

A Sequential Model for Developing Group Cohesion in Music Therapy¹

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ABSTRACT: This article outlines a sequential model for developing cohesive music therapy groups. Included in this model are five developmental stages through which groups progress, beginning at the intake and assessment phase, and culminating in active problem-solving. A review of pertinent theoretical and empirical literature supports the development and use of such a model, as well as defining specific principles to be considered during each stage. Through the structured presentation of music therapy experiences, interpersonal awareness, cooperation, and trust can be fostered, allowing for active problem-solving to evolve from a foundation of underlying prerequisite skills. As music therapists seek to document clinical effectiveness, the presence of theoretical frameworks which guide data collection and analyses will prove helpful. Additionally, clinical procedures must be based upon macro models that take into account variables such as interpersonal relations, group development, and therapeutic processes.

An observation made of successful therapy groups is that a healthy atmosphere is usually present, characterized by perceptions of mutual understanding, group devotion, and interpersonal trust (Butler & Fuhrman, 1983; Orlinsky & Howard, 1978). Historically, theorists and clinicians have referred to this atmosphere as group cohesion (Yalom, 1985). A positive correlation exists between group cohesiveness and successful therapy outcome, thus indicating its importance for therapists leading group therapy sessions (Hurley & Brooks, 1987; Lieberman, Yalom, & Miles, 1973).

Music therapists commonly encounter clients with diverse needs and strengths within the same therapy group. Examples of these situations would include in-patient drug and alcohol groups, sessions with chronically mentally ill clients, or out-patient groups for community-placed clients with dual-diagnoses. The task of fostering a healthy atmosphere in these situations is difficult and challenging.

Recent attention by music therapists to advanced topics in group music therapy has highlighted the variable of group cohesiveness (Freed, under review; Goldberg, 1987; James,

1988). While each of these reports has emphasized the importance of group cohesiveness, no clear direction has been given to music therapists on how to foster this key therapeutic factor. Considering this point, this article will discuss how a structured presentation of music therapy procedures can be applied to the process of group development. What follows is a brief overview of group cohesion, a theoretical model for the development of cohesiveness, and suggested music therapy applications. As a format for clinicians and researchers this model can serve to guide current clinical sessions, as well as to promote a more detailed path of research into the dynamics of group music therapy.

Group Cohesion

A systematic approach for developing cohesiveness in music therapy sessions requires a thorough understanding of group cohesion in general. Recent research pertaining to group cohesion is extremely scarce. This may be due, in part, because researchers have found "cohesion" a difficult term to conceptualize (Evans & Jarvis, 1980). Further, the lack of a universal definition for cohesion has led to the use of a wide variety of measurement techniques, creating difficulty in generalizing research results (Cartwright, 1968). Despite this fact, theorists and clinicians consider group cohesion desirable for the group therapy process.

While definitions of cohesion in the literature are varied, a consensus exists on elements present in most cohesive groups. Members of cohesive groups actively listen and participate in the giving and receiving of feedback. This creates a supportive atmosphere of mutual acceptance and understanding (Corey, 1985; Kellerman, 1981; Yalom, 1985). Under such conditions, group members are more willing to take risks and reciprocate self-disclosures which unifies the group with a bond of trust (Corey, 1985; Stokes, 1983). The establishment of trust allows group members to share painful experiences and confront resistive peers (Corey & Corey, 1987; Frank, 1957; Yalom).

Members of cohesive groups see their group work as helping them achieve personal goals (Corey & Corey, 1987; Stokes, 1983). By receiving support and communicating their own feelings and observations, self-esteem and self-respect are increased as the clients experience a feeling of being helpful to each other (Frank, 1957; Yalom, 1985). Group members are then able to translate insight into action, and transfer new socially appropriate behaviors to their personal lives outside of the group (Corey & Corey, 1987; Yalom). According to Yalom,

¹ The authors would like to thank Barbara Wheeler, Joey Barrickman, Elizabeth Miller, and Hillary Merman for their helpful comments and suggestions on earlier drafts of this article.

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absences from cohesive therapy groups are rare because the group work enables the members to meet their personal needs.

