**Abstract**

Many families face difficult dynamics between members, including generation gaps and flawed or antagonistic communication patterns. Various therapy methods have been developed to help families improve their communication and relationships. In the field of music therapy, performing, improvising, or listening to music are used to create an alternative mode of communication among family members, foster more positive relationships between them, and strengthen their ability to function as a family unit. However, most therapeutic methods focus on families in which one member, identified as the “patient,” has an illness, special needs, or requires extra support. Few music therapy approaches address families without any pathology and view them as a holistic unit, with a focus on empowering them to face the challenges of daily life and to develop as a family.

The current study reports on the development of a model of short-term music therapy for families that do not include an identified patient, but who have difficulties functioning as a family unit and wish to improve their relationships and develop family resilience. Family resilience is defined as a network of processes and group and individual traits that enable the family unit to function, survive, and prosper. This quality of resilience should continue to be integrated into the family dynamic after the therapy ends, enabling their ongoing emotional, psychological, and interpersonal development and providing them with tools to deal with life’s challenges.

My intention in this study was to develop a model that utilizes music therapy tools and techniques that are particularly effective in working on communication skills and interpersonal processes. I based the model on salutogenic and collaborative techniques and theories, such as community music therapy (CoMT) and resource-oriented music therapy (ROMT), which are appropriate for family therapy and focus on resilience-building, reinforcing the family’s existing strengths and abilities, and developing and promoting the family’s functioning.

Much has been written about music therapy in various family contexts. However, the vast majority of the previous research has addressed the dynamics in families in which one member has been identified as a patient. There is a need for research that looks at the family as a holistic unit and focuses on family relationships, communication between family members, and the balance between individual identity and family belonging. In addition, there is ample literature on the importance of family resilience, its benefits for all family members, and various targeted interventions for its development and promotion. However, these studies primarily pertain to the field of social work. There is room to assess interventions in the field of music therapy that develop resilience, especially among families.

The current study uses an action research methodology, which combines research with the clinical/professional field. This method was chosen because it enables effective change processes and yields significant theoretical contributions. The study followed and analyzed the stages of the model’s clinical development, while simultaneously being theoretically and conceptually grounded. As is typical in action research, this study was based on cycles that directed the model’s development process, each with a unique goal and method.

The purpose of the first research cycle, based on phenomenological research, was to assess, design, and test the emerging model’s conceptual framework. In this cycle, I built the conceptual framework and consulted therapists with expertise in the research areas of interest. The research tool was semi-structured in-depth interviews conducted with seven experts in the fields I intended to address: music therapy with families, resilience-building therapy, and short-term focused therapy. All interviews were transcribed and underwent thematic analysis. The various themes identified in the analysis were categorized to reveal insights into the opinions and perceptions of the participants regarding the research questions of the first cycle:

What should be included in a therapeutic plan for building family resilience through music therapy? What therapeutic principles, clinical emphases, and procedures should be used in developing and implementing such a plan?

The first cycle identified various issues important for developing an intervention model aimed at building family resilience. I plotted these issues along an axis ranging from theoretical/philosophical concepts, through therapeutic/clinical principles, to practical items such as the goals of the intervention and the music therapy tools to achieve them.

In terms of theory, the research participants recommended basing the model on principles of resilience-building, salutogenesis, and collaboration, and a psychodynamic view of family relationships and bonding. From a clinical point of view, the results indicated that the treatment should be short-term and characterized by semi-structured therapeutic work. The “patient” in the model’s therapeutic intervention will be the entire family unit. The therapist will work collaboratively, using a flexible and reflective approach. Key issues regarding building family resilience emerged: making connections, communication, personal identity, family belonging, and expressions of love.

In light of the results from the first cycle, I formulated an initial treatment plan of ten sessions. I outlined the stages of the model according to the experts’ recommendations: parent intake, meeting the family, setting goals, selecting goals to focus on, therapeutic work, conclusion with the family, and conclusion with the parents. Additionally, I compiled a toolbox of music therapy activities to help the families achieve their goals.

The aim of the second cycle was initial practical testing of the model that was developed based on the outline formulated in the first cycle. A pilot test was conducted with three families. The research method used in this cycle was a case study. Various research tools were used, as is common in this research method. A therapy log was kept for every meeting throughout the process. All meetings were audio and video recorded. Focus groups were held with each family at the beginning of the therapeutic process, at its end, and six months after its conclusion.

