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WHEN WORDS SING AND MUSIC SPEAKS:
A QUALITATIVE STUDY OF IN DEPTH MUSIC
PSYCHOTHERAPY WITH ADULTS

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CHAPTER I

INTRODUCTION

She sits at the piano and tells her story
A child in a grown-up body.
"I feel like a little girl learning how to walk." she says
"So vulnerable - what if I slip?"
Her tears fall on the keys and she skips a beat.
"Please don't stop singing," she says
So I sing and I sing
And we sing till the storm passes over.
"Why is it so powerful?" she asks
"Why does it feel so sad to hear someone sing
‘Welcome’?"

Music Psychotherapy

The idea of using music as a healing tool is thousands of years old, yet
music therapy as a formal discipline is still young. Music therapy as a
profession can be traced back to the 1940s when music was used in hospitals
to reach World War II veterans. Although musicians working in these
hospitals lacked clinical training, music emerged as an effective therapeutic
modality that could engage and motivate depressed patients (Michel, 1976).

Before 1944 no formal college training in music therapy existed. The
first music therapy education programs arose from a need in the medical field
for musicians with clinical training. Over the next 25 years, the medical
profession became increasingly aware of the benefits of music therapy
particularly to "encourage growth processes and resocialization" (Tyson,
1981, p.12). There were more employment opportunities for music therapists
especially in state institutions, psychiatric hospitals and facilities for the developmentally disabled (Kenny, 1989).

The field of music therapy has come a long way since then. Music therapists now treat a wide variety of populations with a variety of needs. There are so many different schools of thought and various approaches to music therapy that specializations have been developed such as Music in Special Education, Music Healing, Music Medicine and Music Psychotherapy. There are an increasing number of music therapists today who are qualified to work privately with adults (Hesser, 2001). The continued development of specializations within the field of music therapy created a need to define the various areas and levels of practice.

Hesser (1982) delineated three levels of music psychotherapy based on the work of Wolberg (1977): Supportive Music Psychotherapy, Reeducative Music Psychotherapy and Reconstructive Music Psychotherapy. “The level of therapy depends on the education and training of the therapist, the psychological orientation of the therapist . . . the diagnosis of the patient, the particular problems he/she is working with and the environment where the therapist is treating the patient” (Hesser, 1982 p.10). Also influenced by Wolberg (1977), Wheeler (1983,1987) classified music psychotherapy into three levels using degree of change as the criterion. Activity music therapy enables patients to achieve adaptive behavior goals, insight music therapy has re-educative goals and insight music therapy with reconstructive goals utilizes
music to resolve unconscious conflicts and to promote reorganization of the patient's personality.

Reconstructive Psychotherapy "has extensive aims and requires a lengthy commitment on the part of the patient for treatment" (Hesser, 1982 p.16). This level of psychotherapy involves working with the unconscious mind to resolve intrapsychic and interpersonal issues. My work falls into this category.

Bruscia (1998), when referring to music psychotherapy, includes all approaches that focus on the client's emotions, self-contentment, insights, relationships, and spirituality as the main targets of change, as well as those which address medical and didactic factors related to these issues ... practices in this area vary according to the breadth and depth of treatment, the role of music, and the theoretical orientation of the therapist (p.161).

My clinical work has evolved from a version of the therapeutic singing lesson (Tyson, 1981) to a specialized form of music psychotherapy (Austin, 1986, 1991, 1993a, 1993b, 1996, 1998, 1999a, 1999b, 2001). Over the past fifteen years I have worked to integrate the ideas and theories of depth psychology with the practice of music therapy.

Depth psychology is a term used to describe a psychological system that recognizes the full reality of the inner world and places great value on the wisdom of the unconscious and the symbols that transmit this wisdom to the conscious mind (Kast, 1992; Ulanov, 1971). The therapeutic process is long
term for it involves examining and transforming the client’s inner (and outer) life. The term “depth psychology” is often used when referring to Jungian psychology and the process of working with dreams and the deeper, archetypal layers of the psyche in order to integrate split off aspects of the personality into the totality of the self. Becoming “whole” or one’s unique self is the ultimate goal and the relationship between the client and the therapist is essential to achieving this goal (Edinger, 1971; Jacobi, 1973; Jung, 1969; Kast, 1992). This study examines and illuminates the clinical model of music psychotherapy that emerged from my work to integrate these theories and beliefs from depth psychology and ideas from the fields of trauma and addiction treatment with the practice of music therapy.

**Personal Source of the Study**

Because I place so much value on the therapeutic relationship and believe in the reciprocal influence client and therapist have on one another, and because I am studying my own approach to in depth music psychotherapy, it feels necessary to take a close look at my own development as a music therapist. What led me to do this work? What are my personal, musical and theoretical influences and beliefs? What do I draw on within myself when I work with a client?

I have often said that music and the arts changed my life. Being able to express myself creatively and having access to the imaginal world preserved my personal spirit and helped me through a difficult childhood and
adolescence. Some of my happiest moments were spent going to the movies and watching movie musicals on television. My world was expanded by the movies and plays I saw, the books I read and the music I listened to and sang. I could lose myself for hours in magical places filled with beautiful music and imagery.

Mom and Dad were always fighting.  
She was crying; he was leaving.  
I kept trying to get through  
But there was no one to get through to.  
So I'd go up to the attic  
Write a poem, sing a song.  
I'd pretend up in the attic  
Life was happy, long as I was singing  
Nothing could be wrong.

I started singing at a very young age, no doubt influenced by my father, a jazz pianist, who would often accompany me and sometimes even take me to nightclubs where I would perform with him. I wrote my first poem in kindergarten and continued to write poems, songs, stories and plays periodically throughout my life. In high school, I began acting in plays and dreamt of becoming a star and appearing in movie musicals. Looking back, I feel I needed the secure container provided by a song or a theatrical role in order to feel safe enough to express feelings and aspects of myself that were otherwise too threatening.

After graduating from high school, I attended Emerson College in Boston where I majored in Theatre Arts. The characters I played allowed me
to explore unacceptable and unknown parts of myself. The opportunity to express my feelings in song, dance and dialogue provided me with a much needed emotional outlet. Although I did not realize it at the time, performing was therapeutic for me.

College ended. I moved to New York City where I pursued an acting career, with some success. Several years passed and I became disillusioned. I realized that I hated saying the same words and singing the same songs the same way every night. I also became aware of a deep longing to know myself. I did not want to lose myself in a character anymore. I wanted to find out who I was.

An actor I knew suggested Jungian analysis. I knew nothing about Jung but I needed help so I took his recommendation. Of course, I had no idea at the time the profound implications this decision to enter analysis would have on my life. It was a good fit. I liked the emphasis on the creativity of the psyche, and the belief in the wisdom of the unconscious. I loved the world of dreams and myths and the archetypal gods and goddesses. The symbolic approach to life and the belief that there was meaning in the suffering were healing concepts for me. The invisible world beckoned and I followed. Plumbing the depths was terrifying yet worthwhile. I learned that change was slow, but possible, and for me, inevitable.

I quit acting and began to pursue a singing career. My development as a singer seemed to parallel my individuation process. I started out singing in
small nightclubs and taking club dates wherever I could get them. Weddings, Bar Mitzvahs, parties, I sang what people wanted to hear but in my own way.

I began to work more frequently. As my sense of self grew stronger, I became more selective about what I chose to sing. I began to write my own songs with lyrics and music that gave expression to my inner and outer struggles. Songwriting was therapeutic for me. The creative process felt empowering and I found out that putting my feelings and experiences into an aesthetic form enabled me to gain greater clarity and a deeper awareness of issues I was working on in therapy. I could disidentify from overwhelming emotions by observing and having a dialogue with parts of myself. Naming my feelings was ego strengthening and my songs were containers for intense affect. The songwriting process was one of self-discovery and integration.

Now I sing out of joy  
And I sing out of pain  
For the battles I've fought  
And the insight I've gained  
For I know deep inside  
That I've got to be free  
And I just can't sing songs  
That mean nothing to me.

I formed my own band and sang songs that reflected the person I was becoming. I began to sing and write in a more jazz influenced style. I enjoyed improvising and exploring richer, more complex harmonic and rhythmic patterns. I had moments of feeling really free and losing myself in the music the way I lost myself in movie musicals as a child.
It was hard to make a living. Both jobs and salary were unpredictable. I started teaching voice to augment my income. I remember the day I told my therapist that when I taught voice I felt like I was doing therapy. It seemed that some of the people who came to me for singing lessons were really looking for permission to feel. The combination of the deep breathing necessary to sustain tones and the meaningful songs the students chose to sing often evoked strong feelings in them. I began to keep a box of Kleenex tissues on the piano. My therapist asked me if I had ever heard of music therapy.

It was time for a change. I took an introductory course in music therapy and was intrigued by the possibility of combining two aspects of my life that were so meaningful to me, music and psychotherapy. By now, my lifestyle was wearing on me. Late hours, an erratic schedule and often unfavorable working conditions were taking a toll. I was losing my desire to perform.

4 A.M. Once Again.
I'm losing track of where and when
All of these nightclubs look alike
Lousy musicians, lousy "mic"
But I sang tonight
It was so exciting when I sang tonight
And two men started fighting while the music played
I sang and prayed, this job would end.

In 1986 I graduated from New York University with a Master of Arts in Music Therapy. By the time I graduated I had experience working with a
wide variety of people with various clinical needs: blind, autistic and developmentally delayed children, psychiatric adults, women in prison and battered women and children. Throughout my studies, I continued teaching voice to adults but my approach evolved into therapeutic singing lessons with a focus as much on self-expression and self-exploration as vocal technique.

My training at New York University was in music psychotherapy and the theorists I resonated the most with were Florence Tyson (1981) and Mary Priestley (1975). They both utilized music and verbal processing to enable the client to gain insight into unconscious material. I was excited by Tyson’s application of psychodynamic principles (Balint ‘s theories in particular) to music therapy practice with regressed borderline and schizophrenic patients. I related to Priestley’s use of improvised music to access unconscious feelings and associations as well as her emphasis on the use of countertransference in the music therapy process.

Part of my training at New York University included participating in music therapy training groups. These groups were developed in order to give students a firsthand experience of group music psychotherapy and were led by music therapists. My personal experience as a participant and later a co-leader in these groups along with Priestley’s and Tyson’s writings, validated my growing belief that music therapy could be combined with the theories and techniques from depth psychology. I was convinced that analytically-oriented or psycho-analytically-informed music therapy could become a primary form
of treatment for adults seeking an alternative to psychoanalysis or psychotherapy.

It felt like a natural progression for me to move from teaching voice to starting a private practice in music psychotherapy. A few of my former voice students became music therapy clients and sent me referrals. I quickly realized however, that I would need more training to do the kind of advanced work that I felt called to do. I found an institute and an analyst to supervise me. I continued with my own individual Jungian analysis and Jungian thought continued to greatly influence my approach to the psyche.

My work changed and evolved as I continued to study and grow as a primary therapist working with adults, many who required long-term in depth treatment. The majority of the clients I work with are in the creative arts professions - writers, musicians, artists and creative arts therapists. Most of these clients suffer from a variety of symptoms related to emotional, physical and/or sexual abuse, histories of addiction and/or eating disorders and/or developmental arrests associated with being adult children of alcoholics or resulting from a lack of adequate parenting.

Most of these clients have wounds that go back to early childhood or infancy. The majority of them were unable to form a secure attachment to the primary caretaker and/or lacked an emotionally available and consistent good-enough mother (Winnicott, 1971). In these cases an accumulation of unmet dependency needs such as the need for safety and to be seen, heard and

Clients are valuable teachers. The experience I gained working with these clients taught me that relying on one theoretical framework is not sufficient. In order to meet the specific needs of each individual client, I felt it was necessary to be able to draw on a variety of clinical theories and techniques. I studied object relations theory, trauma theory, psychodrama, and approaches from the field of addiction treatment in order to become a more effective therapist.

During the next several years, I found myself using music less and less in my work. As I became more skilled in making verbal interventions, analyzing dreams and offering interpretations, it seemed as if the distance from the couch to the piano increased. I was losing the music. Dissatisfied with this situation, I began working to integrate the theories and ideas from depth psychology and other treatment approaches with the practice of music therapy. This study will examine the clinical model of music psychotherapy that emerged from this integration.

Purpose of the Study

The purpose of this study was to illuminate my clinical model of in-depth music psychotherapy with adults. I examined my process as a music psychotherapist in order to gain insight into my therapeutic interventions and overall approach.
My definition of "in depth music psychotherapy" is evolving. In the past I have referred to my work as Jungian-oriented (1991,1993a, 1993b), psychodynamic music therapy (1996), analytically oriented music therapy (1998,1999) and music psychotherapy (2001,2002). I have previously defined my clinical work as a creative process that utilizes music and words within a client/therapist relationship to facilitate an ongoing dialogue between the conscious and unconscious contents of the client's psyche. A connection between the music and the words is most often established by verbally processing the musical experience and/or musically exploring the verbal experience. The music is usually but not always improvised. When singing improvised music and lyrics, it is often possible to simultaneously process the experience verbally and musically.

As my work has progressed, I have come to the conclusion that none of these names adequately describe my clinical model. The definition above is accurate yet incomplete. It could apply to a number of music psychotherapists currently practicing reconstructive or analytically influenced music therapy, such as Dvorkin (1991,1993,1998) Frank-Schwebel (2002), Scheiby (1991,1995,1998), Robarts (1994, 2000a, 2000b) and Rogers (1993,1995).

I have told you about my background and the journey that brought me to this point. I have been practicing and refining my own model of music psychotherapy for the past fifteen years. My approach grew out of my personal experience in Jungian analysis and other forms of psychotherapy, my clinical training and supervision and my day-to-day experience as a clinician.
The intention of this research was to look closely at the way I view the music therapy process, the role of the therapist, the kinds of musical interventions I use and my reasons for using them, in addition to describing and defining “In Depth Music Psychotherapy”.

The title of this dissertation “When Words Sing and Music Speaks” reflects the importance of the integration of music and words in my model and the various ways this synthesis occurs. Examples of the music in the words, both spoken and sung, and the words or word-like communication conveyed by the music are found throughout this document and are covered in more detail in Chapter VIII.

Need for the Study

Music psychotherapy as a primary form of treatment for normal neurotics or high functioning adults is a growing area of specialization in the field of music therapy. First hand experience gained from teaching and presenting my clinical work at conferences and universities in the United States, Canada, Europe, South America and Asia has led me to believe there is an increasing interest on the part of music therapists and music therapy students in learning more about advanced models and training.

Research on music psychotherapy as a treatment approach is sorely lacking and to my knowledge, there is no research on in depth music psychotherapy with high functioning adults. There are however, some
examples of related research. Two European music therapists, Langenberg and Smeijsters have implemented research programs that should be noted.

Langenberg (1993, 1996) has developed a qualitative research approach to study analytically oriented music therapy. Although not all of her work is translated into English, she has been publishing research for the past ten years. The following study gives an example of her research and methodology.

In 1993 Langenberg, Frommer, and Tress published a pilot study conducted to examine and address questions posed by processes in analytical music therapy (Priestly, 1994). The researchers developed a qualitative method utilizing Priestly’s concept of the resonator function, to analyze an improvisation from a single music therapy session. From the subjective impressions of a nine member panel that listened and “resonated” with the music, motifs were generated that described novel elements of the clinical music therapy process. The main point of the research was to demonstrate that the clinical issues of the client are all manifest in the music and that human beings can perceive or resonate with these underlying issues. The authors stress the importance of conducting further research that will shed light on the conditions and factors that make analytical music therapy effective.

Smeijsters (1993, 1995, 1996c, 1996d, 1996e, 1997) has also developed his own research approach focusing on techniques of qualitative research in single-case studies. In 1999 he conducted a qualitative single-case study of a woman diagnosed with depression and identity issues that is indicative of his
approach. The music therapy process was described as reeducative/reconstructive and used several data sources including descriptions and reports from the client, the music therapist, the researcher (Smeijsters) and the verbal psychotherapist. The music therapist used improvised music to help the client work through her grief and find a personal identity.

Amir (1999) researched musical and verbal interventions in music therapy by studying the experience of six music therapists. The music therapists she interviewed were from Israel and the U.S. and had three main music therapy orientations: Analytical MT-Mary Priestly, Creative MT-Nordoff-Robbins, and GIM-Helen Bonny. One of the motivating factors in her study was the absence of specific literature that dealt with the use of interventions in music therapy. She concludes, "it is my recommendation that many aspects of this phenomenon need to be given much attention in all realms of the profession: clinical practice, supervision, and training programs...we need to carefully explore why and when we are doing what" (p. 173).