In summary, group cohesiveness may be characterized by a high level of group participation, positive mutual feelings among members, and strong interpersonal trust between the members. In cohesive groups, members experience personal growth as well as a feeling of unity while working toward the common goal of meaningful group work (Kellerman, 1981).

The Development of Group Cohesion

Grotjahn (1981) and Yalom (1985) state that the role of the therapist is essential in the development of group cohesion. According to Grotjahn, one of the first steps in developing group cohesiveness is the formation of a working alliance between each group member and the therapist, which is transformed and enlarged into a working alliance with the group. The therapist can facilitate this process by: (a) specifying a purpose for the group, (b) setting clear goals, (c) challenging group members, and (d) clarifying for the clients how completion of the goals can meet their needs (Corey, 1985; Frank, 1957; Plach, 1980).

By demonstrating and modeling some basic music therapy experiences the therapist can demystify some of the perceptions held of music therapy.

In the beginning of cohesion development, therapists must be sensitive to the process of interaction that occurs. Lonergan (1982) states that the way patients relate to others reflects more about them than the content of what they say. Interaction allows the leader to assess the needs and psychological status of group members. By focusing on experiences, and the underlying feelings that clients seem to share, therapists can make appropriate interventions which will meet the clients' needs (Corey & Corey, 1987; Lonergan; Plach, 1980). Several therapeutic interventions are possible to facilitate group cohesion.

Groups led by therapists trained in the use of prompts and reinforcements which might encourage risk-taking have been found to be significantly more cohesive than groups led by conventional therapists (Lieberman, 1970). Risk-taking produces vulnerability which is necessary for growth to occur (Stokes, 1983). A lack of risk-taking encourages group dependence and could be a sign of resistance (Corey, 1985; Grotjahn, 1981; Lieberman, Yalom, & Miles, 1973). In this case clients become too comfortable and the therapist may need to intervene with a caring confrontation so that growth will continue (Kellerman, 1981). It is important for the therapist to challenge group members when necessary, while modeling acceptance and understanding in the process.

In summary, the attitude and skills of the therapist play an important part in the development of group cohesion. Despite forces of resistance which might exist, the therapist can nurture the development of cohesiveness by modeling pos-

itive group behavior, making group expectations clear, and helping the clients understand how the group work will benefit them. The therapist is responsible for conducting group experiences which foster group cohesiveness and promote client growth.

Foundations for a Model

Because group cohesion and client growth are commonly viewed as a process, it seems reasonable for therapists to consider this process when planning sessions. Lonergan (1982) advocates a warm-up phase in the beginning of group work which allows clients to get used to each other by talking superficially. This helps lay a foundation of safety and mutuality.

Some authors recommend the use of structure in promoting cohesiveness in the early stages of group work. Lieberman, Yalom, & Miles, (1973) state that structuring is necessary to avoid unnecessary anxiety, while allowing interpersonal trust and stable relationships to form. According to Plach (1980), the amount of structure needed depends on the level of

functioning of the clients; he suggests that structuring be done in a hierarchy of dyads, sub-groups, then the group as a whole. Regardless of the clients' level of functioning or particular method of structuring, carefully formatted sessions are desirable because they minimize vulnerability which often makes clients uncomfortable (Lieberman, Yalom, & Miles, 1973).

Lack of structure in the beginning of group work could produce confusion and anxiety which would not be conducive for the development of cohesion. Emotional intensity is necessary so that members will take the risks which promote growth, but only after a stable foundation of acceptance and understanding has been established. While the aforementioned authors support the general use of structure to nurture group cohesion, a system for developing cohesiveness is needed.

The process of developing cohesive therapy groups is not as random as might appear upon first observation. The literature on group psychotherapy is consistent in recognizing that groups progress through a variety of stages or steps in their natural development (MacKenzie & Livesley, 1983). Many researchers have outlined developmental stage models which music therapists may use to expedite the process of establishing cohesive therapy groups (Beck, 1974; Hill & Gruner, 1973; Lacoursiere, 1980; Morgenstern, 1982; Tuckman, 1965). By structuring music therapy experiences to correspond to a sequential model for fostering group cohesiveness, a more efficient transition between stages may result.

