranted.
Results of the Mann Whitney U test indicated no significant difference between groups on ACA post-test mean scores (p = .662). However, given the weak effect size (r = -.14), these results need to be interpreted with an abundance of caution. Given that improvement in the group music psychotherapy was statistically and clinically significant, it is possible future research with a larger sample size would find a significant difference between groups. In relation to the third subordinate question – will cancer survivors in the experimental group improve their academic/work scores significantly more than the control group, the null hypothesis is accepted, as between group post test ACA scores were not statistically significant.

The Family sub-scale (FAM) reflects the individual’s feelings of adequacy, worth, and value as a family member. It refers to the individual’s perception of self in relation to his or her immediate circle of associates (Warren and Fitts, 1996). Individuals with high FAM scores (≥ 60 T) have expressed a sense of satisfaction with their family relationships – they derive a sense of support and nurturance in the context of their families. Individuals with low FAM scores (≤ 40 T) have indicated a sense of alienation from or disappointment in their families (Fitts & Warren, 1996).

Within the music psychotherapy group, the pre-intervention mean on the FAM was 44T. Participants in the experimental group only had a positive view of their value as a family member 28 percent of the time before treatment, significantly below average as compared to test norms. Post-intervention mean FAM scores were 52.6T. After 10 weeks of group music psychotherapy, subjects increased their positive view of their value as a family member to that of 57 percent of test norms – above average. Results of the Wilcoxon Rank Sum Test indicate this improvement in FAM scores was statistically
significant \((p = .043)\). Additionally, a large effect size was present; indicating that post-test improvement in FAM scores is also clinically significant. This finding adds to the literature, as previous treatment studies investigating the impact of music therapy on family relationships were not found.

In the control group, the pre-intervention FAM mean score was \(42.3T\). This indicates that participants in the control group only had a positive view of their value as a family member 21 percent of the time, as compared to normative data. The post-intervention FAM mean score was \(47.83T\). The post-intervention analysis indicated that participants in the control group increased their positive view of their value as a family member to the 38 percentile for normals. Results of the Wilcoxon Rank Sum Test showed there was a significant improvement in FAM means scores within the control group \((p = .027)\). Furthermore, based on effect size, these findings are clinically significant \((r = .90)\). However, it is important to note, while there was a significant increase in family self-concept scores, participants in the control group remained below average in their personal view of their value as a family member. While previous research has indicated that group therapy can improve family functioning (Kissane, Bloch, Smith, et al., 2003) with those diagnosed with early breast cancer; only anecdotal evidence was found in relation to family functioning and breast cancer survivors.

In the cognitive-behavioral treatment group, ongoing frustrations with family were often expressed despite interventions to improve such. At times, participants were redirected, as it was easy for them to “spiral downward,” supporting each other’s negative views, versus actively searching for new alternatives. Many expressed that family members, while supportive during the initial period of diagnosis and treatment,
just did not “understand that I am not the same person – I am different.” The very nature of group music psychotherapy prevented this from occurring in the experimental group; the nature of the intervention and the movement inherent in the music encourages subsequent movement towards finding alternatives.

Comparison of post test mean FAM scores between the experimental and control group were done. Results of the Mann Whitney U Test indicated a significant difference between the experimental and the control groups, favoring the experimental group (p = .052). However, given the weak effect size (r = .01), caution is needed in interpreting these results. In relation to the fourth subordinate problem, will breast cancer survivors in group music psychotherapy improve family role relationships, the null hypothesis is rejected. Music psychotherapy improved family self-concept significantly more than cognitive behavioral therapy. However, given the weak statistical significance, further research is needed to validate these results.

Effect on Self-esteem

Self-esteem is the emotional appraisal of self-concept. The relationship between self-esteem and psychological well being (e.g., lack of depression, social anxiety, loneliness, and alienation) may be an important factor in understanding the self-esteem/health relationship (Blascovich & Tomaka, 1991). The Personal Sub-scale (PER) of the TSCS-2 was used to measure changes in self-esteem. On the TSCS-2, T scores range from $\leq 20$ to $>80$, with an average of 49-51, for test norms.

The PER score reflects the individual’s sense of personal worth, feeling of adequacy as a person, and self-evaluation of the personality apart from the body or relationships to others. This score reflects overall personality integration (Fitts and
Warren, 1996). When the PER score is high ($\geq 60 T$ for an individual), it is an indication of a well-adjusted individual. When the PER is low ($\leq 40 T$), it is indicative of an individual who is particularly reactive to temporary circumstances and to the opinions and behavior of others.

Within the experimental group, mean PER score pre-intervention were 48.00$T$. This indicated personality integration of participants in the experimental group matched 42 percent of test norms prior to the intervention. Post-intervention PER mean score was 53.4$T$. The post-intervention data indicated overall personality integration increased to above average, as it matched match 61 percent of test norms. Results of the Wilcoxon U Test indicated group music psychotherapy significantly improved PER scores ($p = .043$). Furthermore, these results are clinically significant, as a large effect size is present ($r = 0.90$). These findings further support the work of Hale (1992); Pienta (1998); & Burns (1999), Guided Imagery and Music affects the self-esteem of breast cancer survivors.

Within the control group, the pre-intervention PER mean score was 47.67$T$. Control groups matched 38 percent of test norms on personality integration pre-intervention. The post intervention PER mean score was 48.3$T$. After treatment, control group participants matched 42 percent of test norms on measures of personality integration. Results of the Wilcoxon U Test indicated participants in the control group did not statistically improve PER mean scores ($p = .599$). However, based on a small effect size, these results need to be interpreted with caution. Previous research has indicated of Edelman, Bell, & Kidman (1999), who found that group cognitive-behavioral therapy enhanced self-esteem in metastatic breast cancer patients (Edleman, Bell, and Kidman, 1999). However no treatment studies where found in relation to breast
cancer survivors. More research needs to be done to determine if group cognitive-behavioral therapy has an affects on breast cancer survivor’s self-esteem.

Post test comparison of PER mean scores was done using the Mann Whitney U test. Results indicated no significant difference between the experimental and control group on post-intervention PER scores. However, based on a moderate effect size ($r = .50$), further research is warranted to validate these findings. In relation to the fifth subordinate problems, will breast cancer survivors in group music psychotherapy improve their self-esteem significantly more than breast cancer survivors in cognitive-behavioral group, the null hypothesis was accepted. While group music psychotherapy significantly improved PER mean scores, results of the Mann Whitney indicated no significant difference between the music psychotherapy (experimental) and the cognitive behavioral (control) groups.