There are some good reasons for this lack of research on music psychotherapy. Although the number of music therapists who have earned a masters degree is increasing, the majority of music therapists working today are not trained beyond an undergraduate level (AMTA, 2002). In the United States, extensive training beyond a master's level is necessary to work effectively within an analytic or psychodynamic framework (Bruscia, 1987).
Very few music therapists have the education and experience to work in depth with adults who desire or require a reconstructive method of music psychotherapy. Another consideration is that the dominant research paradigm today is quantitative and based on the medical model. This method is not suited for researching psychotherapy processes.

There is a need for more research on in depth clinical work as a resource for practicing music therapists as well as in the educating and training of music therapy students (Payne, 1993; Rogers, 2000). Clinicians are likely to become better therapists as they gain a clearer understanding of what their clinical decisions are based on. Wheeler (1987) addresses the dilemma of helping the student therapist determine the appropriate intervention at a particular time or for a particular client. Although my research is on advanced work, the essential aspects of my method, for instance the intentions and kinds of specific interventions, can be adapted and applied to various levels of practice.

There is also a need to build up a body of research that can contribute to theory and model building in music therapy (Bunt, 1994). Bunt believes this research should be carried out by experienced clinicians, and published in language that can be understood by members of other professions. "Such work can contribute to improved professional credibility and academic recognition" (p. 180).

I believe that the systematic documentation and examination of my clinical work might benefit students and practitioners of music therapy as well
as other interested professionals in related fields. This study provides a model of advanced clinical work for the profession. With such a model, music therapy clinicians might gain a better understanding of their own work including the basis of their therapeutic decisions and interventions. Music therapy students and therapists could therefore increase the effectiveness of their clinical work. They would also have a more meaningful as well as an accessible language in which to communicate this knowledge to other health professionals. This study will help to build a bridge between research and clinical practice and expand the constrictions of traditional positivist research in music therapy (Aigen, 1991). Finally, this study proposes to add to the research base for music psychotherapy as not only an adjunct to psychotherapy but also a primary therapy of choice for many adults who desire in depth treatment.

The Clinician/Researcher

There are clearly some issues that need to be addressed when researching one's own work. Smeijsters (1996,1997) and Bruscia (1996) have emphasized the problematic nature of dual roles. Smeijsters believes the therapist cannot be a trustworthy observer of his/her own work and thinks it is preferable to use a research team. Bruscia (1996), while acknowledging the potential jeopardy to the authenticity of the intent of the research and the problems with "fuzzy" (p. 83) boundaries does not feel these difficulties are insurmountable.
Aigen (1996) supports the concept of the clinician-as-researcher. "Experienced clinicians working on an advanced level are in the best position to know what research topics will be applicable to their work" (p. 18). Aigen stresses the value of research that is relevant to clinical concerns and believes music therapist-researchers should develop studies that are interesting, relate to the clinical work, and that will directly or indirectly help other music therapists in their work with clients. Instead of abandoning the idea of combining the roles of clinician and researcher, he prefers to "develop procedures and relationships to address these difficulties" (p. 15).

I have described in detail both my personal and my professional background in the beginning of this chapter. I will discuss my biases and the precautions I have taken to ensure the integrity of this study in more depth in the trustworthiness section of this dissertation.

Here, however, I will briefly address the issue of knowing. I came to this study as a mature woman with fifteen years experience as a clinician. I have learned a lot over the years, from personal experience, professional experience and ongoing education and study. I know certain things. How then will I handle my preconceptions and learn to see the familiar landscape I walk through as uncharted territory?

Fortunately, other clinician/researchers have walked this path before me and I have learned from their experiences either by reading (Forinash, 1990; Gonzalez, 1992; Bruscia, 1995; Aigen, 2000) or being actively involved as a peer support group member (Arnason, 1998; Ramsey, 2002). I have
found that "in depth research can both knock down expectations and bring about new discoveries that were not initially imagined . . . it can pierce through superficiality" (Ely, Anzul, Friedman, Garner & McCormack 1991, p. 129).

I have been and continue to be an active member of an ongoing peer support group comprised of other doctoral candidates doing qualitative research. Peer debriefing (Lincoln & Guba, 1985), is one way to receive feedback at each critical step in the journey. Letting my peers in on my feelings and thoughts throughout the research process has been invaluable in gaining alternative perspectives and monitoring blind spots and biases.

I continue to receive weekly supervision where I can focus on issues such as transference and countertransference as they emerge with the clients-research participants. I have also continued with my own personal analysis so that I have an additional place to explore my issues as they arise in relationship to the research process. Doing qualitative research is a very personal experience and requires the courage to look inward, sometimes at things I would rather not see; things that could affect my self image, and my concept of myself as a clinician. This process is very similar to psychoanalysis and at this point in my personal and professional life I finally feel secure enough to look at my mistakes and prejudices as well as my successes and learn from them.

Working with nontraditional methods of analysis like poetry, art, songwriting, metaphoric analysis and other narrative forms allowed my spirit
of play and curiosity to thrive. The freedom and permission to express myself creatively while analyzing data enabled me to break free of habitual ways of seeing and interpreting information. (Ely et al. 1997; Wolcott, 1990)

Research Questions

My research question has not changed since the inception of this study.

My sub-questions took time to formulate and changed and were refined along the way. When doing qualitative research it is typical to begin with broad queries and important to live with the tension of not knowing while continuing along the road, open and curious to what might present itself (Ely et al. 1991).

My initial main question was:

1. What characterizes my model of music psychotherapy with individual adults?

Final sub-questions were:

1. What is my role as therapist?
2. What is the nature of the client-therapist relationship?
3. What is the basis for my musical interventions?
4. How do the words and music complement each other in the therapeutic process?

These questions served to guide the initial data gathering and analysis of this study. They gave me a starting point and helped me to generate further questions along the way. When I felt like I was drowning in the overwhelming sea of data, these questions served as beacons of light pointing the way back to shore.
CHAPTER II
THE RESEARCH METHOD

A Flexible Foundation

In order to examine my own clinical work and illuminate my clinical model, a qualitative method of data gathering and data analysis was used to establish a grounded theory. A qualitative research approach seemed ideally suited to the task of studying my own approach to music psychotherapy for many reasons. A meaningful research design requires the ability to develop or change; "to be living research" (Rogers, 1993 p. 202). Emergent design, typical of qualitative research, requires that methodological steps be based upon the results of steps already taken and "implies the presence of a continuously interacting and interpreting investigator" (Lincoln & Guba, 1985, p. 102). These principles have much in common with the process of music psychotherapy.

Grounded theory was developed especially for the task of generating theory through the researcher's immersion in observationally derived data (Strauss, 1987). Glaser and Strauss (1967), the developers of grounded theory, define it this way:

Grounded theory is a detailed grounding by systematically and intensively analyzing data, often sentence by sentence or phrase by phrase of the fieldnote, interview or other document. By constant comparison, data are extensively collected and coded . . . thus producing a well constructed theory (p. 22).
Analyzing data inductively is essential to grounded theory and to qualitative research. Theory developed this way “emerges from the bottom up (rather than from the top down), from many disparate pieces of collected evidence that are interconnected” (Bogdan and Biklen, 1992, pp. 31-32). A qualitative approach to naturalistic inquiry (Ely et al., 1991) allows for in depth exploration of research questions. The intensely recursive, personal aspect of the research process emphasizes the value of immersion in the data, descriptive language, the researcher as the primary research instrument and inquiry and interpretation of data to create meanings and insight. (Bogdan and Biklen, 1992; Lofland and Lofland, 1984; Lincoln and Guba, 1985; and Ely et al., 1991).

Often the subject of the research study will be a topic or setting that is of interest because it has touched the researcher's life in some significant way (Bogdan and Biklen, 1992; Ely et al., 1991). This statement certainly applies to the subject of my research.

In order to effectively examine my own clinical work, I needed a research framework that allowed me the freedom to create and adapt methods of inquiry and analysis appropriate to my study. Some forms of qualitative research allow for a flexible approach to method and do not consider this approach to impact the research negatively. On the contrary, this flexibility often proves advantageous by

(a) accommodating the overlapping stages of research,
(b) allowing for the evolution and openness of the research focus, and
c) generating research methods appropriate to the content rather than
the reverse (Aigen, 1995, p.297).

During the beginning stages of research, I realized that studying my
own method of music psychotherapy would be a huge undertaking. I also
understood that at some point I would need to limit the scope of my study to
focus on particular aspects of my work and that these aspects could and would
probably change in the course of analyzing the data.

Qualitative researchers have found that relevant literature emerges as
data collecting and data analysis progresses (Ely et al., 1991; Bogdan and
Biklen, 1982; Wolcott, 1988). As my study evolved, so did my perspective
about the review of the literature. Within the various approaches to
qualitative research, there are different viewpoints about this placement of the
literature review (Ely et al., 1991; Higgins, 1996). Integrating the literature
review into the body of the dissertation proved to be the most effective
method of supporting and enriching the study.

**Participant Selection**

The participants for my study were chosen from my private practice in
music psychotherapy. The clients I work with are self-referred, ranging in age
from their early 20s to late 50s. As described in the introduction, the majority
of the clients I see are in the creative arts professions: writers, artists,
musicians, actors and both creative arts therapy students as well as creative arts therapists. Most of my clients are female.

I used the procedure of purposive sampling (Bogdan and Biklen, 1992) to select potential participants. The clients I invited to take part in the study were chosen for several reasons. I wanted participants who would be capable of, and want to use, a full range of musical and verbal expression during the therapeutic process (this includes playing and improvising music on various instruments as well as singing songs and/or vocally improvising).

Ideally the participants would also be capable of articulating and describing significant aspects of the therapeutic process. I surmised that clients who fit the criteria would be more likely to utilize the full range of my treatment model and potentially create findings that addressed the breadth and depth of music psychotherapy.

Since the human subjects committee would not permit me to work with clients already in treatment and because my work is long term, I needed participants who would be likely to continue in therapy for at least a year. Music therapy students and/or professional music therapists fit all the above criteria. I knew from experience that arts therapists generally make committed clients because they often consider their personal therapy to be not only part of their healing and self-care but also part of their education. Additionally, I thought music therapists might be motivated to participate in a clinical music therapy research study in order to contribute to the development of the field.
I planned to select two or three clients for the study. This decision was guided by the belief that studying a small number of clients would allow me to examine more sessions in greater detail and depth (Ely et al., 1991; Lofland & Lofland, 1984). Both Ann and Cindy entered therapy during the same month. Both were music therapy students but from different universities. Ann was twenty-six years old and Cindy was thirty-seven. Cindy had been in verbal psychotherapy for eight years and felt it was beneficial but that she had never fully addressed the issues related to the sexual abuse she experienced during her childhood. Ann suffered from chronic anxiety but had never been treated for it. Neither Ann nor Cindy had ever been in music psychotherapy.

Both agreed to be part of the study. Several months later, Marie began therapy. Her reasons for seeking help were, “low energy, difficulty sleeping and feelings of emptiness... depression.” Marie had been in verbal psychotherapy for several years while living in another part of the country. I decided to invite Marie to participate because I felt she might enrich the research by introducing different qualities and variables to the study. Although Marie had never played music before, she expressed great interest in singing and exploring musical instruments. As a dance therapist in her mid 30s she also fit the profile of the client population I work with.

Each of the three clients was approached after her initial therapy session with a request for participation. I explained the purpose of my research study and answered all of the potential participants' questions. Clients were assured that their confidentiality would be protected, that I would
use pseudonyms and change geographic locations and other information that might identify them in all of the written materials connected with the study. They were also informed that all written data, audiotapes and copies of consent forms would be kept in a locked file cabinet.

Ann, Cindy and Marie were all interested in participating. Each of them was given a consent form to take home and two weeks to decide if she wanted to be a part of the study (see the appendix for a copy of the consent form). All three agreed to participate. When the consent forms were signed and returned, the data collection began.

**Physical Setting**

The clinical work analyzed for the research study took place in my music therapy office, the room where I normally conduct music psychotherapy sessions. My office is located in my home. It is a large room on the ground floor with a private entrance. The room is painted white and is comfortably furnished with a corduroy sofa against the back wall. There are many pillows on the sofa of varying sizes and a long coffee table directly in front of it.

The coffee table is covered with instruments of all types from many different countries: slit drums, an array of shakers, bells, xylophones, metallophones, tone bars, a steel drum, an umbira and a wooden flute. There is always a box of tissues on this table or on a nearby instrument.
To the left of the couch are different types of large drums. A rain stick and an African walking stick rest in a corner. There are more instruments under the table including an ocean drum and a Korean gong. To the right of the couch there is a small drum kit with a cymbal and very large wooden xylophone from Africa. There are two guitars leaning against the bookcase on the right wall.

The bookcase is filled with psychology, music therapy, mythology and music books. The bottom shelf contains books of music and lyrics: folk songs, songs from musical theater, various popular tunes from the last sixty years and current sheet music.

My desk is against the wall opposite the couch. A computer sits on top of it and a chair is directly in front of it. To the right of the desk are a sound system, a microphone and a small electric guitar. There is also a shelf containing a CD player and a cassette player as well as blank tapes and recording equipment.

A large Yamaha Clavinova stands against the wall to the left of the couch with a piano bench and a large rolling chair in front of it. I usually sit in this chair and purchased it because it is very comfortable and adjustable. I can sit next to someone at the piano or roll over to the end of the table to accompany someone on another instrument with little effort. The clavinova has a full sized piano keyboard and settings for acoustic piano, electric piano, clavinova tone, harpsichord, vibes, strings and organ as well as different
volume settings. A microphone hangs on the wall behind the piano with a picture above it.

The room is decorated with artwork, masks and objects from around the world. There are many stuffed animals, puppets and some dolls on top of the bookcase that clients sometimes use during the therapy session. There are semi-precious stones on the lower bookshelves. A large Persian rug covers half of the room.

There is one small window with a curtain, so the room has limited sunlight and is quite private. A desk lamp and a lamp that stands next to the couch warmly light the space. Beside the lamp is a small table that holds a telephone, an answering machine, art supplies and a clock. In the next room are a large kitchen and a small bathroom.

I believe the physical set up of a music therapy space is very important. I remember my first office, the living room of a duplex apartment where I lived years ago. The openness of the space did not provide the feeling of a safe container. The instruments were against the wall and physically and psychologically were difficult to access. I recall purchasing a larger coffee table when I realized I needed to create a more facilitating environment (Winnicott, 1971). I moved the instruments to the coffee table and placed the table right in front of the couch. I began to sit at the piano when it seemed as if the distance from my chair to the piano was increasing and I was using less music in my practice (Austin, 1999). These changes made a difference in the
way I worked. The new physical positioning put the music front and center, literally and symbolically.

Eventually, I looked for and was fortunate enough to find an apartment with a room that was ideal for an office. The private entrance, thick walls and seclusion the space provided enhanced the feeling of safety necessary to practice music psychotherapy, particularly with some of the traumatized clients I began attracting. When a client brought her stuffed animal to a session one day, we sang to it. I learned from this experience. Her dog was comforting, it was a "transitional object" (Winnicott; 1971, 1989) and it symbolized a part of her. I began collecting stuffed animals, dolls and puppets and making them available to my clients. I bought a cymbal when a young woman said; "I need to hit something loud . . . like a cymbal!"

I purchased more music books when several clients had associations to songs that I did not know. I listen to and learn from my clients, and their responses to the therapeutic environment have motivated me to make changes in the physical setting of my office throughout the years.

Data Collection

I gathered information during and after each individual music psychotherapy session. Each of the sessions with both Ann and Marie lasted one hour. Cindy had to travel a great distance to see me so we decided to work for one and a half hours on alternate weeks.
All sessions were audio taped by a small, black Sony Professional Walkman that sat in plain view on the top of the keyboard. An omni directional microphone hung on the wall behind the piano.

I felt and continue to feel an acute sense of responsibility for maintaining the integrity of the clients' therapeutic process. I also realize that combining research with therapy inevitably changes the clinical process (Aigen, 1996). In order to minimize the intrusive nature of the research study, I used no investigative procedures (interviews, videotaping) that are not a natural part of the therapy process as I practice it. I usually audiotape the musical portions of therapy sessions. The only slight adjustment made in service of the research was to audiotape the complete session.