In identifying developmental group therapy models, theor-

Table 1
Sequential Model for Developing Group Cohesion

Stage One:	Goal-Setting Activities
Goal:	A. Identify the need for music therapy services. B. Reinforce the client's internal locus of control and responsibility to the therapy setting.
Stage Two:	Individual/Parallel Activities
Goal:	A. To develop interpersonal awareness. B. To foster perceptions that the clients have had similar life experiences.
Stage Three:	Cooperative Group Activities
Goal:	A. To promote interpersonal cooperation. B. To display that the group can work cooperatively towards one objective.
Stage Four:	Self-Disclosure Activities
Goal:	A. To develop interpersonal trust. B. To develop perceptions that self-disclosure will be received in a nonjudgmental atmosphere.
Stage Five:	Group Problem-Solving Activities
Goal:	A. Individual therapeutic issues are clarified, identifying deficient skills and ineffective problem-solving strategies. B. To display that the group's integrity can withstand interpersonal confrontations.

ists have obtained direction by adhering to an orientation proposed by "general systems theory" (Durkin, 1981; MacKenzie & Livesley, 1983). This orientation dictates that group change (i.e., uncohesive to cohesive) is dependent upon a hierarchical structure, whereby lasting changes occur through the interrelationships of the individual stages. Each stage is dependent upon a foundation being laid by a preceding stage. Table 1 displays a sequential model for developing cohesive music therapy groups based upon a synthesis of the works of Beck (1974) and Lacoursiere (1980). While the sequential ordering reflects a clear progression, considerable overlap between stages will occur. Additionally, the ongoing processes of assessment and prioritization of goals will necessitate some backtracking. Nonetheless, the basic group interactions should reflect movement from stage one to stage five.

In respect to Table 1, problem-solving and skill-building activities will be more effective if the group has achieved a reasonable level of interpersonal trust. By ignoring the natural progression of developing group cohesion, much time and effort will be misdirected by working on advanced topics which the group is not prepared to address (e.g., self-esteem, depression, learned helplessness). The result of such practices is that temporary progress may be observed, but that difficulty arises in generalizing results outside of the therapy setting.

Group Cohesion Model

Stage One: Goal-Setting Activities

The initial contacts between the music therapist and individual clients should focus on establishing a foundation for therapy. Assessment information should be sought directly

from the clients, other treatment team members, standardized assessments, and informal activities (James, 1986). By involving all clients in this stage, perceptions of self-control and self-responsibility will be reinforced.

Appropriate music therapy assessments should be utilized at the onset of stage one. During the assessment interview with the music therapist, clients should indicate their perceptions of their needs, strengths, weaknesses, and goals for therapy. Also during this stage the music therapist should orient the entire group to the format and rationale of music therapy. By demonstrating and modeling some basic music therapy experiences the therapist can demystify some of the perceptions held of music therapy. The exploration and discussion of initial questions in a group situation will clarify the role of the music therapist and begin the process of fostering group cohesion. Of paramount importance is to communicate how progress in music therapy will have an impact on the clients' goals.

Stage Two: Individual/Parallel Activities

After the initial tasks of assessment and goal-setting (tasks related to individual needs), the music therapist must devote attention to group processes. At this time it is important to slowly break down the psychological boundaries that exist between the group members. Through the discussion of general "life themes/topics," clients can learn more about the values, attitudes, and previous experiences of their peers. It is crucial that a sense of identification be established between the group members. This can be done by focusing on what clients have in common (Plach, 1980). Once perceptions of interpersonal awareness exist, the feedback, suggestions, and comments offered to each individual will have a more meaningful impact and value.

Specific music therapy interventions could include sessions on music-assisted relaxation techniques, song lyric analysis (not composition yet), and the identification of feelings and moods conveyed by music. During stage two the emphasis is not on the creative aspect of music, but its use as a stimulus to encourage interpersonal identification and relatedness. Confrontations should be minimal and individual clients should not become involved in detailed analyses of their personal issues. A helpful therapeutic approach at this time would be that of "unconditional positive regard" (Meador & Rogers, 1979).