Effects of Treatment on Body Image

Body image issues are often associated with impaired self-concept. Body image includes one’s perceptions of shape, size, appearance, structure, and significance of the body (Potter & Perry, 2005). Feelings of body image also include those related to sexuality, femininity, health, and strength. The Body Image After Breast Cancer Questionnaire (BIBCQ) was used to measure changes in body image (Baxter, 1998). It is a descriptive questionnaire designed to assess the long-term impact of breast cancer, enabling meaningful measurement and comparison. Scores capture six domains of body image: vulnerability (feelings of susceptibility of the body to illness and cancer), body stigma (feelings of the need to keep the body hidden), limitations (feelings about competency and ability), body concerns (satisfaction with body shape and appearance),
transparency (concerns about the obviousness of cancer-related changes to the body) and arm concerns (concerns about arm symptoms and appearance). While normative data is not available, decreases in scores were considered desirable, as lower scores indicate healthier views of the body.

Within the experimental group, the mean body image score pre-intervention was 147.4. Post-intervention mean body image score was decreased to 114. The results of the Wilcoxon Rank Sum Test indicated group music psychotherapy significantly decreased body image scores (p = .043). Furthermore, these results are clinically significant, as a large effect size was obtained (p = .90). Specific domain measures indicated that group music psychotherapy decreased participant’s vulnerability, body stigma, limitations, body concerns, transparency, and arm concerns. This supports previous research findings concerning the positive impact of Guided Imagery and Music on body image (Hales, 1992).

In the control group, the mean body image score pre-intervention was 169.7 and reduced to 146.2 post-intervention. The results of the Wilcoxon Rank Sums Test indicate the cognitive-behavioral support significantly decreased body image scores (p = .028). Furthermore, based on a large effect size (r = .90), these results are clinically significant. Similar to the music psychotherapy group, scores on the Body Image After Breast Cancer Questionnaire improved in all domain areas. These findings add to the psychology literature as no treatment studies were found investigating the effectiveness of support groups on improving breast cancer survivor’s body image.

Post test BIBCQ scores between the experimental and control groups were compared to identify any significant differences. Results of the Mann Whitney U Test on
post test BIBCQ scores revealed a significant difference between groups, favoring the music psychotherapy group (p = .030). Furthermore, these results were clinically significant, as a large effect size is present (r = .64). Group music psychotherapy significantly improved the body image of breast cancer survivors as compared to a cognitive-behavioral support group.

In relation to the sixth subordinate question, will breast cancer survivors in GrMI improve their body image significantly more than the cognitive-behavioral group, the null hypothesis is rejected as participants in group music psychotherapy improved significantly more on measures of body image in comparison to participants in the cognitive behavioral support group.

Possible Explanations

Diagnosis with a life-threatening illness can lead to many changes in one’s self. Physical changes associated with acute and chronic effects of treatment, disruptions and changes in the ability to fulfill one’s role within family and society, psychological and spiritual aspects associated with coping, and interruptions to the sense of who, where, and what an individual believes can lead to these changes (Lovey’s & Klaich, 1991; Fife, 1994; Zebreck, 2000; Boehmke & Dickerson, 2006). These changes in self-concept (identity, role performance, self-esteem, and body image) are key to determining the individual impact of major life changes, such as breast cancer, (Pearlin, 1989).

After treatment, cancer survivors are challenged to balance their own notions of healthy self with their actual experiences of new or different physical, spiritual, emotional, or social capabilities. Research indicates cancer survivors must understand the meaning of the cancer in terms of how it affects the self and then refine the self in
relation to breast cancer by integrating different aspects of the breast cancer into the self or by formulating a new self (Carpenter, J., Brockopp, D., & Andrykowski, M., 1999; Coward, D., & Kahn, D., 2005; Boehmke & Dickerson, S., 2006; Collie, K., Bottorff, J., & Long, C., 2006).

Cognitive-behavioral based support groups have served many individuals facing cancer. The traditional role of such groups has been to provide information, teach coping mechanisms, and to provide emotional support. While several studies have investigated the impact of these groups on health-related quality of life, this is the first known study to investigate the effects on self-concept – a key component of not only quality of life but also positive transformation. Results indicate that cognitive-behavior based support groups for breast cancer survivors significantly improves measures of identity, family role relationships, and body image – three key components of self-concept.

Like cognitive-behavioral therapy, group music psychotherapy, is a form of therapy that allows individuals to identify, explore, and develop new ways of coping in a safe and supportive environment. However, this process aims to connect the mind and body. It starts from the individual’s unconscious and aims to open one’s imagination through music. The images evoked by the music may serve as metaphors for life. This offers individuals an alternative process – a process of imagining, and more fully experiencing possible choices in a safe and supportive environment. As the images serve as metaphors of life, individuals can then live, embrace, and define them in a way that allows for needed change as they continue on life’s journey. Results of this study indicated that group music psychotherapy had a significant effect on measures of identity,
family role relationships, self-esteem, and body image, all four key measures of self-concept.

Furthermore, in comparison to cognitive-behavioral based support group, group music psychotherapy had a significantly greater effect on measures of identity, family role relationships, and body image. The key differences between the two treatments can involve several factors. In cognitive-behavioral therapy, the “issue” is identified before solutions are explored. However, in a life-altering event such as the diagnosis of breast cancer, identifying key components of one’s suffering, or what is preventing one from living life to the fullest, can be a rather daunting and challenging task in and of itself. This is compared to the process of Guided Imagery and Music, where participants begin with a more general opening, allowing the individual’s imagery to reveal the underlying obstacles as they reconnect with their body and their emotions.

Another reason for the results can be related to the music. Music, like life, is synonymous with movement. When we are “stuck” in life, we are no longer living, and the image of a broken record comes to mind. The inherent movement present in the music programs applied in Guided Imagery and Music allows for movement in the imagination – more exploration is possible, and this exploration can come from several different “angles” until a new path is discovered.

Lastly, in group music psychotherapy, it becomes difficult for members to “hide” behind other members in the group. While there is an underlying group process, the imagery and resulting experience can be individual, group, or various combinations of the two. Because the music continues regardless, individuals are not forced to sit quietly and
wait their turn – each has her own experience, which may or may not coincide with other group members in the same time frame.

Lastly, in group music psychotherapy, participants are provided with an opportunity to reconnect with their bodies in a multidimensional way. The music allows participants the opportunity to not only to have an auditory experience, but a kinesthetic, visual, and/or emotional experience. By using music to address health, we essentially recognize the multidimensional aspects of self as well as the need for multidimensional techniques to access, explore, recreate, and/or create a new way of being.