Audiotapes of the first six music therapy sessions with each client were transcribed. Verbal dialogue was transcribed verbatim in the first three sessions in order to capture each client's unique personality traits, individual speech patterns and vocal patterns when interacting with me.

The music in the words, the vocal inflections, the volume, rhythm and tempo of each client's speech, the quality and timing of the pauses and the moments of silence were all important sources of information that helped me to hear the subtext within the text. Portions of the verbal dialogue that seemed significant in sessions four through six were also transcribed verbatim. The rest of the dialogue was summarized. The significance had to do with dialogue preceding or following a musical intervention since I had decided to study this aspect of the sessions in greater detail. The data collection was
informed by the emerging theory (Strauss, 1987) as I recursively examined the transcripts.

Verbal dialogue from the fourth through the sixth month of music therapy sessions was also transcribed. I chose to transcribe dialogue that clarified and expanded on themes that had begun to emerge in the evolving data analysis.

The time frame for the study was left open. Prolonged engagement and persistent observation of the subject being studied increase the probability that credible findings will be produced (Ely et al., 1991; Lincoln & Guba, 1985). I planned to "sample to redundancy" (Lincoln & Guba, 1985, p. 233) that is, until the data repeated itself and the amount of new information gathered reached the point of diminishing returns. This occurred during the tenth month of the study (Ann and Cindy were in their tenth month of music psychotherapy, Marie was beginning her ninth month). Although all three clients opted to continue music therapy, I stopped collecting research data at this point.

Verbal transcripts from the last three to four months were summarized except for moments when the dialogue elaborated on and seemed to enrich the evolving data analysis. The musical sections of all therapy sessions were summarized using descriptive language thick with details that is characteristic of qualitative research and also of many case studies found in depth psychology and psychoanalytic journals (Higgins, 1996). When vocal
improvisations included words, the words were usually transcribed (except for sections that were repetitive in which case the lyric content was summarized).

Immediately after each session, I wrote process notes. I would sometimes summarize the entire session. Usually, however, I wrote about what seemed important, the way I would take notes after any therapy session, particularly with a new client. These notes included information gathered in the verbal and musical portions of the session, observations about the client, myself, the therapeutic relationship and/or the therapy process, the "meaningful moments" (Amir, 1992). I also wrote down questions, hunches, concerns and feelings I had during or after the session. The following is an example of a process note from one of Marie's sessions.

She wanted to work with the orphan image from her dream, the part of her that feels withdrawn, "in limbo". I offered her choices. It felt like a collaborative process. She could play, sing, or dance. She wanted to dance and have me play the drum. She wanted a steady, continuous rhythm. Hearing this made her cry, that the music would keep on going even if she stopped. It would ground her. Her dance was like emerging, exploring the space, like coming out of a cocoon and finally standing tall and opening her arms wide. It was very moving. She said, "I needed a witness... to be called out... If I stopped it didn't mean the drum's voice would stop... it would continue to speak to me."

The stance of participant observer, basic to conducting naturalistic research, involves "the inter-weaving of looking and listening watching and asking" (Lofland and Lofland, 1984, p. 13). It requires an attitude of curiosity and focused attention that could easily be attributed to the role of a music
psychotherapist. Qualitative research fits well with psychotherapy in general and my style in particular.

I gathered data by participating and observing, by maintaining a dual purpose that entailed striking a balance between participating in the sessions and watching my client and myself. The necessity to retain a committed marginal stance and the desire to enjoy mutuality without taking over or being taken over by the other felt familiar to me as a therapist (Ely et al., 1991; Higgins, 1996; Spradley, 1980).

The audio tapes of sessions, the transcriptions of the tapes, the process notes and the analytic memos were all invaluable in that I could return to them again and again and check them against each other while in the process of discovering categories and themes. These various resources were important not only for analyzing the data, but as tools in helping me with the challenges of having the dual role of clinician researcher.

All the written data I collected were kept in a research log. My log is a huge blue notebook filled with the transcriptions of the audiotapes, the process notes, analytic memos and other descriptive material such as artwork, poetry and charts. (The exception is one extremely large chart/art piece kept next to my file cabinet). "The log contains the data upon which the analysis is begun and carried forward" (Ely et al., 1991, p. 69). It is the place where the researcher writes thoughts, feelings, hunches, ideas, finds categories, bins, and themes and later makes discoveries. It is "the place where each qualitative researcher faces the self as instrument" (p.69).
The Log

I am a basket, a bowl, a box, a book
I hold significant things
Insignificant things
A smile, a look, the way her voice sounds
When she says hello
The soft, slow melody of the piano
A breath, a phrase, a word
A feeling, so many feelings
So many thoughts
The flurry of ideas coming into being
Listening, seeing
I am a witness
A doubting Thomas
A story, a poem, a song
A long river flowing to an unknown destination
The raw stuff of creation
I am a mirror
A constant and sometimes irritating friend
And sometimes, sometimes it seems
That I will never ever end.

Analytic memos were a part of both the data collection and the data analysis. When, for instance, I was transcribing the audiotapes into my log, I would sometimes write a memo as a way of talking to myself. When I made a connection, had a question or an idea about a methodological strategy or needed to explore and express my feelings about the research process, I would record it in this observational section of the log. Sometimes “observer comments” were expanded into memos (Ely et al., 1991). Many of my analytic memos were eventually incorporated into this research document as part of the text.
Analytic Memo Two

I was more direct and active today I think because I felt better and also from listening to the tapes and feeling frustrated with last week’s session. I do realize that last week’s session was part of getting to this session but it’s interesting to listen to the tapes. I realize how much I pick up from the sound of voices, how the way a word is said is sometimes more important than the word itself. I feel good now – relieved. I guess I was nervous last week realizing this is therapy and research and I would be scrutinizing myself in this process. During today’s session I was able to forget I was doing research and just do what I do! Whew!

Data Analysis

Data analysis was a fascinating, frustrating, exciting and sometimes exhausting process that seemed to go on forever. It required recursively examining all the raw data in order to get familiar with it and then to look for repetitive patterns, themes and points of interest.

Data analysis in qualitative research involves almost continuous and progressive analysis from the very beginning of data collection. The final phase however, required sitting with all the material, sifting, organizing and reorganizing, writing more analytic memos, poems and vignettes until I could make meaning out of the data and answer the research questions (Ely et al; 1991). This was a lonely process at times. Van Maanen (1988) describes that quiet moment when one has finished all the data collecting and “sits before
the blank page that must inevitably carry the story of what we have presumably learned" (p. 12). The various methods I used to examine and make sense out of all the information I gathered helped me to look at my data from different angles and even have fun in the process.

After reading or rereading a log entry, I would write notes in the margins. These notes primarily had to do with topics that were cropping up such as "singing, playing, talking, symbols, feelings". I also wrote observer comments as I transcribed the data. These comments related to biases, analytical ideas and questions that I would bracket in order to set them apart from the raw data. A few examples of observer comments are "is this induced countertransference?" and "metaphors seem to help me and the client understand behaviors and concepts. I use them a lot".

I next combined the margin notes and observer comments into a list of rough categories. I looked for distinguishing features and commonalities in the categories and established meaning units (Giorgi, 1985) or meaningful, relevant segments of data. I then labeled the meaning units and grouped the similar categories under one label that I felt described the whole group. I continued to look for links between labels, while allowing for labels that might not occur many times but seemed important to the research. The coding started to reveal emergent trends in the study. The challenge now was not to rush the process and jump to conclusions too fast, but to form, shape and play with different ways of coding and categorizing until I reached a level of
synthesis and meaning that felt satisfying to me (Tesch, 1990; Coffey & Atkinson, 1996; Ely et al. 1997).

Significant themes emerged and were explored through narrative forms and other creative arts modalities such as vignettes, metaphors and metahoric language, pastiche, poetry, and artwork. Ely (1991) defines a theme as a “statement of meaning that runs through all or most of the pertinent data or one in the minority that carries heavy emotional or factual impact” (p.150).

Narrative Forms and Arts Based Explorations

One of my major categories is “The Role of the Therapist”. One way I explored this category was through the use of metaphor and metahoric language. I wrote about the therapist as a detective, as a container, as a seeker, a wounded healer and an “empath”. An “empath” is a character from the old Star Trek television series. She was an alien who could take away someone’s physical and emotional pain by touching them and absorbing their suffering.

The use of metaphor as a research tool helped me to look at something familiar in a new way. The playfulness of metaphor and its ability to bridge the unconscious and conscious worlds opened up my imagination to new insights and deepened my understanding of the emerging categories and themes.
I have been writing poetry since kindergarten. Poems have always been an enjoyable and emotionally succinct way for me to express myself. Poems capture the essence of an experience, they "condense the story into images that pack the data into one scene" (Ely, et al., 1997, p. 135). Throughout this study, I used poetry to assist in analyzing the data and to present the findings.

Some of my poetic explorations turned into what Ely (1997) describes as "pastiche". Pastiche allows for multiple perspectives simultaneously. "Pastiche assumes that the pieces...that make up the whole communicate particular messages above and beyond the parts" (p. 97). Sometimes this form resembled a collage made up of words and images or a poetic play. Like poetry, pastiche enabled me to get to the heart of the experience I was investigating.

At one point in the ongoing process of binning, sorting, labeling and categorizing, the image of a tree appeared. In a way, this did not surprise me as trees have often emerged in my client's material (dreams, free associative singing) and trees have always been meaningful to me both literally and symbolically. The tree is a symbol for the archetype of the great good mother, nurturing and supportive. It also symbolizes the process of becoming one's unique self (the individuation process) as the tree represents the synthesis of heaven, earth and water and the dynamic life process (Kast, 1992; Jung, 1959; Neumann, 1955). This image seemed very appropriate to represent the research process I was engaged in.
I drew a picture of a tree and used this picture as another container for the emerging data, another way of viewing the emerging categories and themes (see appendix B). The roots of the tree are where I placed the categories that describe the ways I ground myself in my work, how I know what I know as a therapist. Here are some examples of categories in the roots:

- Knowledge from my own therapy
- Knowledge from clinical supervision
- Knowledge from clinical experience and training
- Musicianship

The point at which the roots meet the trunk is where I placed categories related to information I initially gather about the client. Examples of these categories are as follows:

- Knowledge from client’s history
- Knowledge from voice quality
- Body language
- Energy level
- Physical appearance
- Word choices
- Musical expressiveness and choices

Alongside the trunk of the tree I placed labels that identified the bins inside the tree trunk. These labels and bins came together later in the research under the theme “layers of listening”. All the ways I gathered information about the client, myself, and the ongoing process in music psychotherapy were included in this section. Here are some of the labels outside the tree trunk:
I listen to (in the client)
I listen for (in the client)
I listen to (in myself)
I listen for (in myself)
I watch for

Examples of bins inside the tree trunk are as follows:

Sound of client’s voice
Sound of client’s music
Words (text)
Underneath the words (subtext)
Feelings
Patterns
Connections
Strengths and vulnerabilities
Reenactments
Resistance
Complexes
Transference
Countertransference

At the top of the tree around the outer branches I wrote themes that I returned to and renamed several times throughout the study. These themes are related to what occurs in the therapeutic process once I have gathered the information and include:

Therapist’s process
Analysis
Interventions
Client response
Intentions
Lines with arrows outline the outside of the tree to suggest the ongoing creative process that is always in motion, the dynamic flow of the music therapy session. When I look at this picture is suggests that therapy as I practice it, is like qualitative research. It is a recursive process.

Charting the Territory

I have always associated charts and graphs with quantitative research, since this type of research is primarily concerned with measurement and numerical data (Bruscia, 1995). One night while meeting with my doctoral support group, my old views were once again challenged. A colleague felt overwhelmed by the pages of narrative, poems and art I was generating and suggested something more concrete, a chart of emerging core categories.

The first chart I made had three columns: information gathering, intervention, and client response (see appendix C). After sharing this preliminary analysis with the group, I realized I needed to add two more categories (columns) to the chart: therapist’s process and intention (the intention of the intervention). In the process of analyzing a transcription of an audio taped therapy session, I decided one more category was needed, ongoing assessment. The chart now has six columns. They are written in the following order: information gathering, therapist’s process, intervention, intention, client response and ongoing assessment (see appendix D).

The understanding is that the process is a circular one that is ongoing yet does not always include each category. For example, I may have gathered
enough information from the client’s response to the intervention to be able to move right from the ongoing assessment into a new intervention. I also debated whether to put “intention” before or after “intervention”. I realized that I sometimes consciously know the reason (intention) for an intervention before I make it. Often, however, the intervention is formed from the information I take in and process intuitively. It is in looking back that I understand my rationale for the intervention.

Example – Session 12

**Information Gathering:** Her speaking voice is slower and softer today. She laughs frequently when talking. She wants to sing. She picks minor chords.

**Therapeutic Process:** I think she often laughs when she’s nervous or uncomfortable. She picks the minor key a lot. I wonder what it means for her. I associate it to sadness. I think she defends against her sadness yet part of her yearns to feel it.

**Intervention:** I play the chords she’s picked, Dm7 to Am7. I sing unison, harmony; mirror (echo) her sounds and melodies. I attune my breathing and vocal quality to match hers.

**Intention:** To companion her emotionally, to support her voice and emotional process, to give her the experience of being heard, met and responded to.

**Client Response:** She sings sounds “ah” mostly. When we sing in unison our voices swell and become louder. She begins to sing words.
**Ongoing Assessment:** Our voices blend well together. We are breathing together. I often intuit her next word or phrase. We’re in sync. I feel attuned to her. I feel we are connecting in the music.

These charts proved to be another valuable method of analyzing the data. New themes emerged and previous themes were validated when I once again created categories and established meaning units. Layers of meaning surfaced that related to the role of the therapist, the therapeutic relationship and the music therapy process.

**Chart As Art**

My final phase of data analysis was fun and full of color. I looked at the overwhelming amount of data, categories, meaning units, themes, poetry, artwork, and vignettes and wondered how I could sort through all of this. I longed to see everything in one place. I wanted to make sure I had not missed anything. My husband suggested I get a huge sheet of paper and hang it on the wall. I thought he was kidding at first but I went to the local hardware store and bought a large roll of paper and a variety of colored markers. I decided to have fun with this and try out some new ways of sorting and combining data to see what emerged.

I didn’t hang the paper on the wall but spread it out along the floor. It was eventually cut and now measures 3 feet wide by 12 feet long. I ended up
with fourteen columns (major categories). I included some of the core categories from the previous chart: information gathering, therapist’s inner process, interventions and intention of interventions but I listed general qualities under each category this time that were not specific to one session but appeared in most sessions. An example follows:

Therapist’s inner process

I search for meaning
I form impressions
I pick up cues
I assess
I hunch
I analyze
I feel my feelings
I feel her feelings
I question
I make connections

The new major categories I included are as follows:

How I Gather Information
Important Analytic Concepts In My Work
Client’s Actions and Responses
Important Words and Metaphors
Frequently Asked Questions (I ask myself)
Frequently Asked Questions (asked to the client and related to a musical intervention)
Frequently Used Words
Therapeutic Relationship

I then re-examined several session transcripts, this time looking for more basic bins and categories related to the subtext of the therapeutic
relationship. I titled the two last categories “Me” and “Her”. Examples follow.

Me

Who are you?
What’s going on?
Let Me in!
Gotcha!
I get it.
I know this place.
Whose feelings are these?
I want connection.

Her

Who are you?
Can I trust you?
Do you approve of me?
I am afraid.
Who am I?
Understand me!
See me; don’t see me.
I want connection.

I used different colors for each major category. I sat on the paper in order to reach each column. I read and reread what I had written and then spontaneously began drawing different colored lines to link words that appeared in more than one column. For example the word “connection” appeared in many categories such as: Me, Her, Therapeutic Relationship, Frequently Used Words, Therapist’s Inner Process, Client’s Actions and Responses, Intention of Interventions, and Important Words and Metaphors.

Eventually, my chart came to resemble a strange sort of map or piece of abstract art. The evolution of this chart was an organic process that
engaged my body, mind and creative spirit (see appendix E). Once again, I could revisit my research data but from another vantage point.

The recursive nature of this research method allowed for a more substantial analysis, a deepened understanding of emergent themes as well as ample opportunities for new discoveries. Throughout the process I was deeply involved in the ongoing creation of meaning out of the evolving and evolved data.