Stage Three: Cooperative Group Activities

After the clients have learned more about each other it is appropriate to focus attention on experiences which utilize cooperative efforts. Experiences which highlight the role each client plays in influencing the end result will assist in establishing cohesiveness. During these experiences clients will begin to interact more, progressing from parallel to group tasks.

Specific experiences could include group compositions in which individual contributions are highlighted, group improvisations led by the music therapist, and creative perfor-

mances in which each client assumes the role of the conductor. For the latter activity, verbal processing should include the topics of leadership/followership, nonverbal communications, and assertiveness skills. Creating music videos, puppet shows incorporating songs, and group poetry writing accompanied by instruments all require group communication and cooperation. These types of experiences provide an opportunity for clients to use a variety of skills; verbal and nonverbal. They also provide an opportunity for clients to support each other. Stage three experiences should reflect more content specific to the expression of feelings and emotions as a group. During this stage the creative aspect of musical performance should be utilized to promote and explore different aspects of interpersonal cooperation.

Timing and clinical insight are key variables in the effective use of a developmental model for music therapy.

Stage Four: Self-Disclosure Activities

Following the establishment of a group which can work cooperatively towards a concrete task, the music therapist should structure the experiences to be more dynamic, interactional, and focusing on self-disclosure. At this stage the clients have a clear sense of the purpose of music therapy services (stage one), feel a sense of identity towards their peers (stage two), and have experienced some level of unity in working towards a group goal (stage three). This foundation will assist the clients in trusting their peers enough to begin relating their personal issues that brought them into therapy. It is important at this stage that the music therapist facilitate the expression of feelings and emotions by clearly encouraging an open, accepting, and nonjudgmental reaction by the group members. At this stage of trust-building, confrontations should be avoided.

During stage four, music should be used as a nonverbal language to support the expression of feelings and emotions by individuals (stage three focused on these expressions by the group). By striving to communicate musically how loneliness or depression feels, clients can gain insight and feedback from their peers. Some clients may benefit from choosing appropriate musical passages and expressing the way they feel individually through movement, which could then be imitated by the group providing nonverbal support.

A "musical Johari's window" (Luft, 1969) can be a useful activity for many clients. Musical role-modeling, peers musically conveying the moods of each other, and individuals specifically creating musical tone poems to convey their feelings are all helpful. It is common that at this stage some clients will either have a "breakthrough" and express more intense levels of feelings, or emotionally shut down and halt the therapeutic process. If interpersonal trust has truly begun to evolve, many clients gain the emotional support they need to begin the process of active problem-solving.

Stage Five: Group Problem-Solving Activities

Music therapy groups which progress to stage five will reflect most of the characteristics of cohesive groups. The clients will value the sessions, absences will be rare, verbal interactions will reflect honesty and openness, and confrontations will result from feelings of support rather than primitive defense mechanisms. Clients will accept critical feedback more positively, realizing that these observations represent opportunities for personal growth. At this stage clients can truly begin the process of self-change.

Music therapy experiences for stage five should be used to support and stimulate the process of verbal therapy. In this respect, all of the activity formats used previously can be

helpful, but should reflect more content and pertinence to individual issues. Additionally, individual clients will often suggest the activity format they feel most comfortable with. Music-assisted relaxation experiences can be reviewed for specific individual needs, now being utilized as a "skill-building" experience rather than an "atmosphere-building" experience. Individuals will be confronted and challenged more often than in any preceding stage.

During stage five specific efforts by the music therapist should be devoted to insuring that generalization outside of the therapy setting will occur. Joint family sessions may be helpful in this process. Clients should be continually asked to reflect on how the current therapy topics relate to their individual lives, what progress has actually been made, what potential problems are to be anticipated, and what new alternative plans for handling problems have been learned. Role playing activities focusing on problems elicited from the music therapy experiences are appropriate in this stage to "practice" new behaviors. Finally, a sense of closure should be developed in conjunction with an appropriate aftercare plan.