Limitations

Several limitations are present in this study. While comparisons between two treatment groups were made, comparison with a no treatment control group was not made. Therefore, there is the possibility that scores would have improved regardless of treatment interventions. A second limitation is sample size; only eleven subjects participated in this study, five in the experimental group and six in the control group. Time constraints on data collection as well as the lengthy number of treatment sessions prevented inclusion of more participants. While effect sizes were reported, sample size limits applicability of these findings. Furthermore, all of the study participants were recruited from various support groups within the greater Charleston, SC area. Given the small geographical size for the participant pool, further caution is needed in determining the clinical applicability of these results. All of the participants in this study had attended a support group for breast cancer patients on at least one occasion. It is possible that they were suffering from higher levels of psychosocial distress than the general breast cancer patients, again calling into question the applicability of these findings on the overall
population of breast cancer survivors. Lastly, all participants were of European descent—no African-American, Latina, or Asian-American women participated in this study. While several research studies have been done investigating the impact of breast cancer on various ethnic groups the same has not been done for treatment studies. Treatment studies including racial and ethnic diversity are greatly needed.

Future research should be undertaken to validate the results of this study, investigating both cognitive behavioral support groups as well as group music psychotherapy. When possible, future research studies should not only include larger sample sizes, but include ethnic and racial diversity. Furthermore, research is needed to determine the optimal number of group sessions needed, as this has not been established in the literature, and a lengthy number of treatment studies prevented more participant recruitment for this study. Lastly, future research should also establish any short and long-term lasting treatment effects of music psychotherapy and cognitive behavioral therapy on the self-concept of breast cancer survivors.
Based on the results of the study, the following conclusions have been made:

1) Music psychotherapy significantly improved identity, as did cognitive behavioral therapy; however, music psychotherapy led to greater improvements in measures of identity than cognitive behavioral therapy.

2) Music psychotherapy significantly improved family role relationships, as did cognitive behavioral therapy; however, music psychotherapy led to greater improvement in family role relationships than cognitive behavioral therapy.

3) Music psychotherapy significantly improved body image, as did cognitive behavioral therapy; however, music psychotherapy led to greater improvements in body image than cognitive behavioral therapy.

4) Music psychotherapy significantly improved social self-concept, cognitive behavioral therapy did not; however, music psychotherapy did not lead to greater improvement in social self-concept than cognitive-behavioral therapy.

5) Music psychotherapy significantly improved self-esteem, cognitive behavioral therapy did not; however, music psychotherapy did not lead to greater improvements in self-esteem than cognitive behavioral therapy.
Music psychotherapy significantly improved academic/work role relationships, cognitive behavioral therapy did not; however, music psychotherapy did not lead to greater improvements in academic/work role relationships than cognitive behavioral therapy.

Implications

Secondary to advances in screening and treatment, the population of breast cancer survivors is growing. As such, treatments that effectively address the psychological needs of survivors are needed. Results of this study indicated music psychotherapy is an effective treatment modality for addressing self-concept and for addressing the needs of breast cancer survivors. Furthermore, music psychotherapy is as effective, or in some cases, more effective than traditional forms of treatment in treating self-concept and the needs of breast cancer survivors.

There is a paucity of research, both in traditional and alternative methods of therapy, addressing the effectiveness of treating the psychological needs of breast cancer survivors. Furthermore, no treatment studies were found comparing the effectiveness of two different treatment methods. The results of this study indicate both music psychotherapy and cognitive behavioral therapy may be effective in treating issues of self-concept as well as treating the needs of breast cancer survivors. However, further treatment studies are needed to support these findings.
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May 10, 2009

Joy Allen, M.S., C.T.
Coordinator of Music Therapy
Trident Health System
5030 Medical Plaza Drive
Charleston, SC 29466

IRB: IRB Protocol #2193 - The effectiveness of group music psychotherapy in improving the self-concept of breast cancer survivors: A randomized control trial

Dear Ms. Allen,

The above-referenced protocol, informed consent, and permission to audiocope were present for expedited review on May 11, 2009. The clinical research was approved.

This approval is for Trident Health System only. The approval is for a period of up to one year from the date of the informed consent form. If the project will continue beyond the expiration date noted, an amendment for continuation must be granted by the IRB prior to that date. If the project is concluded on or before the expiration date noted above, a final report must be submitted to the IRB. If changes in the protocol, whether major or minor, are required, the IRB must approve such changes before they are implemented.

If you have any additional questions, please feel free to contact me at 843-7004. Thank you for using the Trident Health System IRB where our #1 goal is protecting the rights and welfare of human subjects.

Sincerely,

[Signature]

William Houston, MD
IRB Chairman
Trident Health System

Trident Health System

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Institutional Review Board (IRB)/Independent Ethics Committee (IEC)
Authorization Agreement

Name of Institution or Organization Providing IRB Review:
Trident Health System

IRB Registration # 00034340 FWA# 0007861

Name of Institution Relying on the Designated IRB:
Temple University
FWA# 0004064

The officials signing below agree that Temple University may rely on the designated IRB for review and continuing oversight of its human subjects research described below:

Name of Research Project:
The effectiveness of group music psychotherapy on improving the self-concept of breast cancer survivors: A randomized control trial

Name of Principal Investigator:
Joy Alkin

Sponsor or funding agency:
Trident Health System

The review performed by the designated IRB will meet the human subject protection requirements of Temple University OHRP-approved FWA. The IRB at Trident Health System will follow written procedures for reporting its findings and actions to appropriate officials at Temple University. Relevant minutes of IRB meetings will be made available to Temple University upon request. Temple University remains responsible for ensuring compliance with the IRB’s determination and with the Terms of its OHRP-approved FWA. This document must be kept on file by both parties and provided to OHRP upon request.

Signature of Signatory Official
[Signature]
Date: 6/14/05

Print Full Name: [Signature]
Title: [Signature]

Signature of Signatory Official
[Signature]
Date: 6/17/09

Print Full Name: [Signature]
Title: [Signature]
Informed Consent

Study Title: The effectiveness of group music psychotherapy in improving the self-concept of breast cancer survivors: A randomized control trial

Researcher:
Joy Allen, MMT, MT-BC
Coordinator of Music Therapy, Trident Health System
Doctoral Candidate, Temple University
843-847-4134
Joy.Allen@HCAHealthcare.com

Faculty Advisor:
Kenneth Brescia, PhD, MT-BC, FAMI
Professor of Music Therapy, Temple University
215-204-8214
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Purpose of Research: You are being asked to participate as a volunteer in a study involving the examination of the effectiveness of group music psychotherapy in improving the self-concept of breast cancer survivors. For the purpose of this study, group music psychotherapy is defined as a form of psychotherapy that allows one to imagine, explore, and more fully experience possible life choices in a safe and supportive group environment. A cancer survivor is identified as an individual who has completed initial treatment for breast cancer and is currently in remission or receiving maintenance therapy.