Trustworthiness

Lincoln and Guba (1985) among others have emphasized how essential it is to develop criteria for evaluating qualitative research. For the researcher studying her own clinical work, establishing trustworthiness is a major concern. I have addressed some of the issues raised by the dual role of clinician/researcher in Chapter one of this dissertation. I have openly written about my personal biases in the stance section of the introduction to this study and continued to do so in analytic memos, observer comments, and throughout the data analysis.

I agree with Bruscia’s (1996) statement “who I am as a person provides a context for everything I do as a researcher” (p. 97). Just as I have undergone significant change in the past six years while working on this study, so has my work. I no longer feel I have a theory to prove as I did when Jungian psychology was the basis of my clinical work and a primary aspect of my identity as a therapist. I have published extensively on specific areas that
are important to me, such as the use of improvised singing in analytically oriented music therapy. Having had my say on subjects near and dear to me leaves me open to explore the unknown. I feel the freedom to be curious and to welcome the unexpected. If I have an agenda, it is to better understand what it is that I do four to five hours a day and how I do it. This study will benefit my clients and me by improving the quality of the work I do.

Other clinician/researchers have come to the same conclusion Payne (1993) has written about the enormous benefits of researching her own clinical work.

Since we are in the client’s service as practitioners we are obliged to continue our professional development. Research is one way of doing this. It is my firm belief that research can provide us with an avenue for improving our service to the betterment of our clients (p. 32).

Rogers (2000) points out how studying her own work as a clinician/researcher led to positive changes in, and increased insight into her music therapy practice. Aigen (1996) speaks to the potential benefits to the client involved in research projects such as the increased level of attention and scrutiny the therapeutic process will undergo. In addition, some clients experience gains in self-esteem from feeling they have something to contribute.

I have taken precautions to ensure the integrity of this study. Lincoln and Guba (1985) define four criteria for achieving trustworthiness: Credibility, transferability, dependability and confirmability and discuss techniques for meeting these methodological criteria. They suggest prolonged
engagement and persistent observation of the research participants and the phenomenon under study. I spent nearly a year examining music psychotherapy sessions with three clients. I could have continued with my research since all three clients are still involved in music therapy (two years later) but the data was repeating itself and I felt I had accomplished what I needed to in order to gain a feeling of completion (Bogdan & Biklen, 1982). Prolonged engagement and persistent observation provide the scope and depth that contribute to the study’s trustworthiness (Lincoln & Guba, 1985).

Checking data obtained by various methods is another way of contributing to trustworthiness. “Watching for the convergence of at least two pieces of data... can be as suspenseful as it is important” (Ely et al., 1991, p.97). As discussed in the data analysis section, I verified the accuracy of my findings by studying, comparing and contrasting post session notes with audiotapes of the session, transcriptions of the audiotapes, and other contents of the log such as analytic memos and observer comments. Narrative forms and arts based explorations provided additional methods of validating the appropriateness of interpretations while illuminating the complexities and multiple realities of the research process (Ely et, al., 1997; Witherwell & Noddings, 1991; Wolcott, 1990).

Member checking (Lincoln and Guba, 1985) or checking one’s assumptions and perceptions with the research participants is another important technique for establishing the credibility of the findings. Since I wanted to limit the influence of the research process on the therapeutic
process as much as possible and I had no way of knowing how long each participant would continue in therapy once the research ended, formal member checking (for example, interviewing the clients, checking emerging data with them) was not an option.

I realized, however, that music psychotherapy and clinical research have much in common (Bruscia, 1996; Higgins, 1996; Payne, 1993). My approach to music psychotherapy and the fact that my research participants are verbal made it possible to conduct informal member checking. Eliciting and sharing feedback with the client is a natural part of the way I conduct music psychotherapy sessions. Throughout this study, while verbally processing the music during the sessions, I gained information that enabled me to verify my impressions and hunches and also gain insight into the effectiveness of interventions. Sharing my feelings, thoughts, images and sensations with the client provided another opportunity to determine how well my hypotheses matched the experience of the participants. Checking assumptions and perceptions with one’s clients is an ethical and therapeutically necessary part of the clinical process; it is also a way to informally conduct member checking (Arnason, 1998).

In the introduction to this study I discussed my belief (bias) that any therapist working in depth with clients needs ongoing supervision and extensive psychotherapy. Because I was researching my own clinical work, it became even more important to have a safe space (my own psychotherapy) to discuss personal issues that were related to and/or triggered by the research
process. I used my supervision group to help me monitor my countertransference reactions both as a clinician and a researcher.

My peer support group was invaluable throughout the entire process. The group consisted of other music therapists I know and trust. With them, I underwent peer debriefing, a technique Lincoln and Guba (1985) recommend for establishing research credibility. In peer debriefing, the researcher meets with a peer in a manner paralleling an analytic session. This peer or peers is free to pose questions regarding methodological, ethical or any other aspects of the study. The goal is to “bring to light implicit, unconscious aspects of the researcher’s procedures and reasoning process...in order to increase the researcher’s self awareness of these matters” (Aigen, 1995, p. 306).

My group also offered ongoing support when I felt avoidant or discouraged or simply stuck. However, they were not afraid to be honest with me. As a result the feedback I received was very helpful as when one member’s comments led me to create a chart of the music therapy clinical process as I practice it. I was also challenged and supported by my doctoral advisers. I had many sounding boards whose comments contributed to the creation of varied, multi-faceted methods of analysis along with richer, more trustworthy research findings.
CHAPTER III
BEGINNING STORIES, BEGINNING SONGS

Introduction

This chapter is comprised of vignettes that are a composite of the first six music therapy sessions with each of the clients in this study, Ann, Cindy and Marie. The purpose of a vignette is to capture in a succinct narrative what has been learned over a period of time.

Vignettes help you tap into what you are learning as well as help you identify gaps, silences and contradictions you might address. They offer an invitation for the reader to step into the space of vicarious experience, to assume a position in the world of the research - to live the lived experience along with the researcher (Ely et al., 1997, p.72).

My intention in presenting these beginning sessions in vignette form is to introduce the research participants while giving the reader a sense of the early phase of therapy with each person. I aim to illustrate the similarities and differences in the client/therapist relationship, my use of countertransference, and the verbal and musical interventions as well as to describe some of the significant issues that can emerge in the initial stage of music psychotherapy with individual adults.

Wall of Words

Ann enters the room and immediately begins talking about why she is late (by five minutes). She talks quickly as she walks to the couch and takes a
seat (in the middle of the couch). We make eye contact as she segues into thoughts she had after our last session. She is having difficulty with Allison, a colleague at work who she describes as "judgmental and dominating".

She refers to a comment I made last week that the dynamics of her relationship with Allison sound similar in some ways to her relationship with her mother. She tells me about a recent phone conversation she had with her mother and how stifled and annoyed she felt afterwards.

I notice her voice sounds tense and pressured and that she talks quickly and does not leave any space between words. She interrupts herself at times leaving sentences unfinished to begin new ones. She sounds rushed to me, and nervous. My sense is there is a lot bottled up inside of her that she has been holding in for a long time, and she is now about to burst.

I feel like she is skating on the surface. I listen carefully for feelings and symbolic content, the subtext beneath the text. I nod; I say things like "yeah" and "hmm" to let her know I am present in the room and listening to her. I feel like it is hard to get in a word, hard to interact with her. Occasionally I ask a question or reflect or amplify something she has said to support and empathize with her. For example, at one point I said, "it sounds very difficult for you to assert yourself with your mother." She readily agreed.

Ann talks about some attempts she has made to communicate honestly with Allison and how hard it has been. Her voice has a judgmental tone and as she continues talking it becomes clear how critical she is of Allison. When
she tells me about a mistake Allison made at work, Ann becomes more animated. There is intensity in her voice and the sound is pushed and rushed. She sits at the edge of the couch and maintains eye contact with me while talking yet I feel a distance between us. I wonder about her transferential feelings toward me but know it is too soon in our relationship to explore this with her.

I know that some clients need a lot of space to talk and simply be listened to and accepted. This is also an indication to me that Ann was probably not sufficiently seen, heard and understood as a child. Her history supports my assessment. Yet, I cannot help feeling some annoyance and a desire to connect and have more interaction with her. I have an image of a "wall of words" that she is hiding behind. I wonder how much of this is my issue (need to connect) and how much is induced, in other words, anyone would have a similar response to Ann.

I think music will help her to slow down, breathe, enter her body and access her feelings. It would also create a space for the two of us to come together. At the same time, I am finding it difficult to move from words into the music. I ask myself if I am colluding with her resistance to the music. I feel pulled into a pattern that is hard to break out of, perhaps merged with her on an intellectual plane that reinforces her defense system.

We laugh together over something her mother said on the phone and the laughter changes the energy in the field between us. Our conversation begins to take on a more musical quality. There is more space between words.
The rhythm of our voices becomes more flowing and our vocal sounds overlap like waves crashing to shore. I am reflecting things that she has said, back to her and it seems she feels heard and understood. Now she is saying, "yeah, yeah...right...exactly...that's true!" Her words are like percussion punctuating my statements as I summarize and reframe her experience. Now I feel propelled forward and supported by her sounds and the timing of her words. We seem more in synchrony.

I begin to intervene toward the music but I am not direct enough. The conversation has become circuitous and I don't feel the sense of a specific issue or feeling to focus on.

Diane: What if we were to just take what you're feeling right now as you talk about it - there's so much energy...

Ann: Yes, I know

Diane: Are you aware of that? (My words overlap with her statement.)

Ann: I am, well, now that you point it out even more so, but I know as I was thinking about Allison and my mother during the week I was, that's where the energy is, you know...

Diane: Where is it? How would you describe it?

Ann begins talking about her relationship with her boyfriend. I am wondering how this subject relates to her mother and Allison. I ask her. This leads to a discussion of her feelings of impotence, when she feels stuck and unable to take action. I reflect that it seems difficult for her to take
responsibility for her feelings. She agrees and says she often feels she doesn't have the nerve to assert herself. I intervene toward the music.

Diane: What if we took this into the music and just play what feelings are coming up for you as we talk about these issues?

Ann: Okay.

Diane: Would you like to play, or sing?

Ann: I'll play the piano.

Diane: Would you like me to play with you, or listen or play something else?

Ann: Well...whatever you'd like to do.

Diane: What do you need?

Ann: Whatever comes to you, I mean, yeah, I think I'd like you to play. You know, um, respond to what seems to be coming.

Her last words are spoken softly. She seems ambivalent about wanting to play with me. My hunch is that she might want to play alone but might not feel entitled to say that. She gets up from the couch and comes to the piano and sits down on the piano bench. I sit close to her on a separate seat. I suggest we begin by inhaling and exhaling together a few times. We breathe slowly. I suggest we make a space for her feelings to emerge and that when she feels ready, she allow her hands to lead her.
She begins by playing an E flat minor 7 chord. She continues playing and stays centered around the Dorian mode. The music has a classical feeling and sounds Spanish influenced at one point. I decide to play the conga drum with her. I play softly and build to a crescendo when she does. I gently accent her rhythms. She plays with a lot of flourishes. She briefly moves into the key of E flat major. The music is harmonic in the beginning and sounds very romantic. She begins to add more dissonance and repeats a melodic phrase of three notes over and over again (C, B, A). I feel the loss of a key center. The music sounds all over the place to me, disorganized. Then gradually she returns to E flat minor 7 and the rhythm becomes steady. She slows down suddenly and I stop drumming. The drum feels out of place now. I feel there is a melancholy quality to this music.

I begin to play the xylophone sparsely. I am attempting to support and connect with her. I don't feel satisfied with what I am playing. I am having difficulty finding a place in the music (a musical metaphor reflecting the session so far?) The music is now quite legato and soft. She plays a repeated trill on F to F sharp and ends in E flat minor. It was a short improvisation.

We briefly sit in silence. I breathe deeply. I am aware that we are nearing the end of the hour. I feel she is still disconnected from her feelings. I ask her what she is feeling now. She says, "Unfinished ... like there's something that is emotional and wants to be heard but isn't clear."

I say, "It seems like there are a lot of feelings bottled up inside of you that want to come out." She agrees and vaguely alludes to a fear of the
intensity of her feelings. I respond with a metaphor of a pressure cooker, gesturing with my hands to make the point that when feelings are pushed down and suppressed for a long time the intensity builds up and then there is often a fear of exploding. She says "when I saw you do that (make the hand movements), I realized how much I hold myself back when my feelings start to get intense...something makes me shut down!"

I ask her if she experienced this "shutdown" during the music. She pauses and says "yeah" in a soft voice. I question her further and she says she thinks she was starting to feel sad near the end of the improvisation. I share my feelings with her and tell her I felt a quality of sadness starting to emerge in the music near the end. Inwardly I was thinking she stopped playing the piano because she started to feel and became frightened (resistant) because of the intensity of her feelings. I can identify with her fear. I remember times when I used to compose and would make myself stop in the middle of writing to go and wash the dishes. I remember discussing this in my own analysis and how my behavior related to a fear of pleasure. These memories help me understand and empathize with Ann.

Ann talks about her inner censor and how it inhibits her musically and in all aspects of her life. Once again our conversation takes on a more flowing rhythm. I feel more attuned to her. We are nodding together and our speaking voices have a similar energy and tempo. We laugh together. Our voices overlap and at times there is a call and response feeling to our verbal interaction. We are beginning to connect.
Singing the Unspeakable

"Hi Diane", Cindy greets me with a smile as she enters the room. She puts her bags on the floor, comes over to the piano and sits on the bench next to my chair. She makes eye contact with me while asking if she can have a glass of water. I say "sure" and get one from the kitchen for her.

She seems to have thought about what she needs from today's session. She says, "I have a sense that there is a huge scream stuck in my throat." She had a dream about this stifled scream and believes the way to access it is through vocal improvisation therapy.

She tells me the scream feels related to her history of early sexual abuse by her uncle. She also talks about feeling angry toward her mother and distant from her father. She feels that her parents emotionally abandoned her and tells me she feels ready to "get the scream out and deal with the pain."

As she talks, I notice that she speaks slowly and sighs occasionally. Her voice lacks energy and the melody of her sentences often descends at the end. She sounds slightly depressed to me.

We have spent several sessions taking her history. I feel it is important for her to tell her story slowly with time for us to interact and relate to the material and each other. I have learned through experience that very wounded people can become traumatized when they have to condense a lifetime of painful and/or intense memories into an hour-long therapy session. Going slowly helps them to digest the feelings that emerge.
I ask Cindy if she feels like singing. I want to get a sense of her music and her singing voice. I also sense that her words are disconnected from her feelings. I think singing can offer her a way to access and express some of the emotions contained in the memories and incidents she has been describing.

Cindy has many strengths and both inner and outer resources. Still I am wary of her enthusiasm to "get the scream out." It seems too soon in the process to work deeply.

I offer her choices. "We could tone, sing a song or improvise over two or three chords." She says she has read a few articles I have written about vocal improvisation. "I read about how you work ... I'm curious about how you free associate singing over two chords ... I'm a little afraid but ... yeah, I'd like to try that."

I ask her what she is afraid of and she says she's not sure, "Probably just the unknown of it ... maybe the closeness." She repeats "let's try it". I ask her what two chords she would like. She says, "I like the key of D flat." I begin playing D flat to G flat/B flat, medium tempo and dynamics. Cindy likes this combination. I suggest that we begin by breathing together several times and that whenever she feels ready she can begin singing sounds or words.

I feel curious. What will it be like to sing together? She sighs, we sing "ah" in unison on an "F" then we move to a "B flat". I sing in unison to support her vocally and emotionally. I am also feeling out her response to the
unison to get a sense of what she needs and what she feels comfortable with. Is unison comforting, supportive or too merged? Does she need more tension, more distance, more differentiation?

She begins to sing softly, "m-m-m" then starts growling, increasing the dynamics, range and intensity of her sounds. I sing in unison with her then mirror (repeat) her sounds and at times hold the tonic to ground her vocalization. My intention is to accompany her on this journey so that she feels supported and met in the music.

She begins to sing long, legato phrases on "ah". She goes rapidly up the scale like a siren and then switches to intricate rhythmic patterns, syncopated "da da, ba da" repetitive, drum-like sounds on E flat.

She seems to be exploring her range, different rhythms, vocal qualities and emotional states. I notice that she has a well-trained voice with a deep rich quality and a wide vocal range. At times it is difficult to follow her. I feel challenged yet determined to stay with her. I am living in the unknown of the moment with her and I don't know where we are going.