Group Case Study

Various elements of the group cohesion model have been utilized by the senior author (Mr. James) in a 45-day residential unit serving adolescents with chemical dependency. The implementation of stage one occurred when a large influx of admissions resulted in a stable group of 14 clients beginning therapy within six days of each other. During the first week the music therapist met both individually and with small groups to complete several assessments, questionnaires and client self-report evaluations. At the end of the week the first large group session was held to outline the goals and guidelines for future music therapy groups. Guidelines were largely determined by group consensus with minimal refocusing by the therapist.

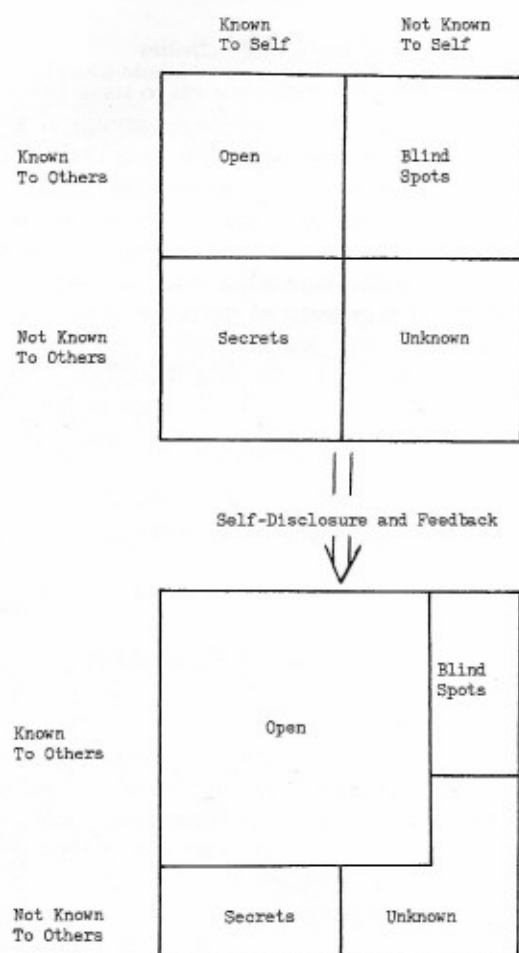


Figure 1. Changes in information locations.

Stages two and three had not been formally delineated at this time, subsequently they occurred simultaneously during the next two weeks. The adolescents began week two by outlining a musical life history, documenting their past and current preferences for certain artists, songs, and musical styles. While this experience was presented as an individual project, four small groups emerged based upon a clustering of similar interests. The musical life histories were shared during several group discussions. Within these discussions several of the adolescents noted that all 14 members were part of one of the sub-groups; everyone "belonged" to a group. Session processing focused on group identity, peer relations, and the problem of how to blend the four sub-groups into one large group.

It was jointly decided that each sub-group should work on a 15-minute presentation identifying the positive and negative aspects of their music in respect to each client's use of drugs. At the end of the third week the 14 adolescents were to make a joint presentation to their peers in the adult chemical dependency unit. This activity served many useful functions: each sub-group was allowed to retain its identity; the four sub-groups had to cooperate to plan the joint presentation;

the adolescents engaged in a constructive activity in the evenings when supervision was minimal; the adolescents seemed to be proud of making a presentation to their adult peers; and the adolescents gained a greater awareness of how music can be considered a conditioned cue to trigger a possible relapse back to drug use.

While the adolescents independently worked on this project during three evenings, the daily music therapy groups were used to explore other therapy formats (music-assisted relaxation, writing group song lyrics, improvisational music). The Friday presentation went well, lending a sense of closure to a "stage" of therapy and solidifying a developing sense of cohesiveness for the clients. By the end of the third week the adolescents were fairly cooperative, but tended to maintain their discussions on topics superficial to their hospitalization for chemical dependency.

At the beginning of the fourth week a session was devoted to explaining "Johari's Window" (Luft, 1969), and to indicate how this model could be related to the adolescents' progress in therapy. The Johari Awareness Model (Luft) can be used by music therapists to highlight the processes of self-disclosure and feedback within therapy groups. Figure 1 displays the four areas that the model outlines as information locations between people. Through the process of self-disclosure the space devoted to "secrets" will decrease, increasing the space devoted to "open" information. The process of receiving feedback decreases the space devoted to "blind spots" and also increases the space devoted to "open" information. It is assumed that positive life changes optimally occur when information crosses from "secrets" and "blind spots" to the "open" area. In this manner, one key goal for music therapists to concentrate on is to facilitate this transfer of information.