Subject Eligibility: Twenty subjects will participate in this study. Subjects may be eligible to participate if they satisfy all of the following requirements:
1) age over 18 years of age
2) are able to read and speak English
3) have normal hearing
4) are able to engage in conversations
5) are female
6) have completed initial treatment for breast cancer and are currently in remission or receiving maintenance therapy

Your eligibility to participate will be assessed by the researcher during the initial contact.

What the study involves: As a subject, you are asked to participate in a support group for breast cancer survivors over 10 consecutive weeks. Subjects will be randomly assigned.

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Group music psychotherapy in improving the self-concept of breast cancer survivors

Subjects randomly assigned to the group music psychotherapy support group (GrMI) will attend weekly sessions, led by the researcher, each lasting approximately sixty (60) minutes. The format for each session will be: 1) Preliminary Conversation; 2) Relaxation Induction; 3) Music imaging experience; 4) Return to alert state; and 4) Postlude discussion.

The preliminary conversation serves to identify the goal, concern, theme, and/or conflict that is relevant to the group or any of its members for that session. This may be determined by the therapist, based on assessment of group needs or wants or based on what members present in the opening discussion. Alternatively, group members may develop the theme based on a group discussion of concerns. Once the overall theme is decided upon, the type of listening experience, the interactional format of the imaging, the induction and focus, and the music will be selected.

The purpose of the relaxation induction is to prepare group members physically and emotionally for the group music and imagery experience. The type of induction for each session will be based on the nature of the group, theme and music selection. Inductions may include breathing exercises, progressive body stretches, autogenics (repeating verbal phrases focused on a particular effect to facilitate a deeper state of relaxation), and/or directed imagery (e.g., ball of energy messaging each part of your body). The induction will conclude with the therapist providing a starting image based on the theme and chosen music.

During the music imaging experience, group members will image while listening to music in a relaxed state, assisted by verbal interventions by the therapist, all aimed at helping each individual explore and work through the selected theme. Based on the preliminary conversation, group members may interact within the imagery independently, as a group, or within subgroups. Additionally, the image may be directed, unguided, progressive and/or interactive. As the music imaging experience comes to a close, the therapist will then help members return to the here-and-now and the session will transition into the postlude discussion.

The purpose of the postlude is to process, work through and/or consolidate the music-imaging experience. The therapist may work with the group to process and reflect on the experience in an effort to find connections and meaning. Alternatively, the therapist might explore the experience even further or consolidate the experience to closure. The specific approach taken during the postlude is based on the overall direction of the session as decided on in the prelude.

Participants randomly assigned to the cognitive-behavioral based support will attend ten consecutive weekly sessions, led by the researcher, each lasting approximately sixty (60) minutes. The format for each session will be: 1) An Introduction; 2) A group discussion; 3) Education; and 4) A discussion of personal commitment statements.

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MAY 29, 2009
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During the introduction, the therapist will identify the goal or theme of the particular group session based on an assessment of group needs or based on general concerns often experienced by breast cancer survivors.

During the group discussion, the therapist will facilitate participant interaction around the chosen theme. The therapist will emphasize that participants speak from a personal, specific, and emotional way while supporting one another.

During the education phase, participants will be presented with various resources and experiences to highlight coping strategies related to the chosen theme. The focus will be on teaching skills and reflecting on problems that occur in daily life. Exercises (including worksheets and dyads) may be applied to emphasize self-guided discovery.

Prior to the end of the group session, participants will be asked to create a personal commitment statement based on the overall theme of the group and targeted coping strategies. This personal commitment statement is designed to hold participants accountable for change.

At the first group meeting and again at the end of ten consecutive weeks, participants will complete the Tennessee Self-Concept Scale and The Body Image After Breast Cancer Questionnaire.

Information you need to know before you give consent:

I understand that my participation in this study is completely voluntary. I understand that I will not be charged for participating in this study. I also understand that no compensation is available to me for participating in this study. I understand that I am free to withdraw from the study at any time. My participation in the study is in no way connected to my care from Trident Health System, and my decision to participate or withdraw will in no way affect my care or treatment from Trident Health System.

I understand that all information about me will be kept in the strictest confidence. My name will not appear on any data sheets. Instead, I will be assigned a subject number, and this will be used to identify my information. There will be one list which links my name to my subject number. This list will be kept in a locked cabinet in the researcher's office at Trident Medical Center. No one will have access to any of my information besides the researcher listed above.

I understand that there may be benefits to my participation in this study: 1) I may experience reduced emotional distress 2) I may experience increased self-awareness 3) I may feel additional support and validation 4) I may experience improved coping skills as a result of the group sessions.

I also understand that there may be risks to my participation in this study, although these are very unlikely: 1) I may experience distress or discomfort in telling or reliving my life
Group music psychotherapy in improving the self-concept of breast cancer survivors experiences. If this happens, I understand that the researcher will talk to me and support me until I feel better.

I understand that my participation in this study does not constitute routine therapy, and it is not meant to substitute for such therapy.

I understand that these data are being collected for research purposes only. If the results of the study are published, my name will never be mentioned. All individual results will be held in the strictest of confidence.

If I have Questions: I understand that I am encouraged by the investigator to ask questions at any time, and that my questions will be given prompt and full answers. I understand that I may refuse to participate further in this project until my questions are answered to my satisfaction.

I understand that if I wish further information regarding my rights as a research subject, I may contact Dr. William Hueston, IRB Chairman of Trident Health System by phoning (843) 847-7000 or Richard Throm, Program Manager & Coordinator at Office of the Vice President for Research of Temple University by phoning (215) 707-8757.

HIPAA Authorization to Use and Disclose Health Information

By signing this consent form, you authorize the collection of your Protected Health Information (PHI) for the purpose of this research study. Once your health information has been disclosed to anyone outside of this study, the information may no longer be protected under this authorization.

The researcher will record information about you on study forms. The information will include your medical history as well as the treatment you receive and the results of music therapy treatment done during the study. The researcher will keep a copy for his/her study file. You have the right to review the researcher’s copy of these study forms.

Your name will not appear on the study forms. Instead, you will be assigned a patient identification number. The researcher will keep a list that matches patient identification numbers to patient names, but the researcher will not send that list to the study sponsor. However, the study forms will contain other information about you, such as your age, sex, and medical history. It is possible that this other information could be used to identify you though your name does not appear.

Representatives from the following organizations may also need to review your study forms:

- the institutional review boards (ethics committee) that approved this study
- Trident Health System

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MAY 20, 2003

THIS IRB

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Medical Records Other Than Study Forms. Representatives of the institutional review boards, may need to look at your medical records to make sure that the information on the study forms is correct. Reviews like that will take place at the study site or where the records are stored.