The data for each family case were first analyzed separately, followed by a comparative cross-sectional analysis between the family cases. The written data extracted from the therapeutic logs and the focus groups underwent thematic analysis. The recorded audio and video materials were analyzed interpretively based on the method for analyzing musical pieces produced in music therapy developed by Langenberg et al. (1993). To ensure the reliability of the research, given that I led the therapeutic interventions alongside being the researcher, regular and extensive clinical guidance and consultation with the research supervisor and with experts in family music therapy and resilience-building therapy were conducted.

The results of the second research cycle included the three individual family case studies and a comparative analysis of these three cases. The research questions of the second cycle were: In what ways did the therapy meet the families’ needs and in what ways did it not? What were the challenges in implementing the model? In what ways did the families’ resilience improve and in what ways did it not?

The analysis raised four main issues:

1. The degree to which the therapeutic meetings are structured must be flexible and sensitive to the family’s needs, which may best be served by more or less structure (i.e., order, organization, security, authenticity).
2. Integrating the resilience-building approach with the psychodynamic approach is particularly sensitive and necessitates a delicate balance of the approaches and the transitions between them.
3. Flexibility is needed in the intervention design and focus of the therapy, taking into account differences in families’ traits (i.e., developmental stage, children’s age range, parents’ marital status).
4. Providing the therapist with training and ongoing support should be an integral part of the model. This is essential due to the complexity of understanding, including, and referring to the multiple relationships and personalities within the families, and the challenge of applying different and even contradictory approaches (such as the resilience-building and psychodynamic approaches). This training should address how to integrate the theoretical approaches and interpret the family dynamics. It should also provide the therapist with support and assistance in bearing the intensive and dynamic load of working with an entire family in the therapeutic process.

Following the results of the second cycle, the third research cycle tested the model on five additional families. The goal of the third research cycle was to arrive at a conceptual and practical formulation of the model that other music therapists could utilize. The research method in this cycle was documentation and analysis of the five family case studies, from the beginning to the end of the therapy. The results of the third round emerged from an analysis of the five individual family case studies and a comparative analysis of them. The research questions to be answered in the third cycle were: In what ways did the family therapy meet the needs of the families and in what ways did it not? What were the challenges faced in implementing the model? In what ways did the resilience of the families improve and in what ways did it not?

The analysis dealt with similarities and differences between the families and the benefits they derived from the therapeutic process. The analysis revealed multiple insights:

1. Typical dynamics recurred among the families. Specific interventions in the toolbox can help address the challenges and conflicts raised by these dynamics.
2. Therapeutic goals emerged from the case descriptions, including resilience-building for the families and other goals that arose in response to the specific needs that the families brought to the therapeutic sessions.
3. The meanings produced from the model and its components (family meetings, parental meetings, music therapy, and the therapeutic relationship) were unique for each family.
4. Regarding the results of the therapy, although all the families apparently made progress both in resilience-building and in achieving additional goals that emerged during the therapeutic work, it cannot be said that all of them “completed the process.” This reflects the concept of resilience, in which it is assumed that after initiating the process, it will continue to develop naturally within the family.

Corrections and adjustments were made at each stage throughout the research process in response to the results of the previous research cycle. In this way, a practical therapeutic protocol was developed that includes an outline of the model’s stages of activity, the schedule of meetings, goals for building resilience, a toolbox of music therapy techniques, and clinical responses regarding the level of structure and collaboration in the model. The clinical protocol is anchored in an integration of several theoretical approaches: resilience-building, psychodynamics, salutogenesis, and collaboration.

The study had several limitations. The researcher and therapist were involved in the study. Application of the model under the guidance of other music therapists was not tested. The model was only tested among families from one region in Israel, and they all had similar family structures. Follow-up studies may address the model’s effectiveness when applied by other therapists and assess the training processes needed to train therapists in using this model. The model should be more extensively tested among families with a wider range of compositions and situations. It may be tested in therapeutic contexts other than private practice. Finally, in light of the findings of this study, follow-up studies may address the expression of love among family members and its meaning for family resilience.