Cindy begins singing louder, then laughs and returns to the "m-m-m" sound in the lower part of her range. She builds on a simple melodic line of repeated 3rds and 4ths and works her way up the scale ending with a scream on "ahh". She then slides down the scale and laughs loudly.

She returns to "m-m-m" now singing softly and rocking herself back and forth. I notice that she is changing dynamics, phrasing, pitch and vocal qualities rapidly. I am trying to stay with her and meet her screams, laughter
and gentle melodies. I change the chords slightly, adding some dissonant notes and play the piano louder to support her screams and growls.

I rock back and forth with her and attune myself to her breathing, phrasing, dynamics and vocal quality. I notice how similar our voices sound. She stops singing but continues rocking back and forth and breathing deeply. I continue to sing and rock back and forth with her. I would usually stop singing when the client stops but there is something in the way that she is rocking herself that makes me feel like continuing to sing, probably the sense that she needs this vocal holding and containment. I feel I am soothing her. I sing "ooo" to a melodic refrain built around A flat, B flat, D flat, A flat for a few minutes, then slow down the tempo and gradually bring the music to a close.

I breathe deeply. I do not speak. My intention is to leave space for us to be in the silence together and to allow her to speak in her own time.

She breaks the silence quickly. She looks at me and says, "I sang longer than I thought I would." I wonder if she is speaking because she is uncomfortable with the silence and the intimacy of breathing together. I ask her what she is experiencing. This is a typical question I ask to gather information about feelings, sensations, images and associations that might emerge during the music. This kind of a question can deepen the process and move it forward.

Cindy says she feels in touch with her "inner child". She starts talking quickly, giving me more information about her childhood. I sense she is
disconnected from her feelings. I ask her what she is experiencing in her body. She stops talking. I ask her to slow down her breathing. She says she feels some pain in her stomach. I am curious. I suggest we "hang out" with the sensation. After a few moments I again ask what she is experiencing. She says, "The pain has grief and fear in it."

I feel some tension in my body. I breathe deeply to release it. I ask Cindy to breathe into the pain and try to stay connected to her body. I breathe with her. She begins to cry. She says, "I can see my little girl... she is scared." I ask Cindy if there is anything she wants to say to her. She says, "It's okay to be afraid."

I begin playing D flat major 7 to G flat/B flat, Cindy's original two chords. I tell her we can sing to her little girl if she wants to. I play slowly and softly. I feel a lot of empathy for Cindy. I can identify with her feelings. I have my own inner "scared little girl". I feel the music can offer Cindy a soothing container for her feelings and that I can connect with her in a deeper way by playing holding chords and singing with her in unison and harmony.

I begin singing, "It's okay to be afraid." I sing first because I sense she needs the additional support and modeling. She joins in right away and sings in unison with me. She sounds young and vulnerable. Her voice is soft and light. Her crying stops. She sings, "I am with you" and I harmonize with her. I am with Cindy. I am with her "little girl" and I am singing as Cindy's "double" (her inner voice) supporting her. I feel very connected to Cindy. I
also feel connected to myself. I think what and how we are singing is healing for me as well.

**See Me, Hear Me**

Marie is telling me what brought her to therapy. She was very moved by a presentation I gave at a recent conference. "There was something about the singing...when you sang together." She is referring to a tape I played of a client who was singing about being lost and crying about her inability to find herself. I make a mental note of this clue. Does Marie have similar abandonment issues?

She speaks slowly and softly, tentatively. She leaves space between her sentences. Occasionally in the silence she makes eye contact with me and laughs nervously. She talks about her dreams and fantasies. She seems to be more at home in the inner realm of symbols and images than in the outer world of concrete reality.

I have the sense that she is more spirit than flesh, disembodied almost as if she were unborn and waiting for a midwife to help her give birth to herself. I am intrigued. She reminds me of the archetypal child (Kalsched, 1996), the child who is sustained by her connection to a rich inner world of fantasy and imagination, who has not entered life yet but hovers on the brink. I think of the movie "Wings of Desire", which has a related theme. Is Marie like the angel who wants to become real but must sacrifice immortality to do so?
My reverie is broken by her words. She has brought a song with her today, "Killing Me Softly with His Song" (Gimbel & Fox, 1972).¹ She wants me to sing it with her. "I haven't been able to get this song out of my head since your presentation so I finally bought the sheet music."

I invite her to come to the piano and sit beside me. I know this song and like it. I feel curious about the meaning of her choice and I am aware of the significance of the first song that a client brings to therapy. It is similar to a presenting dream in analysis and often reveals much about the client's core issues (Austin, 1993; Diaz de Chumaceiro, 1992a, 1996b).

She sits down on the bench beside me, looks at me and laughs nervousely. This is our first time singing together. I suggest we begin with breathing. "Imagine you have a straw in your mouth and you are sipping in something delicious, then when you are full, exhale on an f-f-f sound." We breathe together. I notice her breathing is shallow and that she uses her shoulders to compensate.

We begin singing. Her voice is light and airy. I attempt to match her volume and vocal quality. I am wary of overpowering her as she sings very softly. She seems more fully "in the room", more present, while singing.

When we reach the chorus, her eyes overflow with tears.

Strumming my pain with his fingers,
Singing my life with his words,
Killing me softly with his song,
Killing me softly with his song,
Telling my whole life with his words,
Killing me softly with his song.

We finish singing the song then sit in silence for a few moments. I ask, "What were you experiencing?" Marie breathes deeply then says, "That's how I felt at your presentation, like you were singing about me, 'where are you, I need to find you' and the music, the connection- the words go in deeper when we sing." She looks wide-eyed as if surprised by her own tears. I am touched by what I perceive as her fragility.

She talks about feeling lost and confused. We talk about the long commute she has to make to get to school in another city. "I have never felt settled . . . we moved so much from one place to another. I don't remember much about my childhood except being in different houses." I reflect how disorienting that must have been. I ask if she ever felt safe anywhere. "The two years we spent in France with my grandparents . . . I remember how depressed I was when we moved back to Germany. I felt happy in France . . . I felt alive."

She talks about wanting to remember more about her childhood in order to understand why she feels so detached from life. She says, "I'm also aware of another part of me that wants to resist therapy." We identify this "scared part" and I suggest that we make space for it to join us. I ask if she could play or sing as or to that part of herself. She decides to sing and play the xylophone.
We begin with breathing and then I suggest she allow her hands to lead her without thinking about the notes she is playing. She plays slowly and softly, mostly in A minor. I support her melody by playing chords on the piano. I say, "You can sing sounds or words and I'll sing with you." She nods her head and begins singing "oo" to a simple melody (A to C). I notice the minor third, which makes me think of "Lullaby". I sing in unison with her.

After a few minutes, she changes to an "ah" sound. Her melody alternates between A to C and A to E. Sometimes she sustains one note for a full measure and sometimes she sings a descending line adding passing tones. I play A minor to D minor, occasionally adding E dominant 7. I attempt to harmonize with her a few times but she follows me and we end up singing in unison again.

I wonder if this indicates an inability to hold her own note (a matter of musical skill) or is symbolic of her need to stay closely connected to me, or both. I check in with my feelings; there is a merged quality to the music. I feel like she needs to lean on me for support, that she needs a lot of containment. As we continue singing I have the sensation of leading her (this scared part?) out.

Gradually she begins to sing the words, "Can you hear me?" I repeat her words and her melody. She continues, "Can you see me?" Again I repeat her words and melody. She continues to sing these phrases several times, then adds," I am hiding."
This time I break out of the mirroring, reflecting role and sing a question. "Are you afraid?" She sings, "I am not nice to look at". I sing as her alter ego or double "I am ashamed" and she repeats my words and music (which indicates to me that what I sang rings true for her). After a moment she sings, "I am afraid of the bright light." I repeat her music and lyrics. I then add, "It is alright to feel afraid...I don't have to come out yet." Marie picks up "I don't have to come out yet" and we sing this refrain several times.

I am deeply affected by this music. I can identify with Marie's scared part. I understand the feeling of shame and the desire to hide away. I have been there. Her fear of the bright light reminds me of times when I have shed another layer of defenses and feel raw and exposed. I remember only feeling uncomfortable at night, in the dark. I believe it is important for Marie to know that she can come out at her own pace. There is no rush.

We briefly process the music. Marie says, "I saw a small child...she looked weak...she was all alone in a dark room." I assure her that we can make contact with this child whenever she wants to. Marie cries, "I don't know if she saw me." We talk some more and then I gently interpret her ambivalence about being seen and heard. We speak about her need to be seen and accepted versus being seen and judged. Marie says “My mother was never very good with feelings...she was good at doing things for us but I never felt really close to her.” Marie and I talk about making this a safe place where the little child won't have to be afraid to have feelings and needs. She smiles at me and says, “thank you”.
CHAPTER IV
THE ROLE OF THE THERAPIST: THE WOUNDED HEALER

Introduction

My purpose in this chapter is to begin to answer the primary research question of what characterizes my model of music psychotherapy with individual adults, by addressing a significant sub-question; what is my role as a therapist? Throughout the data analysis various themes appeared that related to my role as therapist: psychic detective, human instrument, container, seeker, witness, companion, co-creator and wise wound. As the analysis continued a larger theme emerged that contained the essence of all the others. The theme, “Wounded Healer”, most accurately describes the way I view my clinical role.

As a music psychotherapist to other creative arts therapists and a teacher and lecturer in the field, it seems to me that creative arts therapists tend to suffer from psychological wounds to an extent that is greater than people drawn to other types of vocations. These injuries to the self may unconsciously induce people to enter the helping professions. Alice Miller’s (1997) analytical work with psychotherapists led her to conclude that many of her clients had been highly intuitive children with an amazing ability to perceive and respond unconsciously to the needs of their narcissistic parent or
caretakers. Her clients’ needs for understanding, empathy and mirroring, however, were not met and had to be repressed. An accumulation of unmet dependency needs in childhood resulted in the loss of the true, feeling self. Being needed became a substitute for being seen and accepted and guaranteed the child a measure of security.

Later, these children not only become mothers of their own mothers but also take over at least part of the responsibility for their siblings and eventually develop a special sensitivity to unconscious signals manifesting the needs of others. No wonder they often choose to become psychotherapists (p. 9).

There are wounded therapists who are unaware of being injured and/or unconscious of the extent of their psychic wounds. Guggenbuhl-Craig (1971), Miller (1981), Sedgwick (1994), and Pearlman & Saakvitne (1995) describe some of the negative repercussions that can occur when wounded therapists do not recognize or have not sufficiently worked through their own issues. These therapists may attempt to heal themselves vicariously by healing their clients; they may unconsciously use their clients to meet their own unmet needs for understanding, mirroring and idealization. They may re-traumatize clients through their own “addiction to trauma” (Austin, 2002, p. 245), the need for emotional intensity and drama to compensate for the lack of connection to their own authentic feelings. “A therapist creates safety in part by knowing, noticing and understanding what she brings into the therapeutic relationship” (Pearlman & Saakvitne, 1995, p.178). When awareness of inner conflicts or traumatic events remains unconscious or dissociated the therapy is
jeopardized. Many music therapists, especially those new to the field, are unprepared for the intensity of the feelings and the intimacy that can occur within the therapeutic relationship. There is no substitute for personal experience in psychotherapy (ideally music psychotherapy) to increase self-awareness and gain first hand knowledge of complex dynamics like transference, countertransference and resistance.

There are also therapists who have been deeply wounded and have undergone personal analysis or another healing process and are still able to recognize both their own wounded part as well as their healer part (Guggenbuhl-Craig, 1971). By working through their childhood injuries, these wounded healers gain an enhanced capacity to understand and empathize with their client’s struggles (Rippere&Williams, 1985). They know what it is like to feel frightened when expressing difficult feelings and shame when revealing parts of themselves that have been hidden and never seen the light of day. They understand the vulnerability of trusting another human being (the therapist) when their experience has taught them that people are by nature untrustworthy. Consciously or unconsciously, they often draw upon the wisdom of their wounds to make therapeutic interventions. Such therapists often bring an unsurpassed commitment to their work and a special appreciation of the courage necessary to confront one’s difficulties in order to regain a sense of self. They can make excellent role models.

I am one of these therapists both wounded and healer and I view my clients as having both a wounded part and a (self) healer part. But for me,
being a wounded healer means more than having an awareness of and working through my own childhood injuries. It means more than possessing an enhanced ability to understand and empathize with my clients’ deepest fears, rage and grief because I too, have experienced such feelings and have traveled through the dark corridors of my own psyche. It means more because being a wounded healer has a strong impact on my clinical approach to music psychotherapy.

Historical and Mythological Background

In Jungian psychology the shaman is a manifestation of the archetypal pattern of the Wounded Healer (Reinhart, 1989). An archetype is a transpersonal, universal pattern of psychic experience and meaning comprised of emotion and image (Jung, 1968; Edinger, 1972). Even though the details of shamanic practice vary from one tribal culture to another, the essential characteristics and meaning remain consistent.

Initially set apart from his or her tribe by the force and intensity of personal religious experience that resulted from mystical communion with the spirit world, the shaman came to be highly regarded as a healer, visionary and mediator between the worlds.

In every shamanic tradition, the candidate must undergo a period of intense psychological, physical and spiritual trial, a night sea journey into the unconscious...during which the future shaman may become physically and/or mentally ill...He must be able to travel to the land of the dead and return to acquire and consolidate the skills necessary for his future work (Reinhart, 1989, p. 15).
The shaman was believed to have access to inner realms and extraordinary states of consciousness. In a deep trance state he/she would enter the underworld to search for and recover the lost souls of the wounded. Shamans could shield humans from destructive spirits by rendering the spirits harmless. A shaman could pass specific knowledge on to another shaman and the record of his/her inner journey was often communicated through painting, music, dance and storytelling (Halifax, 1982; Campbell, 1983).

The mythological image of the wounded healer is very widespread. "In Babylon there was a dog-goddess with two names: as Gula she was death and as Labartu, healing. In India Kali is the goddess of the pox and at the same time its curer" (Guggenbuhl-Craig, 1971, p.91). The Greeks represented the ancient figure of the Wounded Healer in Chiron, the Centaur. Chiron had the body and legs of a horse and the torso and arms of a man (Graves, 1955).

Abandoned by his parents, Apollo, the sun god, adopted him and taught him many skills. Chiron became a physician, a wise man, a teacher and a musician. During a fight, Chiron was struck in the leg by an arrow that created an un-healable wound.

Ironically, his ability to help others was increased by his continual search for relief from his own un-healable wound...Chiron is associated with the principle of homeopathic healing, where like cures like, for example minute quantities of snake venom can be used to cure snakebites (Reinhart, 1989, pp. 23-27).
Chiron's most famous pupil was Aesculapius, who became a physician with
great healing powers. Aesculapius was also wounded. Hades struck him
down for daring to raise the dead but Aesculapius became immortalized as the
Greek God of Medicine.

The Wounded Healer in Psychology

Carl Jung (1951a) was the first psychologist to write about wounded
healing and the wounded physician. In 1951, he made the point that it is not
the analyst's openness, mental health, or knowledge that is most important but
"it is his own hurt that gives him the measure of his power to heal" (p.116). A
wounded healer himself (1961a, 2000) he struggled with psychosis in midlife.
For six years he confronted his own unconscious psyche and was drawn
deeper and deeper into the visions, dreams and voices within. He returned
from his night sea journey (a mythological initiation into death and rebirth)
with new knowledge of the inner world and its wisdom.

In his biography, "Memories, Dreams, Reflections", Jung (1961a)
wrote:

It is of course ironical that I, a psychiatrist, should at almost every step
of my experiment have run into the same psychic material which is the
stuff of psychosis and is found in the insane. This is the fund of
unconscious images which fatally confuse the mental patient. But it is
also the matrix of a mythopoetic imagination which has vanished from
our rational age (p. 188).

Later in his biography, he speaks of this difficult period as the most important
time of his life, the time when he gathered the primal material that was the
basis for his most significant contributions to psychology.

The knowledge I was concerned with, or was seeking, still could not
be found in the science of those days. I myself had to undergo the
original experience and, moreover, try to plant the results of my
experience in the soil of reality... It has taken me virtually forty-five
years to distill within the vessel of my scientific work the things I
experienced and wrote down at that time (p. 192).