Use of Information. The information collected about you may be used in many ways. The researcher may use study information to prepare reports or publications. The sponsor may also use the information in any of the following ways:

- to analyze and make conclusions about the results of the study,
- in documents sent to government health agencies throughout the world (for example, documents sent to the FDA to request approval of the medicine used in the study),
- for reporting side effects to the FDA and other government health agencies,
- to provide overall study results, including your information, to other researchers and
- to reanalyze the study results in the future or to combine your information with information from other similar studies.

The information sent to the sponsor will no longer be protected by US Federal Privacy Laws and the sponsor could use or disclose it in ways other than those listed here. However, your name will never appear in any sponsor forms, reports, databases, or publications, or in any future disclosures by the sponsor.

Authorization to Use and Disclose. By signing this consent form, you are giving the researcher authorization (permission) to use and disclose your study information as described in this section of the consent form. You are also giving permission for review of your medical records (described above) by the sponsor and other authorized people. You do not have to give permission for this use and disclosure of information. However, if you do not, you will not be able to participate in the study.

Stopping Early. If you stop participating in the study early for any reason, the researcher will tell the sponsor why and will send the sponsor any study information that has already been collected about you. If the researcher asks you to come to any more study visits and you agree, your doctor will send the sponsor information from those visits as well. If knowing your health status at particular time points after treatment is important to the purpose of the study, the researcher may send that information to the sponsor even after you have stopped participating in the study.

Revolving Authorization to Disclose. If you stop participating in the study, you also have the right to revoke (cancel) your authorization to disclose information. Revoking your authorization means taking back the permission you gave the researcher to send information about you to the sponsor.

If you revoke your authorization, the researcher will not send any more information about you except to tell the sponsor that you have stopped early and revoked your

Approved

May 10, 2009

IRB
Group music psychotherapy in improving the self-concept of breast cancer survivors

authorization. That means the researcher will destroy any study forms that have not yet been sent to the sponsor. However, the sponsor can still keep and use any information that it has already received.

There is one exception to this. If knowing your health status at the time of revocation or the reason for your stopping early is important to the purpose of the study, the researcher may also send that information to the sponsor.

If you want to revoke your authorization, you must do so in writing. You can get a revocation form from the researcher or you can write a letter to the researcher.

You may revoke your authorization at any time. However, once you do so, you can no longer continue to participate in the study.

Expiration of Authorization. There is no expiration date for your authorization to use and disclose your information. The sponsor may keep and continue to use your study information for many years. The researcher may need to add to or correct information about you even after your study participation is over. This could include providing updates of your health status if that is important to the purpose of the study. The review of your medical records (described above) may also take place after the study is over.

I understand this document and the information that has been given to me. I have been given the opportunity to ask questions and have had all questions answered to my satisfaction.

I understand that my signature below indicates my voluntary consent to participate in this study as described above. I understand that a copy of this signed consent form will be given to me.

Name __________________________
Address __________________________
Telephone Numbers __________________________
Signature __________________________
Date __________________________
Witness __________________________
Date __________________________

Approved
THS 128
Permission to Audio-Tape

Researcher:
Joy Allen, MMT, MT-BC
Coordinator of Music Therapy, Trident Health System
Doctoral Candidate, Temple University
843-847-4134
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Faculty Advisor:
Kenneth Bruscia, PhD, MT-BC, FAMI
Professor of Music Therapy, Temple University
215-204-8214
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Study Title: The effectiveness of group music psychotherapy in improving the self-concept of breast cancer survivors: A randomized control trial.

Subject ___________________________ Date _____________

I give Joy Allen, MMT, MT-BC, permission to audiotape me. This audiotape will be used only for research purposes. I have already given my consent for my participation in the research project. At no time will my name be used.

Where will I be audiotaped?
I agree to be audiotaped during group sessions.

How long will the tapes be used?
I give my permission for the tapes to be used from June 16, 2009 to June 16, 2010.

What if I change my mind?
I understand that I can withdraw my permission at any time. Upon my request, the audiotapes will no longer be used. This will not affect my care or treatment from Trident Health System in any way.

For further information:
If I want more information about the audiotape, or if I have questions or concerns at any time, I can contact the investigator at the number listed at the top of this page.

APPENDIX C
PERMISSION TO AUDIO-TAPE
Group music psychotherapy in improving the self-concept of breast cancer survivors

I understand that my signature below indicates my voluntary consent to be audiotaped. I understand that I will be given a copy of this form.

Name __________________________
Address __________________________
Telephone Number __________________________
Signature __________________________ Date __________________________
Witness __________________________ Date __________________________

Approved
May 20, 2009

THS IRB
APPENDIX D

GENERAL WELL-BEING SCALE

Please indicate your level of agreement with the following statements by marking an “X” along the line.

I feel in control

Disagree  Agree

__________________________

I feel empowered

Disagree  Agree

__________________________

I feel good about myself

Disagree  Agree

__________________________

I feel connected to others in the group

Disagree  Agree

__________________________

This session helped me access a part of myself that I need at this time (post-session only)

Disagree  Agree

__________________________
APPENDIX E
COGNITIVE-BEHAVIORAL GROUP DECISION TREE

1) Preliminary Conversation
   a. What does the group want or need to explore?
      i. Coping with Breast Cancer
      ii. Who am I?
      iii. Identifying Feelings/Reactions
      iv. Family
      v. Communicating Needs and Taking Responsibility
      vi. Body Image and Sexuality
      vii. Strengths
      viii. Issues related to illness and dying
      ix. Taking care of me
      x. Who will I be?