During the fourth and fifth weeks, the 14 adolescents engaged in a wide variety of music therapy experiences which highlighted the processes of self-disclosure and feedback. Prominent themes included the struggle to recognize and appropriately express certain feelings and emotions, and to clarify a myriad of issues related to the use of drugs to suppress or enhance certain feelings. Extensive use of improvisational music therapy facilitated the exploration of these themes. Sessions were generally related to topics presented in the adolescents' education lectures. During this stage of therapy the clinician offered structure and appropriate activity suggestions to the groups, but placed some responsibility on the clients to personalize the issues to their specific life circumstances.

During the sixth week a turnover in the census began, resulting in new clients being added to the group. Four of the original 14 adolescents had their hospitalization extended for approximately 30 days. These four clients requested separate groups to work on "advanced" issues that had emerged in the last few weeks. In a joint meeting between staff and these "older" adolescents it was decided that two separate "advanced problem-solving" groups would be conducted weekly. The four adolescents were also given the responsibility to

assist in orienting their new peers into the core therapy and education groups.

The eight final music therapy sessions for these four adolescents focused on communication skills. Specific attention was given to musical styles of communication between peers, and between parents and children. The various concepts presented in the first six weeks of music therapy were also reviewed in the context of situations appropriate to the adolescents' home and school environments. Suggestions were made for individualized aftercare plans, and time was devoted to several closure activities.

Staff discussions which reviewed the progress of this group of 14 adolescents highlighted the need to move slowly at the onset of therapy. By establishing a healthy therapeutic atmosphere the core therapy tasks seemed easier to facilitate. Stages two and three were more clearly delineated, and a second review of pertinent literature emphasized the validity of the stages proposed in the model.

Discussion

The music therapy literature reflects a longstanding emphasis on the interpersonal nature of music. Cody (1965) stated that through music the emotionally isolated patient may be provided the experience of relatedness and sharing with others. Because music draws people together to engage in activities that require group participation and cooperation (components of the model), it appears that the application of music to group psychotherapy could promote cohesiveness (Radocy & Boyle, 1979). Music offers a common starting place for discussion and personal work (Mezza & Price, 1985; Plach, 1980), and group singing can specifically promote interpersonal trust and group cooperation (Anshel & Kipper, 1988). Since music is capable of evoking a number of thoughts and feelings at the same time, it can convey either individual or group emotions and ideas which might not be revealed in ordinary discourse (Noy, 1967; Radocy & Boyle).

The proposed sequential model for developing group cohesion should assist music therapists to foster a therapeutic atmosphere within group sessions. The integration of numerous global goals within a single theoretical model offers a framework for both clinicians and researchers. The basic premise for establishing a sequential model to develop group cohesion is that the advanced task of active problem-solving (stage five) will be most efficiently reached through a structured format. The empirical and theoretical literature reviewed earlier supports this concept.

The specific music therapy experiences noted in the group cohesion model are intended only as suggestions. Music therapists are encouraged to innovatively expand and refine these sample applications. Future research in music therapy should seek to validate several aspects of the group cohesion model. Specifically, is each stage necessary for the development of cohesiveness, are additional stages needed, is the ordering of the stages correct, and do the suggested experiences accomplish their intended goals? The use of appropriate multivariate

research techniques (i.e., path analysis) to estimate the validity of theoretically informed models would be one such research project.

One dilemma inherent in proposing a model which purports to guide the internal maturity of group music therapy sessions is that many treatment programs utilize open group formats where clients may enroll at any given time. It is fairly common that as clients depart from therapy groups and other clients are added, the levels of interpersonal awareness, cooperation, and trust regress temporarily. Considering this, the music therapist must be an experienced group clinician to sense where the group is within the model. This aspect of applying the group cohesion model (when to move from stage to stage, either forwards or backwards) can be considered part of the art of being a therapist. Fundamentally, timing and clinical insight are key variables in the effective use of a developmental model for music therapy.

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