Guggenbuhl-Craig (1971) suggests, “there is no special healer
archetype or patient archetype” (p. 90). He stresses the Jungian viewpoint that
each of us contains both poles of the archetype within us, healer and patient.

He believes there is danger if the illness side is left entirely with the patient
and the analyst loses awareness of the patient within him/her self and projects
it entirely onto the patient. Similarly it is unhealthy when patients
continuously project their own inner healer onto the analyst. Both projections
are understandable and appropriate for a time but a shift needs to occur so that
the archetype does not remain split. The analyst needs to acknowledge his/her
inner patient and become “the wounded healer who confronts the ill and
constellates their inner healing factor” (p. 93). Patients need to take
responsibility for their sickness and with the support of the analyst or doctor
activate their own intra-psychic healer. Something in the patient’s body and
psyche must help in order for the patient to recover. Guggenbuhl-Craig
supports the ideal of the Greek physician, Aesculapius who taught, “only the
divine healer can help while the human doctor merely can facilitate its
appearance” (p. 96).
Jess Groesbeck (1975), also draws on the wounded healer archetype in his therapeutic approach. He focuses particularly on countertransference and like Guggenbuhl-Craig (1971) believes that ultimately the mutual projections of "patient" and "doctor" need to be withdrawn. The analyst has to lead the way by experiencing the archetype in its totality, by allowing him/her self to be infected by the patient's psychic wounds while simultaneously acting as a role model and a catalyst for the patient's inner healer. Because of the deeply personal aspect of this approach, he suggests that some analysts are "constantly being analyzed and illumined by their patients" (p. 133).

Sedgwick's (1994) strong reactions to his patients led to his examination of the wounded healer, both the archetype and those analysts who use countertransference as a primary tool in their work. His study of his own countertransference-based work led him to conclude,

It is not only where the patient feels troubled but where the analyst also does that transformation takes place...something of parallel depth and sometimes parallel confusion goes on in the analyst (p. 107).

Sedgwick stresses that it is essential for analysts to undergo their own analysis and work through their core complexes. He points out, however, how important it is to recognize that these complexes are never totally worked through and can sometimes be re-constellated by the patient's unconscious.

Theodor Reik (1948) does not address the wounded healer archetype as such, but conveys an attitude that is not dissimilar from Jung's when he writes,
“There is no basic psychological difference between him (the analyst) and the patients he is treating...we are all wrestling with the same emotional problems and it is often only a matter of proportion that determines whether we are victorious or defeated (p. 59).

He suggests that it is only a matter of luck that determines whether we lie on the couch or sit behind it and that this truth becomes evident to any clinician whose self-analysis goes deep enough.

The Shaman in Music and Creative Arts Therapy

Music has historically played an essential role in healing in the traditions of shamanism and spirit possession rituals. The rhythmically repetitive music typical of many shamanic journeys supports an altered state of consciousness and encourages trance induction. Music and movement facilitate the shaman’s travels to the spirit world where communal and individual healing is effected through the shaman’s interactions in the sacred realms inaccessible to most people (Moreno, 1988; 1995).

“The shaman’s work is analogous to the music therapist’s, as both involve musically accessing inner sources of wisdom, power and health” (Aigen, 1991b, p.95). Shamanic and other ritual forms of healing “represent the first efforts to effect self-transformation through music” (p.85).

Many creative arts therapists have drawn parallels between shamanism, ritual healing and the clinical processes that take place in music, drama, dance and art therapy. The act of participating in creative activity can provide a ritual space where transformational and healing experiences can
occur. Connecting with one’s creativity or relating to others through the arts can allow for transpersonal experiences and can fill the void in a society bereft of meaningful ritual and myth (Aigen, 1991a, 1991b; McNiff, 1992; Moreno, 1988, 1995; Jennings & Minde, 1993; Kenny, 1982).

**Walking the Walk**

There is no better example of “like cures like” than the worldwide fellowship, Alcoholics Anonymous. Its founder, Bill Wilson, after many failed attempts at getting sober, eventually discovered that in trying to help others with the same problem he was able to help himself (A.A. World Services, 1984).

In 1935, Bill Wilson had an experience that changed the course of his and millions of others lives. He was out of town on a business trip. In New York, he had kept himself sober for more than five months through working with other drunks at the mission. The work protected him and kept him safe from his own addiction. Now he was on his own in a hotel lobby in Akron, Ohio with a bar at one end of the lobby and a church directory at the other. He panicked and thought he was going to get drunk. He felt the irresistible urge to walk into the bar.

Then I remembered that in trying to help other people, I had stayed sober myself. For the first time I deeply realized it. I thought ‘You need another alcoholic to talk to. You need another alcoholic just as much as he needs you’ (A.A. World Services, 1957).
Bill Wilson’s realization and the positive chain of events that followed, led to the founding of Alcoholics Anonymous. A.A. is an organization where people addicted to alcohol come together to tell their stories, share their experience and support each other on the road to recovery.

It was at an open A.A. meeting that I first heard the saying, “You gotta walk the walk and not just talk the talk.” I never forgot those words. They spoke to me of the courage necessary to be authentic, to practice what you preach (Austin, 1998).

Walking the walk is fundamental to being a true wounded healer. It is not enough to know the psychological terms, the diagnoses, the interventions. It is not enough to talk the talk. Walking the walk is what you learn on your own psychological battleground of conflict and suffering and not merely by reading a book of tactics.

The Wounded Healer as Therapist

What happens to a broken heart?
   It can fall forever
   then shatter
   a fragile Humpty Dumpty
   never to be put back together again

   It can bind itself
   with tough and tender vines
   and hide behind a crusty wall
   sacrificing life for safety
Or it can heal
become holy but not quite whole
Its wound a space where
every song and sigh and every
cry is welcome
a place where no scream
is too loud
and no fear too fierce to
be held
It can heal
and knowing all that it knows
still love again
Then the broken heart becomes a
wise wound

I wrote this poem while analyzing data and working with the theme of the Wounded Healer. I wrote it about the therapist (myself) but later realized it could just as easily have referred to my clients. Such is the proximity that can exist between client and therapist.

There are, of course, also potential dangers when the client and the therapist have similar issues. The boundary between self and other can become very slippery especially when working in the music. It can become difficult to discern who owns which feeling and “if the therapist is reacting to the client’s unconscious as it resonates through the music or is the therapists’ music activating the clients’ unconscious?” (Austin, 1998, p. 332).

The preceding pages of this chapter, however, have stressed the importance of the therapist’s woundedness. Being emotionally present and compassionate is challenging. It requires an open and resilient heart. When used consciously, the clinicians’ injuries are a valuable resource for
understanding and empathizing with the client and are also a significant help in making well-timed, effective interventions.

**The Primacy of Countertransference**

In my model of music psychotherapy, countertransference is used by the therapist as a primary instrument to gain understanding, information and knowledge of the client as well as to increase empathy and strengthen the therapeutic partnership. I refer to countertransference in the totalistic sense (Racker, 1968), which includes all the feelings, sensations, images, thoughts, in short everything that arises in the therapist as a psychological response to the client.

This viewpoint is much broader than Freud’s original description (1912), of countertransference as the therapist’s unconscious reaction to the client’s transference. Freud believed countertransference was related to the therapist’s own neurosis and was something to be mastered. Later, however, he realized that these countertransferential reactions could be useful in understanding the client.

The totalistic definition encompasses all the various kinds of countertransference and the names given to them by prominent analysts. I will mention some types most frequently referred to in the psychoanalytic literature.

Racker (1968) defines”complementary identification” as countertransference that occurs when the client treats the therapist as a
significant person or thing from the client’s life. The therapist identifies with this person and may even act and feel like the person.

Racker (1968) defines “concordant identification” as a type of countertransference that occurs when the therapist identifies and empathizes with the client. There is a union between the various experiences, impulses and defenses of the subject and the object. Racker makes the point that concordant identification is usually excluded from the concept of countertransference unless the term is used in its wider sense.

The wider sense is preferred. If one considers that the analyst’s concordant identification (his understandings) are a sort of reproduction of his own past processes, especially of his own infancy, and that this reproduction or re-experience is carried out as response to stimuli from the patient, one will be more ready to include the concordant identification in the concept of countertransference (p. 135).

Priestly (1994) equates concordant identification with what she calls “empathic” or “e-countertransference” (p. 87). She associates e-countertransference with the image of “a plucked string instrument (the patient) whose music resonates on its sympathetic strings (the therapist)” (p. 87). In this process the therapist resonates or feels the patient’s feelings, often before these feelings are available to the patient’s conscious awareness. She makes the point that e-countertransference is an “echoing form of countertransference” (1994, p. 99) in which the patient’s physical or emotional pain echoes in the body of the therapist and that some e-
countertransference manifestations only appear while the music therapist is improvising.

Projective Identification is a primitive defense mechanism that was given special emphasis by Melanie Klein and her followers. It involves a strong countertransferential reaction on the part of the therapist. There are differing interpretations of this phenomenon but most definitions include at least two steps. First, the patient splits off parts of the self, emotions and/or transference reactions and projects them onto the therapist. Second, the therapist identifies with the projected aspects and feels controlled by them and may unwittingly act out the feelings with the patient (Moore and Fine, 1990; Ogden, 1991; Davies and Frawley, 1994).

Jung (1946) rarely used the term “countertransference” but referred to it in different ways. He viewed countertransference as the unconscious transferring of the patient’s illness to the analyst. He spoke about “psychic infection”, “induction” and “participation mystique”. He believed it was the fate of the analyst to be psychologically affected and infected by his patients. These fusion states, which he classifies under the category of “participation mystique” have both a creative and a destructive aspect and could be synonyms for projective identification (Schwartz-Salant, 1989).

The following example of countertransference in music psychotherapy is from my research study:
Analytic Memo – Session Twenty-seven

Today’s session with Cindy was interesting. I felt very critical of her. I judged her music as superficial. We improvised using piano, voice and drum. She played a major chord progression and I played the conga drum. We sang sounds together, lots of call and response and lots of short melodic phrases. I felt she was attempting to be playful but it didn’t feel real to me. Afterwards, when we talked about the music, I thought she was avoiding something. Her avoidance brought up anger in me. I was surprised by my reaction; I am usually more patient and would understand that she was most likely experiencing resistance. I asked her how she was feeling with me today and she replied, “uncomfortable.” The discomfort had to do with feeling good, with having good news and feeling awkward and embarrassed for wanting to tell me about it. She said, “I don’t want to be a show-off”. After verbally processing the origins of her fear of “bragging”, I thought I sensed some anger underneath. Anger is very difficult for Cindy to feel and express. We talked about how it felt to suppress good feelings and to keep a low profile in order to feel safe. She said, “There’s a critical part of me that tells me it’s wrong to say good things about myself.” I asked her if she could play that part. She agreed and picked up the woodblock. She hit it over and over again. She asked me to play a grounding rhythm on the conga drum so I did. Her playing had a relentless quality to it. She sped up the tempo and played louder. I felt like she was beating someone up. Then she stopped abruptly and said, “it’s like my father’s voice . . . he used to say things like, ‘who do you think you are’ whenever I felt proud of something I did or wanted something more out of life”. I asked her if she ever got angry at him or at that critical part of herself. She said, “I never got angry at him . . . that part, maybe . . . I probably turn my anger against myself.”

Days later, when I returned to this memo, I had many thoughts about this session and my countertransference-related reactions. I was struck by the similarities between complementary countertransference, projective identification and psychic infection. It seemed as if Cindy was treating me as if I were her father (a negative father transference) and I was identifying with and feeling like him (complementary countertransference). Projective Identification could also be used to describe what occurred. Cindy split off a
feeling and/or a part of herself (anger, the critic or negative father complex) projected it onto me, and I unconsciously identified with the feelings and experienced them as my own (psychic infection).

Projective identification is activated when feelings are so intolerable that clients defend themselves by keeping the feelings out of conscious awareness. Although projective identification can be a disturbing experience for the therapist, it is also a way to learn about the client’s inner world on a gut level, to walk in their shoes so to speak. More than a defense, projective identification provides the client with a means to communicate important information about the self, information that is too unbearable to consciously know about and express.

There were other countertransference feelings present during Cindy’s session. I felt her playfulness was not authentic and I thought she was avoiding something. I identified with her fear of being attacked for “showing off”. I also had a parent who could be very critical of me and I felt as if I had heard “who do you think you are” many times while growing up. I felt protective of Cindy while drumming and concerned that she might be beating herself up (symbolically). So using clinical terminology, there were many moments when I experienced concordant identification or e-countertransference, many moments when I felt like a positive mother and many moments when Cindy’s wounds resonated with my own and brought us closer.
I have described concepts and ideas about countertransference and how it operates. These concepts, these terms, are of value not only as an aid in understanding the client and the therapeutic process but in conveying information to other professionals. But more important than the terms used to convey what occurred during Cindy’s session, was the experience she had while playing the woodblock and the insight she gained into her issues. This insight enabled her to begin to differentiate between her authentic self and the critical, persecutory part of her. Being able to identify an aspect of the self is the first step in separating from it, separating out and peeling away the ‘not me’ so there is more room for the ‘me’.

The Therapist’s Hook

Sometimes in the distance between us
   I come too close
   A door opens and I stand on a
      Slippery threshold
   Your hand beats out a cruel rhythm
      And my heart jumps
    Hungry eyes look into mine
   A child walking on the railroad tracks
  Sings of hidden rooms and lost love
     I fear, I long, to hold her
   She vanishes then reappears like a
      Recurrent dream
     Part familiar, part mystery
  Does she belong to you or me?

The therapist’s hook, the area of woundedness that allows the therapist to get caught in the client’s material, is a theme that emerged in the process of examining my role as a wounded healer. Although I had been aware of this
phenomenon in the past, it took on greater clarity and significance after researching my use of countertransference.

I believe the therapist and the client co-create the therapeutic relationship and it is important when working with countertransference to avoid placing all the responsibility on the client for inducing feelings in the therapist. I found that when I could acknowledge the reciprocity of the relationship and take responsibility for the part I played in the interaction, it greatly benefited the client.

This was my experience when I apologized to Cindy for an empathic failure. I failed to pick up on the importance of what she was talking about, an upcoming dinner party. She was describing details with little affect and I thought she might be avoiding her feelings about her mother's lack of support with the party. I made an abrupt intervention toward the music and suggested she play her feelings about the situation. She agreed to play but looked hurt. I asked her what she was feeling and she said, "misunderstood." She had never given a dinner party before and her mother didn't "know about these things" so she really needed my help and support. We continued talking and gradually she told me she didn't think the party was a serious enough matter to merit my attention. "It's not that important . . . and you didn't seem that interested." She also said that she felt shame for needing help. We continued exploring her feelings and she made a connection to the way she felt with her mother. "I never asked her for help. It just wasn't an option . . . I had to help her all the time."
I pointed out that asking for my help this directly was new and a major step for her. I apologized for failing to understand the significance of the party. She began crying and said my apology touched her.

My mother never owned her stuff . . . she put it all on me . . . She said hurtful things and never apologized when I confronted her. When I was younger I always just assumed she was right cause she was the parent . . . and I was so used to feeling wrong all the time.

The following excerpt from my log is an example of the therapist getting ‘hooked’ in the client’s material. It illustrates the valuable information that can be obtained when the therapist is willing to look closely at his/her part in the interaction.

Analytic memo: Session 23

Ann came to the piano and played the feelings she had about her boyfriend’s confession the night before. The music was in a minor key and slow in 4/4 time and seemed very structured and controlled. It lacked feeling. I felt no impetus to join her nor did she ask me to. Afterwards, she said she didn’t want to feel, especially to feel the impact of her boyfriend’s behavior. It wasn’t “convenient”. I took a deep breath. She said, “I feel numb.” I checked in with myself. I didn’t feel anything either. We both seemed to be disconnected-disconnected from each other and ourselves. When the session was over I noticed I felt mildly depressed and tired. I thought I had picked up Ann’s “numbness”. Upon further reflection I noticed some anger, but at who? Was I angry with her boyfriend or at Ann for showing no reaction to what I perceived as a betrayal. I realized I wanted Ann to get angry instead of putting up with this. I felt angry at her passivity. Images flashed before me of times when I put up with unacceptable behavior because I was afraid of the repercussions of getting angry and taking action. I would then feel angry with myself for being passive. I eventually learned the reason for my numbing out, and developed some compassion for myself. I feared losing the person if I became angry at him or her.
This association to my previous fear of anger and the connection to loss enabled me to have more compassion for Ann and insight into her behavior. My frustration with her passivity was related to the anger I felt toward myself when I became passive. My ability to identify with her tendency to disconnect when feelings became unmanageable made me more sensitive to when and how she dissociated in sessions and how to work with this symptom. I gained a clearer understanding of Ann’s abandonment issues and how they intensified her fear of anger. If she equated anger with loss (and I think she did) then she would experience great resistance to feeling and expressing anger at her boyfriend.