2) What will help the group explore theme or issue?
   a. Group discussion
   b. Breaking down into dyads
   c. Supporting individual members

3) Education – what resources and/or experiences will highlight specific coping strategies to emphasize self-guided discovery
   a. Worksheets
   b. Breaking down into dyads

4) Personal Commitment Statement
   a. How can participants be active agents of change

5) Potential Topics
   a. Support Groups – how can the group help each other
      i. Group discussion
         1. Why am I here
      ii. Education
         1. Break into dyads to share expectations/fears and practice active listening skills
      iii. Commitment Statements
   b. Coping with breast cancer
      i. Group discussion
         1. share personal stories
      ii. Education
         1. emphasize capturing and saying out loud emotions and active coping strategies
   c. Who am I (Loss of identity)?
      i. Breaking down into dyads
         1. life before cancer
         2. life now
         3. what would I like to be
      ii. Education
1. Notice personal reactions to others stories
   iii. Commitment Statement
       1. What is one thing I can do this week to capture who I would like to be?

d. Family
   i. Group discussion
       1. Who is the most important person in my life?
   ii. Education
       1. Worksheets –
          a. what are the current struggles with relationships in my life
          b. What is preventing me from forming relationships that I long for
   iii. Commitment Statement
       1. What will I do to improve my relationships?

e. Communicating Needs and Taking Responsibility
   i. Group discussion
       1. What do I need to say and who do I need to say it to
       2. What do I feel in control of?
       3. What would I like to be in control of?
   ii. Education
       1. break into dyads
          a. How can I communicate more effectively my needs/wants
       2. Worksheet
          a. What am I in control of/what am I capable of controlling
       3. Commitment Statements
          a. What will I surrender control of/take control over

f. Body Image and Sexuality
   i. Group discussion
       1. How has your body changed?
   ii. Education
       1. group discussion
          a. How has body changes affected you personally, emotionally, physically?
   iii. Commitment Statements
       1. What will you do for your body?

g. Strengths
   i. Group discussion
       1. What have I learned from the breast cancer experience
   ii. Worksheets
       1. What do I have to offer to myself/others
   iii. Commitment Statement
       1. What will I celebrate?

h. Issues related to illness and dying
i. What recurrent thoughts/feelings/emotions do I have
ii. Worksheet
   1. identify one thought/feeling/emotion and associated triggers
iii. Commitment Statement
i. Taking care of me
   i. What do I do for myself
ii. Education
   1. group discussion on improving quality of life through healthy lifestyles
   2. worksheet – leisure activities
iii. Commitment Statements
j. Who will I be?
   i. Group discussion
      1. What have I taken from this experience
   ii. Group dyads
      1. I am… and I will be….
iii. Commitment Statement
   1. I will…. 
1) Preliminary Conversation
   a) What part of the self does the group want or need to explore?”
      i) Nurturing Self
      ii) Creative (Adventurous) Self
      iii) Introspective (Reflective) Self
      iv) Self in Relationship – Family
      v) Self in Relationship – Spouse/Partner
      vi) Social Self
      vii) Physical Self
      viii) Emotional Self
      ix) Spiritual Self
      x) Strong, Victorious Self
      xi) Past Self
      xii) Other parts of self
   b) How is this part of the self described by the group?
      i) Verbal metaphors and associations
      ii) Sensory channels
      iii) Dreams, previous imagery and their symbolism

2) Music Selection (Program Selection)
   a) What music will assist participants in exploring themes or issues discussed?
      i) Select music according to groups readiness: imaginal, emotional, musical, and physical
      ii) Select music according to relevance to part of self in focus:
         (1) Nurturing Self
             (a) Caring Short Version I (Music for the Imagination (MFI) – Supportive)
                 (i) Cut 1 Haydn Cello Concerto
                 (ii) Cut 5 Dvorak Serenade
                 (iii) Cut 6 Warlok Pieds en l’air
             (b) Nurturing – M (MFI – Positive)
                 (i) Cut 1: Britten: Simple Symphony (Sentimental Sarabande)
                 (ii) Cut 2: Walton: Touch her soft lips and part
                 (iii) Cut 5: Puccini: Madame Butterfly (Humming Chorus)
                 (iv) Cut 6: Massenet Orchestral Suite #7 (Sous Le Tilleuls)
             (c) Quiet Music – Piece 1,4 or 2,4 (Bonny, 1978)
                 (i) Piece 1: Debussy Danses Sacred & Profane
(ii) Piece 2: Debussy Afternoon of a Faun
(iii) Piece 4: Vaughan-Williams Fantasia on Greensleeves

(2) Creative (Adventurous) Self
(a) Creativity I - M (MFI – Creative)
   (i) Cut 6: Sibelius 2nd Symphony (1st Movement)
   (ii) Cut 8: Delius: La Calinda
   (iii) Cut 9: Kallinikov 2nd Symphony (Andante)
   (iv) Cut 10: Bizet Intermezzo from Carmen
(b) Explorations: Short Version 2 (MFI – Explorative)
   (i) Cut 4 Ravel Daphnis and Chloe
   (ii) Cut 5 Brahms 1st Symphony (Allegretto)
   (iii) Cut 6 Respighi Pines of Rome (Gianicola)

(3) Introspective (Reflective) Self
(a) Nostalgia (Bruscia, 2002)
   (i) Cut 4: Elgar Dream Children (Andante and Allegretto)
   (ii) Cut 5: Bach Concerto in E
   (iii) Cut 6: Alwyn Sinfonietta for Strings (Adagio)
   (iv) Cut 7: Parry Lady Radnor’s Suite – Slow Minuet
(b) Quiet Music – Pieces 1, 4 or 2, 4 (Bonny, 1978)
   (i) Piece 1: Debussy Danes Sacred & Profane
   (ii) Piece 2: Debussy Afternoon of a Faun
   (iii) Piece 4: Vaughan-Williams Fantasia on Greensleeves
(c) Creativity II – (Keiser Mardis, 1986)
   (i) Vaughan-Williams Norfolk Rhapsody
   (ii) Transitions – M (MFI – Transportive)
   (iii) Cut 6: Borodin 1st Symphony (Andante)
   (iv) Cut 7: Brahms 3rd Symphony (Poco Allegretto)
   (v) Cut 9: Brahms 2nd Piano Concerto (Andante)

(4) Self in Relationship – Family
(a) Relationships – M (MFI – Plaintive)
   (i) Cut 9: Chopin 1st Piano Concerto (Romanze)
   (ii) Cut 10: Rachmanioff 2nd Symphony (Adagio)
   (iii) Cut 11: Respighi Fountains of Rome
(b) Comforting (MFI – Supportive)
   (i) Cut 1: Haydn Cello Concerto in C (Adagio)
   (ii) Cut 2: Sibelius Swan of Tuonela
(c) Conversations (Skaggs)
   (i) Cut 1: Elgar Cello Concerto, Op. 895 (Adagio)
   (ii) Cut 2: Ravel Piano Concerto in G major (Adagio)

(5) Self in Relationship – Spouse/Partner
(a) Conversations (Skaggs)
   (i) Cut 2: Ravel Piano Concerto in G major (Adagio)
   (ii) Cut 3: Bizet Carmen Suite #1 (Entr’acte)
   (iii) Cut 4: Mendelssohn Violin Concerto (Andante)
   (iv) Cut 7: Stravinsky The Fairy’s Kiss (Adagio)
(b) Nostalgia (Bruscia, 2002)
(i) Cut 4: Elgar Dream Children (Andante and Allegretto)
(ii) Cut 5: Bach Concerto in E
(iii) Cut 6: Alwyn Sinfonietta for Strings
(iv) Cut 7: Parry Lady Radnor’s Suite