Stein (1992) makes the point, that it is often “impossible to tell with complete assurance who owns which psychic contents in the transference/countertransference process” (p. 69). This implies that therapists should at least consider what their clients are suggesting about them without automatically assuming the client is projecting his/her feelings onto the therapist.

I find this to be especially true when working within the intense field of a musical encounter. The intimacy of creating music together is especially challenging because the unconscious contents for both client and therapist are easily accessed through music. Client and therapist can deeply affect each other on a level that goes beyond words. Defenses and boundaries are easily
bypassed. Spontaneity is evoked and the client is often directly involved on a sensory and feeling level with the music therapist (Austin, 1996).

Neutrality is a questionable concept when client and therapist are making music together. Music therapists cannot avoid consciously or unconsciously drawing on their personal relationship to music if they are present and participating in the creative process. The connection between their relationship to music and their emotions and inner life is an intimate and multi-layered one. It follows that therapists will at times psychically affect and “infect” (Jung, 1946), their clients as much as their clients affect them.

Therapists will not usually have a strong reaction to a client’s material unless they have a psychological “hook”, a place when the client’s issues intersect with their own and a client’s projections will not hold unless there is a hook to hang them on. The therapist who knows this “recognizes time and again how the patient’s difficulties constellate his own problems and vice versa” (Guggenbuhl-Craig, 1971, p. 130).

Sedgwick (1994) believes the client unconsciously finds or even creates “areas of parallel woundedness” (p. 109) in the therapist. The purpose is to induce an intense empathic connection in the here and now so that the therapist will feel and understand the client’s experience. Sedgwick finds there is

a fundamental difference in degree and quality between a countertransference wound and empathy as usually described . . . the usual empathic connection seems more transient and less ‘hooked’ (p. 109).
This symbiotic, merged type of empathy is essential for some severely wounded clients if any kind of healing and transformation is to take place (Maroda, 1991).

The Musical Hook

The following example is taken from my session notes and research log. It illustrates one of my research findings. The “musical hook” is a theme that emerged from the data and refers to a moment when the music and/or lyrics, intersect with the therapist’s issues and trigger associations, memories and feelings for the therapist. I have found that this kind of transference to the music induces a strong reaction in the therapist.

Marie brought in a song today, “The Rose” (McBroom, 1977).² She heard it on the radio and it touched her. She had never heard it before. I knew the song well. I had a history with it. I never liked the song. I thought it was corny. Then recently, I was asked to sing it at a relative’s funeral service. I have been singing all my life but I never lost it before. I got to the middle section and I started crying. It took me several moments to pull myself together and finish singing the song. So there I was playing the song and Marie and I were singing together. I started thinking I would be fine today, that I probably cried before because it was a funeral and I was feeling emotional. Then we got to the same section and I felt the tears start. I looked at Marie. She was crying too. I straightened up in my seat, took a deep breath, and stopped crying. We finished singing. Marie was sniffling and blowing her nose. After a few moments I asked her what she was experiencing. ‘Different things ... aware of how dead, how asleep I have felt since moving here ... sad ... hovering near the earth but not landing ... last week I had a waking dream, a sensation of being born in the middle of the sitting room, an image of being curled up, very intense ... awe at being alive ... and real.’

We talked about how she identified with the lyrics, how she has felt isolated for so long in a still quiet place inside of herself, afraid to wake, afraid to live. But now she feels hopeful like the seed that is becoming a rose.

This was a difficult session for me. I felt close to tears much of the time. The song, the lyrics but also the music reminded me of my recent loss. The middle section really affected me, especially the lyrics “it’s the heart afraid of breaking that never learns to dance, it’s the dream afraid of waking that never takes the chance” and the lyric “it’s the soul afraid of dying that never learns to live.” This part of the song opened up my “middle section” and held up a mirror to some difficult issues that were front and center for me at that time.

The Wounded Healer as Companion

What is a companion? The origins of the word are illuminating when viewed in terms of the psychotherapeutic process. According to Webster’s International Dictionary (1993), “companion can be traced back to a probable translation of a Germanic word meaning fellow soldier” (p. 461). The Latin roots of companion are “com + panis meaning bread, loaf or food” (p. 461). The dictionary defines companion as someone who “goes with or attends... adds to or joins” (p. 461). Then, of course, there is the accompanist, “who plays the accompaniment for a vocalist or instrumentalist” (p. 12).
The wounded healer makes an ideal companion for someone on the path to recovery and the road to self-realization. To companion someone in the “soldier” sense is to walk the walk with them, share in their adventures, their battles, their victories and defeats.

There are times when a companion needs to join with the client to lend his/her ego when the client is faltering on the road or to provide a more symbiotic way of relating when there are early developmental injuries blocking the way. Participating in the “illusion of symbiosis” (Machtiger, 1992, p. 127) can provide clients with a reparative experience so that they can renegotiate separation – individuation and continue on their journey to selfhood. Searles (1979) has written extensively on the necessity for therapeutic symbiosis and mutual regression when working in depth with clients, especially clients with severe psychological injuries. He believes that a therapist without an “affliction” could not work effectively in the symbiotic phase of the client’s treatment but it is critical that the therapist have the capacity to function while being partially regressed.

There are times when the client needs to be nourished and fed with support, empathy and understanding in the form of music, words and silence. The companion offers this nourishment before, during and after accompanying the client into the desert, the closet and the room where the abuse took place and while experiencing feelings and sensations with the client and not from a safe distance.
To accomplish this, the companion needs courage and strength born of familiarity with the interior world so that he/she can face whatever emerges from the client’s and his/her own unconscious while remaining emotionally present. Permeable boundaries allow therapists to have a reasonably controlled regressive experience in order to share in the client’s affective states rather than simply observing them. It is, of course, a matter of degree (Maroda, 1998). Therapists’ boundaries also need to be strong and resilient enough to feel intense emotions without being flooded by them. If the concept of therapeutic regression is accepted as desirable, “then the therapist’s capacity for merging and separating become vitally important” (Maroda, 1998, p.36).

Anne Alvarez (1992) describes the ideal therapist as someone capable of being disturbed enough to have the capacity to relate to and feel for patients but sane enough to be with them. I would add sane enough to contain and help the client digest the unprocessed affects and conscious enough (because of working through one’s own issues) to assist the client in transforming unproductive or destructive patterns and ways of being.

Wounded healers are well trained for the role of companion by virtue of their acute sensitivity and almost psychic ability to tune into other people’s feeling states. The ‘antenna’ that helped them survive difficult childhoods now enables them to finely attune in a way that is “beyond empathy” (Sedgwick, 1994, p.109). I experience this kind of enhanced empathy when there is a deep unconscious connection with the client. It feels like a
combination of empathy, intuition and identification that allows me to enter
the psychic space of another person and retreat if the integrity of my
boundaries is threatened. There is an ‘in and out’ quality to the experience
like diving into water and surfacing especially when vocally improvising or
working within the fluid, permeable, musical environment. In these moments,
I feel as if I am submerging myself in the client’s inner world, consciously
loosening my boundaries and allowing a part of myself to regress and merge
with the client (if it is therapeutically indicated) and then emerging, affected
by the experience but psychically intact (under optimal circumstances).
Examples from my log follow:

I remember making a conscious effort to sing the lower note
when harmonizing with Ann. I had a strong feeling she needed
the grounding and support.

My support group asked if there was meaning in the fact
that I often sing in unison or harmony on the same word at
the same time. They felt this showed a high level of attunement
to be able to be so ‘in sync’ with the client.

Ann sang: ‘you never received the support you needed’
I sang: ‘ the support.’ Together we sang: ‘To survive’

I made a leap of faith – used my intuition and sense of Ann,
where she was emotionally. She had been singing about how
hard she works and yet her brother was getting on with and
enjoying his life. We sang about how hard she worked as a
child and I sang, ‘so they would love me’, and she repeated
‘so they would love me’, acknowledging this as truth. We had
never discussed this before...I felt so sad. It seemed as if she did too.

Marie played a minor melody and gradually I added dissonance. She
was playing how it felt growing up in her home. I got chills. I felt we
were going into a ‘black hole’. I wasn’t sure where she was except
that I felt we were entering a room that had been locked for a long
time. I felt young, scared and like it was hard to breathe. I forced
myself to take a deep breath and played chords to hold the melody. She also took a breath. When the music ended she said, 'I don't know...I didn't see anything but it felt so lonely. I don't even know which house I was in but it was empty and I was alone and frightened...but then I heard your music and I knew I wasn't alone. The music was giving sound to my experience and making it real. It sounded like how I felt.'

Marie dreamt of a sick dolphin dying in the snow. I asked her if she could sing to or as the dolphin...She regressed to seven or eight years old, a time when she felt depressed and wanted to die. She sang about stillness, not being able to reach out and feeling isolated. I sang 'I need help... does anybody see me, or hear me...does anybody care if I just fade away?' I kept breathing deeply and checking in with myself, noticing how I was being affected by Marie and the music. Marie started crying. I continued to sing what I sensed she was feeling, about being left alone and withdrawing from life ‘Where is my cousin? I miss her. Where are my grandparents?’ She cried throughout my singing and afterwards she said, ‘the dolphin couldn’t connect to the other dolphins so she gave up – it was so good to hear you put words to my tears. I didn’t have the words; I couldn’t say it but you were my voice and what you sang was true.’ I was singing about the abandonment and disconnection she felt when she left France and her cousin and grandparents. I felt on the verge of tears while singing. I went into my own ‘still snowy place’. I thought of a song I wrote years ago about snow and loss... I cried after the session was over.

Guiding and Guidance

Companioning clients in the music as they enter the unconscious realm and experience creative regression and altered states is enhanced when the therapist is able to assume different roles. For example, clients in a regressed state may need to be met by another ‘child’ or ‘adolescent’ that can play with them and share in their grief or anger. Or, they may need a nurturing figure to
comfort or protect them (For example, I sometimes sing a lullaby-like melody or offer a song to a client who is crying or needs extra support or containment). The client in an adult state may need an adult traveling partner, a parental figure or the quiet presence of a witness. I have found that when working in the music, especially when vocally improvising, roles can shift frequently and quickly.

There are times when it is necessary for the companion to actively guide the client. The role of the guide is to be observant and watchful of the therapeutic process and on the look out for potential pitfalls and dangers (clinically this is often referred to as utilizing one’s observing ego). When working with traumatized clients, these pitfalls may take the form of psychic fragmentation and/or emotional flooding and loss of ego boundaries and can result in uncontrolled regression and retraumatization.

An example of actively guiding the client toward safety and away from a traumatic reenactment is when Cindy was pushing the ‘little girl’ part of herself to scream louder and louder. She was becoming overstimulated and stressed. I realized what was happening and stopped her from continuing. She was able to breathe, calm down and gradually access her feelings. We sang quietly together and she became conscious of all the fear that was underneath her aggressive stance.

There are also occasions when clients need to be actively guided through resistance and into unconscious feelings and unfamiliar territory. This happened frequently when working with Ann. Her intellectual defense
often kept her from connecting to her feelings and life energy. The world of emotions was daunting to her. Guiding her toward and within vocal and instrumental improvisations enabled Ann to rely less on the rational, thinking part of herself and become more comfortable trusting her spontaneous, feeling side.

My research findings revealed many examples of times when I drew on my own experiences in psychotherapy to guide myself as a therapist. As an analysand, I have personally experienced various kinds of therapeutic interventions and there are moments when I find myself asking, “What worked for me when I was in a similar situation?” Sometimes I recall my analyst's words, something he said or did that was effective. Other times I turn to techniques and information I learned from experiencing alternative therapies like psychodrama, body centered psychotherapy and twelve step groups.

An example follows from a session with Marie:

Marie sat still on the couch and spoke in a soft tentative voice. She had a new job and it involved a long commute. She looked pale and disembodied. I asked her what she was experiencing. She said she didn’t know. ‘I feel tired... heavy, a bit confused... like I’m not grounded’. I asked her if she felt disoriented. She said, ‘yes’. We talked about her difficulty with transitions, a theme we had been exploring recently. Transitions make her anxious and she tended to dissociate when she was anxious. I thought about my own difficulties with transitions and anxiety and about what helped me to feel more grounded. I know that connecting to my breath and my body is very important. Moving, dancing and being playful also help me to stay in the present. I asked Marie if she felt like doing some breathing
exercises that involved moving. I felt it was important to move because just sitting and breathing could make her feel even more 'spaced out'. I led her in a breathing exercise and we moved our arms and bodies up on the inhalation and down on the exhalation. She laughed and said, 'I feel like a bird'. I then suggested we add sound and take turns changing the movement and sound. It felt playful and energizing to me and Marie seemed to be enjoying herself. We ended up stamping our feet and saying 'no!' When we finished Marie laughed. She looked more present and lively. She said 'I'm here now'. We talked about never being able to say no to her parents when they kept moving from one house to another. 'I had no choice...I felt completely powerless and depressed. I imagined I lived in my own apartment on the top floor of a beautiful building and it felt very real to me. I could go there whenever I needed to...I loved stamping and yelling 'NO' and I'm not feeling as tired now.' We talked about how helpless she felt growing up but how she could assert herself now.

Diving Deep and Surfacing

"It is she who is at home in the sea of the unconscious who can dive more easily without being drowned" (Claremont de Castillejo, 1973, p.63).

As I recursively examined my log contents I was struck by a difference in quality between times when I felt unconsciously overtaken by the clients’ feeling states and times when it seemed I consciously chose to enter into the clients’ experience. In the former situation I felt I had no control, tears sprang to my eyes, rage pulsed through my body, in what could be clinically described as projective identification or a participation mystique, a primitive psychological connection in which there is often no clear sense of difference between the psychic boundaries of two persons (Perera, 1932).

I have written about these kinds of intense, countertransferential reactions that can overtake and sometimes overwhelm the therapist (Austin,
1998, 1999, 2002). More compelling, however, was the discovery that I often chose to enter the clients' inner world, (what I previously referred to as submerging, merging and emerging) and my findings describing the ways I 'get in' and 'get out' again.

My research log contains numerous references to the connection between physical and psychological/emotional closeness and distance. Some examples of physical proximity and the relationship to psychic connection are as follows:

I leaned in toward Marie as she was speaking. I wanted to get a sense of what she was feeling. A wave of sadness flowed through me.

I moved my chair closer to Ann while she was playing. I closed my eyes and allowed her music to fill me so that I could experience her inner world.

Cindy and I sat next to each other as we sang. I attuned my breathing to hers and all of my senses were focused on her. As we sang, I felt her fear and then an overwhelming sense of grief.

My findings validated my intuitive feelings about singing and vocal improvisation. I realized that every time I invite someone to the piano to vocally improvise with me, I am making a choice to open myself to the client's unconscious. There is the physical closeness of sitting next to each other combined with the emotional closeness breathing and singing together engenders.

Singing with someone is a very intimate experience. Singing is about opening, opening to oneself and the other. The internally resonating
vibrations open the heart and break up and release blocked energy allowing for a natural flow of sensations, feelings and images to be exchanged between the client and the therapist. Improvising with another requires leaving the safety of the structured song behind and entering the unknown together. The playful, spontaneous nature of improvisation creates an environment where unconscious aspects of the client and the therapist can easily emerge and co-mingle. Singing together can be an intense experience for both participants.

The following excerpts are from my research log:

There is usually more contact when Marie and I sing together. I feel closer to her. She appears more accessible and embodied. Am I also more present and embodied when singing? Today we sang about her childhood. Her mother was not very affectionate or comfortable with feelings. Marie sang about how lonely she felt growing up. I began to feel very spacey and sleepy. The words became sounds, "oo" mostly. I was playing in G minor. I sang unison and harmony with her. Her melodies became more varied and she utilized more of her vocal range. I began to feel sad. Afterwards, I asked her what she was experiencing when we were singing. She said, "there is so much I don't remember...it all seems blurry whenever I think about my childhood. When we were singing the sounds, I felt like I was comforting a sad child."