(c) Nurturing-M (MFI – Positive)
   (i) Cut 1: Britten: Simple Symphony (Sentimental Sarabande)
   (ii) Cut 2: Walton: Touch her soft lips and part
   (iii) Cut 5: Puccini: Madame Butterfly (Humming Chorus)
   (iv) Cut 6: Massenet Orchestral Suite #7 (Sous Le Tilleuls)

(d) Relationships-M (MFI – Plaintive)
   (i) Cut 9: Chopin 1st Piano Concerto (Romanze)
   (ii) Cut 10: Rachmaninoff 2nd Symphony (Adagio)
   (iii) Cut 11: Respighi Fountains of Rome (Villa Guilia)

(6) Social Self
   (a) Relationships-M (MFI – Plaintive)
      (i) Cut 9: Chopin 1st Piano Concerto (Romanze)
      (ii) Cut 10: Rachmaninoff 2nd Symphony (Adagio)
      (iii) Cut 11: Respighi Fountains of Rome (Villa Guilia)
   (b) Recollections (Bonny & Keiser Mardis, 1994)
      (i) Cut 1: Sibelius Swan of Tuonela
      (ii) Cut 2: Villa-Lobos: Bachianas Brasileiras (Aria #5)
      (iii) Cut 4: Glinka Ivan Susanin (Susanin’s Aria)

(7) Physical Self
   (a) Transitions – M (MFI – Transportive)
      (i) Cut 6: Borodin 1st Symphony (Andante)
      (ii) Cut 7: Brahms 3rd Symphony (Poco Allegretto)
      (iii) Cut 9: Brahms 2nd Piano Concerto (Andante)
   (b) Grieving – M (MFI – Plaintive)
      (i) Cut 1: Albinoni Oboe Concerto in D minor
      (ii) Cut 2: Rodrigo: Concierto de Aranjuez (Adagio)
      (iii) Cut 3: Grieg: Holberg Suite (Air)
      (iv) Cut 7: Bridge Lament
      (v) Cut 8: Delius 1st Aquarelle
   (c) Mournful (MFI – Supportive)
      (i) Cut 7: Sibelius Swan of Tuonela
      (ii) Cut 8: Goreczki 3rd Symphony (2nd Movement)
      (iii) Cut 9: Boccherini Cello Concerto

(8) Emotional Self
   (a) Explorations: Short Version 2 (MFI – Explorative)
      (i) Cut 4: Ravel Daphnis and Chloe
      (ii) Cut 5: Brahms 1st Symphony (Allegretto)
      (iii) Cut 6: Respighi Pines of Rome (Gianicola)
   (b) Transitions – M (MFI – Transportive)
      (i) Cut 6: Borodin 1st Symphony (Andante)
      (ii) Cut 7: Brahms 3rd Symphony (Poco Allegretto)
(iii) Cut 9: Brahms 2nd Piano Concerto (Andante)

(c) Nurturing-M (MFI – Positive)
  (i) Cut 1: Britten Simple Symphony (Sentimental Sarabande)
  (ii) Cut 2: Walton Touch her soft lips and part
  (iii) Cut 5: Puccini Madame Butterfly (Humming Chorus)
  (iv) Cut 6: Massenet Orchestral Suite #7 (Sous Le Tilleuls)

(d) Caring – Short Version 1 (MFI – Supportive)
  (i) Cut 1: Haydn Cello Concerto
  (ii) Cut 5: Dvorak Serenade
  (iii) Cut 6: Warlok Pieds en l’air

(e) Consoling (MFI – Supportive)
  (i) Cut 5: Dvorak Serenade in E (Larghetto)
  (ii) Cut 9: Boccherini Cello Concerto (Adagio)
  (iii) Cut 12: Shostakovich 2nd Piano Concerto
  (iv) Cut 6: Warlock Capriol Suite (Pieds en l’air)

(9) Spiritual Self
(a) Nurturing –M: cuts 1, 2, 5, 6, 7 (MFI – Positive)
  (i) Cut 1: Britten Simple Symphony (Sentimental Sarabande)
  (ii) Cut 2: Walton Touch her soft lips and part
  (iii) Cut 5: Puccini Madame Butterfly (Humming Chorus)
  (iv) Cut 6: Massenet Orchestral Suite #7 (Sous Le Tilleuls)

(b) Sublime (Bruscia, 2002)
  (i) Elgar Cello Concerto (Adagio)
  (ii) Mozart Clarient Quintet in A (Larghetto)
  (iii) Mendelssohn 7th String Symphony (Andante)
  (iv) Bach Piano Concerto in F (Largo)

(c) Quiet Music (Bonny, 1978)
  (i) Debussy Danes Sacred & Profane
  (ii) Debussy Afternoon of a Faun
  (iii) Vaughan–Williams Fantasia on Greensleeves

(10) Strong, Victorious Self
(a) Heroine’s Journey – Bruscia 2002
  (i) Canteloube: Songs of the Auvergne – Bailero
  (ii) Glazunov: Spring Opus 34
  (iii) Schmidt: Intermezzo from Notre Dame
  (iv) Canteloube: Songs of the Auvergne – Antony
  (v) Mussorgsky: Pictures at an Exhibition: Great Gate

(b) Positive Affect – Short Version 2 (MFI – Positive)
  (i) Cut 9: Elgar Enigma Variations 8 and 9
  (ii) Cut 11: Barber Adagio for Strings
  (iii) Cut 7: Schumann Funf Stucke

(c) Peak Experience – M (MFI – Transportive)
  (i) Cut 1: Beethoven 5th Piano Concerto (2nd Movement)
  (ii) Cut 2: Vivaldi Gloria (et in terra pax)
(iii) Cut 4: Faure Requiem (In Paradisum)
(iv) Cut 5: Wagner Lohengrin (Prelude to Act I)

3) Induction Decisions
   a) What is needed to prepare the group to enter into the music-imagery experience?
      i) Create induction according to:
         (1) Metaphors, images, symbols from prelude
         (2) Preferred sensory channels
         (3) Presenting physical and emotional needs
      ii) Relaxation” what will induce an expanded state of consciousness
         (1) Physical
            (a) Tense-release: use when energy or emotions are blocked or need expression
            (b) Stretch-relax: use when clients need to change or find new easy of doing something. Use in times of transition
            (c) Raise-Lower: Use when client is tired of holding everything up or together or taking care of others rather than self. Also helps resistant clients let go
            (d) Limb lift: when client needs to trust and receive love, or when fearful.
            (e) Face massage: Use to comfort client in sadness of loss
            (f) Others: design according to physical issues raised by client
         (2) Sensory Imaginal
            (a) See-feel:
               (i) Ball of light: helps the intellectual or visualizer
               (ii) Pencil of light forms line around perimeter of body, giving a sense of your own body form, then perimeter moves inward to being sense of calm: helps someone who is anxious, hysterical, or loses boundaries easily.
            (b) See-see:
               (i) Ray of light moving along object or person to show details: helps person to go deeper in the process
               (ii) Point of light starts in center of body, gets larger, and moves outward: helps to have expanded experience
               (iii) Light enters body and begins to illuminate the body: prepares for transpersonal
            (c) Feel-feel:
               (i) Tingling sensation that refreshes and energizes: helps sleepy and tired
               (ii) Moving each body part under waterfall cleanses and refreshes: relates to guilt, prepares for transpersonal
               (iii) Taking in deep breaths, feel air going into body, cooling, warming, relaxing, enlivening
               (iv) Take in deep breaths and let oxygen go into brain, clearing out all old thoughts and patterns, letting fresh air in
            (d) Feel-hear” Become aware of every situation in each body part, tell each part: legs relax, etc.
(e) Feel-see: tingling sensation or temperature brings light or color: helps kinesthetic person be more aware
(f) Hear-feel: tone to vibration to refreshing or energizing: helps auditory person to relax; helps to be responsive to music
(3) Fantasy Inductions: after a very short relaxation, begins story line with or without music in background. Helps people who resist relaxation inductions; also helps to engage person very deeply into one particular image or psychological process
(a) Standard imagery scene: place traveler in scene (e.g., with mountain, lake, stream, etc.), and fill in lots of details, using all the senses. Avoid setting up definite situations. When traveler appears ready, have him/her continue.
(b) Metaphoric Stories: Create an allegory or metaphoric story for the client based on previous work, and relate to client in very continuous, sequential fashion. Avoid cognitive material, and make the story very symbolic but enigmatic
(c) Myths, fairy tales
(4) Countdowns: use when continual verbal contact is needed
(a) Numerical countdowns: after a few deep breaths and orientation to body relaxation, start with the number ten, then give repeated suggestions for relaxation (All your thoughts are beginning to pass through your awareness, let them pass, one at a time, etc) then go to nine (you are beginning to feel your mind emptying, each thought is passing through and leaving), then go to eight (your body is beginning to feel a difference): use when clients are intellectual; also use when need to regress.
(b) Steps: start traveler at top or bottom of steps and give suggestions at each one as in the numerical countdown. Escalators can also be used, going to different floors. (Use for deeper work).
(c) Years. Start traveler in the present year, and take back in time, one year at a time. Key into common things such as clothes, car, house, hair, etc. in each year without being too specific. Let client continue to move backward when ready, and stop whenever he/she wants to explore.
(d) Past events: When a traveler had had any event occur several times in the past (e.g., moving, graduating, having children), use the events to regress in time. Let client continue to move backward when ready and stop to explore at will.

iii) Focus – what starting image or scene will help the group explore part of self discussed in Prelude?
(1) Music
(a) Leaves it up to the traveler to create an image or follow the experience based on the music: useful for clients who have authority issues, as will as clients who are experienced and nonresistant.
(2) Scenes in nature – provides a context for imaging rather than a specific imagery focus. Metaphoric aspects of the scene should be considered
(3) “Safe Place” – use for travelers that have one and for those who do not hide there
(4) Objects: single small objects useful in helping focus very intensely, and thereby go very deeply into something.
(5) Movement related: Good for people who are working on transition and change. Select according to type of challenge.
(6) Actions: Put the traveler into a particular process with the metaphor being key to effectiveness. Example: looking into the water, playing in sand, building a wall, cleaning a window.
(7) Biographical: The traveler focuses on a significant event, person, or object from his own life, past or present. The traveler must be intrigued to avoid resistance. Examples: house you grew up in, wife at dinner table, a scrapbook
(8) Animals: Selected according to client’s previous images or dreams, or according to symbolic significance. Be sure traveler is in safe place in relation to animal, and the music is consistent with animal
(9) Mythical characters: Useful for beginning clients who can only approach their work from a distance; they can also be very effective with experienced travelers, and those ready for transpersonal work.

4) Music Imaging Experience: what type of interaction and what level of guiding is needed to help members access, explore, and work through the theme.

   a) Types of interactions formats
      i) Directed music imaging
         (1) Clients image what the therapist presents while listening to music. The focus may be selected by the therapist or group and may be geared toward the group, individual, or a general issue. Only details are left to individuals so that the entire group has a very similar inner experience.
         (2) Unguided individual imaging in group
             (a) Each member images to music freely, separately and without direction or dialogue with the therapist.
         (3) Peer-Guided Dyads
             (a) The group is paired off, with one member guiding another, and the therapist observing. Therapist still does preliminary conversation, induction, and postlude
         (4) Individual Go-rounds
             (a) Each member takes turns imaging something about each of the other members or the entire group. Members may or may not respond within the image direct toward them. Helpful when members need to see what others members see about them
         (5) Group go-rounds
             (a) The group focuses on each member, one at a time, creating or co-creating images about that member, while being guided by the therapist
         (6) Progressive group imaging
             (a) Each member takes a turn in contributing to an evolving image or story
Guided interactive group imaging

(a) Therapist guides the entire group as members co-image to music

5) Postlude: help client return to here-now reality, while respecting their need for additional time or space to answer the following: what did the psyche disclose, work through, or give meaning to?
   a) Allow immediate reactions to surface and elaborate: what was most vivid or important
   b) Probe significant images and experiences (verbally and nonverbally) to uncover information that was unconsciously forgotten and to help say things out loud, so that they can come into his/her immediate awareness
   c) Find connections between images. This can include relating images within the same session, or relating present images to those of previous sessions
   d) Identify patterns in imagery process. Often, images are related in that they provide a metaphor for what happens repeatedly in the client’s inner life.
   e) Find connections with life: does the image remind the participant of anything that happens or has happened in everyday life? Are repeated images repeated life patterns? How does a repeated pattern in the imagery provide a metaphor for some aspect of the client’s life
   f) Bring closure
   g) Provide reassurance – help participants see signs in the session of their good intentions, work, accomplishments, or growth.
APPENDIX G

MUSIC PSYCHOTHERAPY GROUP PROCESS TREE

1) Getting Comfortable with GIM
   a. 1-2 Sessions
2) Discovering Parts of the Self
   a. 2-3 Sessions
3) Exploring Parts of Self
   a. 2-4 Sessions
4) Integrating Parts of Self
   a. 2-3 Sessions