I hesitated and then asked Cindy if she'd like to sing to, as or about her 'little girl'. I was feeling vulnerable today and somewhat reluctant to go with her into a place that I suspected contained feelings of fear and loss.

Ann went into a high-pitched crying sound. I joined her and sang unison and then dissonant harmonies. Her voice sounded more raw and primal than usual. Her singing grew louder and I felt a mixture of sadness and anger going through me.
The therapist’s intention is an important aspect of this process. When my intention is to enter into a state of psychic connectedness, I allow my ego boundaries to relax and move from a focused to a more diffuse state of consciousness. Claremont de Castillejo (1973) refers to diffuse consciousness as a receptive attitude, “an awareness of the unity of all life and a readiness for relationship” (p. 15).

Emerging from a state of partial identification with the client is not always so easy. My log also contains many examples of physical distancing as an aid to psychological distancing or reining in one’s ego boundaries.

Then I had to pull back a bit to get clear, to maintain my own viewpoint. I pushed the chair back and the physical distance helped me to tune into my own feelings.

In most of the examples, I found I used a combination of methods to disidentify from the client. Physical distancing, body awareness and consciously moving from feeling to thinking helped me to clarify the distinction between self and other. Sometimes simply straightening my posture was helpful; other times I would feel my feet on the floor and/or my pelvis on my seat to ground and center myself in my own body. Deep breathing also enabled me to both focus on my own internal feelings and sensations as well as to release feelings I absorbed from my clients. Since feelings of empathy can easily move into feelings of identification, I learned the value of shifting into thinking mode when I felt I was losing my therapeutic stance. I was not always able to do this, of course, but when I
could I found it most helpful. The music was also a resource for me as well as for the client. Certain rhythms and chord patterns grounded me in my own body and helped me to separate from the client when I needed to.

I forced myself to take a deep breath and played chords to support her melody. I played a simple, repetitive rhythm in the bass part of the piano. I took another deep breath and continued playing.

It felt good, the sensation of my hands hitting the drum. I felt my body moving. I was coming back to myself. My energy was returning. It was a relief.

I straightened up in my seat, took a deep breath and stopped crying.

I rolled my chair back. I needed distance, space to think about where we were and where we needed to go.

There was a hypnotic feeling to the music. I felt like we were still in it (altered state) when the music ended. It felt good to breathe. It helped to think about what I played and sang and what she sang. I needed to help her make sense of her experience and integrate it.

Working in-depth requires using myself as the primary instrument. As Yalom puts it, “the most elegant and complex instrument of all – the Stradivarius of psychotherapy practice – the therapist’s own self” (p. 51, 2002). It is through this instrument that I gain information and knowledge of my clients so that my empathy and understanding is increased. Like Priestley (1994) I often resonate to the client’s music when it “strikes a chord” in me. At those moments I may feel the client’s feelings (especially when they are not available to the client). This phenomenon can occur while talking as well. Some metaphor, turn of phrase or description might trigger a sympathetic vibration (Nachmanovitch, 1990) in me. I may respond with a feeling,
sensation, have a memory or see an image that helps me gain more insight into my client.

My own wounds have contributed to the creation of an especially sensitive instrument, an instrument that picks up subtle nuances of feelings and changes in the client’s ego state and emotional presence. It is easy for me to duet with a client’s grief, fear or anger. It is easy to empathize with the client’s songs of struggle and hope. My own woundedness and my passion to become my true self has led me to this career and is a factor in my ability to participate more deeply and personally in the client’s healing process.

Instruments are sensitive. Pianos go out of tune, violin strings can wear out and drums sometimes need repairing. Being a human instrument requires commitment to self-care. A human instrument needs the continued fine tuning and monitoring that personal psychotherapy and/or supervision provide in order to achieve the self-knowledge and maintain the self-awareness necessary to recognize and work effectively with transference, countertransference and other unconscious dynamics that emerge in the therapeutic relationship.
CHAPTER V

THE THERAPEUTIC RELATIONSHIP

Mutuality

When I began my private practice I was studying at a psychoanalytically informed institute. The model of the therapist-client relationship that I was taught was one in which the therapist remained neutral. My own analyst also worked this way, not exactly a “blank screen”; he was caring, compassionate, but non-disclosing and more or less anonymous so that he was available for my transferential projections.

I tried to follow this model. I remember that I stopped wearing my favorite long, dangly earrings in order to look more the part. After a while I missed my singing career. I felt like I was wearing a strait jacket. I realized I could not and did not want to work this way.

Over the years I studied at various institutes and eventually found a supervisor who was a Jungian analyst but also trained in object-relations theory and was very interested in alternative therapies. It was during this period that I continuously wrestled with my role as a music psychotherapist. How neutral should and did I want to be? How possible was neutrality when working so collaboratively in the music with the client? Was it wrong to sometimes share my own experience, touch or hug someone, cry with my clients? The findings of this research study reveal a change in the way I now
perceive my role as a therapist, my approach to the therapeutic relationship and the effect this has on my overall approach to music psychotherapy.

Like many depth psychologists, one of my core beliefs is that the relationship between the client and the therapist is the primary healing agent in psychotherapy. In human development the self cannot develop without a relationship to another self or selves (Kohut, 1977). In music psychotherapy, music can be a bridge to relationship. It can help create a safe, transitional space between the inner and the outer world (Winnicott, 1971). It can provide an environment where two people can play together, where the client can explore and experiment with new ways of being and relating. Music can be a catalyst for the client's feelings and provide a means of expressing them so that they can be witnessed, shared, and accepted within a significant relationship. The musical connection can help to build and strengthen the relationship between the client and the therapist just as a trusting client/therapist relationship can deepen the musical interaction. Music can also provide a container within which a therapeutic regression can be facilitated and conscious and unconscious memories, feelings and associations can be accessed, processed and gradually integrated within the safety of the client/therapist relationship (Austin, 1991, 1993, 1996, 1998, 1999, 2001).

A therapist's ability to remain present and to fully participate in the relationship with the client is essential if transformations of consciousness are to occur. Whether the therapist or client is silent or actively engaged in
speaking, singing or playing music both therapist and client are co-creating the therapy session.

Jung (1929) suggested the analyst is as much in the analysis as is the client and that “the analyst’s personality is one of the main factors in the cure” (Jung, 1916, p.260). Sedgwick (1994) expanded on Jung’s idea that the therapist’s “getting right with himself” (p.7), can have a significant transformative effect on a client. Many contemporary psychoanalytic perspectives refer to the reciprocal influence and the complex conscious and unconscious impact therapist and client have on one another (Ferenczi, 1988; Kalsched, 1998; Kohut, 1977; Ogden, 1994). Psychological growth of either party eventuates in growth of the other. Natterson and Friedman (1995) refer to the contemporary perspective in which therapist and client are both portrayed as real people who co-create the therapeutic relationship, as “intersubjectivity”. An intersubjective approach places great importance on the interplay of the subjective lives of both the client and the therapist.

Early on in my career, I remember hearing and agreeing that a client could only progress as far as the therapist herself had progressed in her own process. I have had the experience of working through a difficult issue, and then observing a breakthrough in a client with a similar issue. Colleagues I have spoken with are familiar with this phenomenon. One of my first clients, a very sensitive and intuitive young woman, looked at me one day and said, "You can help me grieve but I don't think you can help me with my anger." Of course, this remark could be interpreted as a defense and/or transference,
but I believe she was making an accurate assessment of the situation. At that point in my life, I was not very comfortable expressing anger or having anger directed toward me. I believe there is a direct correlation between what I can accept in myself and what I can accept in my clients (and others). Since then, I have worked hard to become comfortable feeling, expressing and receiving anger. I have observed that now many of my clients are able to identify and express their anger toward others and toward me and are willing to work toward transforming their anger and rage into creativity and self-assertion.

Maroda (1998) examines the therapist's motivation for doing treatment and suggests that just as most clients have the desire to be transformed and healed by the therapist, many therapists also have a need to be healed by the patient. This need will of course vary from therapist to therapist.

We seek to be healed ourselves and we heal our old 'afflicted' caretakers as we heal our patients... As therapists we are allowed the control that eluded us as children. This control offers the legitimate possibility for facilitating a better outcome, yet also proffers a situation where our frustrated needs for intimacy are gratified while minimizing the interpersonal risks we must take (p.38).

No matter how much inner work we have done as therapists to resolve our complexes and conflicts, there is always the possibility for more growth. Each client brings unique challenges. Some will require us to dive a little deeper and in the process of facilitating their journeys, we might experience a measure of healing that has not occurred before.
Working as a therapist provides me with an opportunity and the impetus to continue on a path of self-awareness and individuation. Sometimes while accompanying someone through the inner world of the unconscious, darkened areas of my own psyche are illuminated and in order to be of service to my client, I must face these unwanted and/or unfamiliar aspects of myself and work to accept them.

Collaboration

She wanted to work with the orphan image from her dream, the part of her that feels withdrawn, 'in limbo'. I offered her choices and we discussed different ways we could work with her image. It was a powerful image. I felt a connection to the image and to Marie. It felt like we were on the same 'wavelength'. It felt like a collaborative process . . . She wanted to dance and have me play the drum.

(process note, session 15)

Collaboration is one of the themes that emerged from my study. I place great emphasis on the collaborative nature of music psychotherapy. Collaboration does not mean that the client and therapist are identical or that their roles are the same. The relationship is equal but not symmetrical, equal but not the same (Natterson & Friedman, 1995). The therapist’s role is to be in service of the client, to guide, witness, support, companion and oversee the therapeutic process. The therapist is capable of providing a reparative experience and can help clients recognize and express feelings and needs.

Because a collaborative approach is non-authoritarian, it frees therapists from the pressures of perfectionism and the unrealistic need to have
all the answers. Therapists bring their professional expertise to the relationship but this approach allows them to take more risks, make more creative interventions and offer more open interpretations because their expertise does not entitle them to arbitrary power and the client is directly involved in sharing the responsibility for the treatment (Natterson & Friedman, 1995). In addition, a non-authoritarian approach supports and encourages spontaneity and authenticity in the client.

The collaborative nature of the therapeutic relationship leads to eventual consensual agreement and empowers the client. Clients can often teach the therapist how to help them. Schafer (1983) believes the client is often an unacknowledged source of strength and stability in the therapeutic relationship.

I am aware that I am learning from my clients all the time. My research findings have revealed that when there is an authentic relationship between the client and myself, I am more likely to get an honest reaction to a question or an intervention. I agree with Maroda (1998) that the client “will tell you everything you need to know if you will only listen to him and consult with him” (pp. 21-22). Of course, the client has to trust the therapist in order to risk the vulnerability of complete honesty. Much has been written about building trust and how important it is for the therapist to be consistent, dependable, accepting and empathic (Greenson, 1967; Herman, 1992; Kohut, 1977; Miller, 1981; Winnicott, 1965; & Yalom, 2002). Many clients, especially those with deep trust issues, require even more. They require the
therapist to endure being seen realistically as another human being, a human being who can admit to a feeling that the client has accurately identified, a human being who also makes mistakes and can acknowledge and take responsibility for them. With Cindy, this occurred through our discussion of an inappropriate song choice I made:

Cindy said she felt happy to see me. “My little girl has been jumping up and down at the thought of coming today... it’s my birthday!” I asked her what she would like to do to celebrate. She said she had been singing “Happy Birthday” to herself all morning. I asked if she’d like to sing it. ‘I feel silly but... yes the little girl would like it’. I played “Happy Birthday” on the piano and we sang together. Cindy laughed afterwards. We talked about birthdays and how disappointing they’d been in the past. I felt like doing more to celebrate with her. I pulled out “Happy Birthday” from “Getting My Act Together and Taking It On The Road”. She had never heard of the show or the song and I was eager to share it with her. When we finished singing she smiled but didn’t say anything. She started talking about other birthdays. I realized I really like this song but it probably wasn’t the right song for her. When there was a pause in the conversation I asked her how she felt about singing the birthday songs. She hesitated then said, “the first one was enough... it felt really satisfying”. I replied, ‘the other one wasn’t your kind of song, lyrically maybe, but not musically”. She nodded in agreement. I wondered if I sang the song to meet my own need. She asked me if it was a favorite song of mine and I said “yes”. We both laughed. In that moment it felt as if we grew closer.

And with Marie, something similar occurred when she accurately perceived my emotional state and I acknowledged it:

Marie stared at me for a few moments. Her eyes grew wide. We had just finished playing music together. She played the large metalophone and I played the small one. It was a sweet, melancholy improvisation – minor and slow. There was a flow to it, a nice exchange of musical ideas. “Are you alright?” She asked. I wasn’t
crying or teary but I wasn’t alright. I had received some bad news that morning. “I’m feeling sad today”, I said. She kept staring then shook her head up and down sympathetically. We sat in silence for a few moments and then she said, “me too”. I asked her how my revelation affected her. She said, “I’m sorry – I hope it isn’t anything too bad.” I assured her it wasn’t. She then smiled and said, “Thank you for telling me . . . I was afraid you wouldn’t”.

Little (1981), Maroda (1998) and Searles (1979) address the significance of responding to clients who accurately perceive the therapist’s state of mind. As discussed in the previous chapter, many clients are extremely sensitive to the therapist’s conscious and unconscious feelings and thoughts. These clients were often intuitive children whose feelings and perceptions were denied and/or went unacknowledged by their parents. They end up mistrusting their feelings and their sense of reality. As Marie put it, “No one ever talked about feelings . . . I thought I was imagining how bad things were . . . I felt crazy.”

Many traditionally trained analysts and psychoanalytically-oriented psychotherapists analyze why the client asks about their health rather than first answering the question. Or, they remain silent in the interest of not burdening the client (Maroda, 1991). These therapists forget that although they can control their overt verbal responses, they cannot control what they are communicating in the interactive field between client and therapist. Thus, they may unwittingly harm the client by reenacting an all too familiar scenario.
Alice Miller (1997) describes how silence can sometimes feel punishing. She recalls the abuse she suffered but says none of it, "was as threatening or destructive as my mother's silence at the time of my greatest dependence on her...as a child I had no choice but to suffer my mother's vindictive silence and assign the blame to myself" (pp. 21-22). Of course there are times when silence is necessary and even healing. Miller's concern and my own is when therapists are unnecessarily withholding.

Because of the interactive nature of music psychotherapy it is impossible for therapists to remain completely "silent", to avoid bringing themselves into the relationship. Working deeply within the music requires an awareness of the complex multi-layered verbal and non-verbal communication that takes place between client and therapist. The importance of transference and countertransference to and within the music has been written about by Austin (1998, 1999, 2001), Dvorkin (1998), Priestly (1975), Scheiby (1998), Streeter (1999), Turry (1998) and others who stress the benefits and challenges of the musical encounter.

Musical Meetings

Making music with another person is by its very nature collaborative. Client and therapist are both involved in a creative process that requires mutual participation and cooperation. Particularly when improvising "the music and the communication in the music come from two minds finding meaning together" (Ansdell, 1995, p.13). Collaboration promotes
understanding of self and other and increases the potential for the development of trust and intimacy. It necessitates humility on the part of the therapist and the capacity to relinquish the need to know and the need to be in control. Then we can truly listen and allow our clients to teach us how to help them.

There are many aspects of a musical collaboration. As client and therapist work to create something together they explore the various elements of music. The client has the opportunity to experience the aesthetic and emotional significance of the effect of different harmonies, melodies and rhythms. Therapists must remain sensitive to their clients’ musical and psychological needs and aware of their own musical biases while shaping musical interventions.

Improvising lyrics adds another dimension to the musical collaboration. The use of words can create a greater differentiation between the client and the therapist perhaps because words are generally more concrete and specific than music is. I have found that when I sing my own words in response to the clients’ words (instead of repeating their words), the transference and countertransference can become more complex. I am taking a more active role by questioning and using my countertransferential feelings to deepen the therapeutic process and help the clients understand and make meaning out of what they are experiencing (Austin, 1998).

As my clients explore their feelings, perceptions, and imaginings in the music, I explore mine and we affect each other. Although as therapist, my
attention is focused primarily on the client’s musical, emotional and psychological world, the fact remains that together we are creating something that did not exist until we came together, such as a rhythm, a melody, a chord, a new way of perceiving the self, each other and the world.

Sounds – loud, soft, soothing
Two voices traveling together
Intimate strangers
Out for a swim
There is a sadness in the waves today
We both feel the pull
Tears fall from her eyes
And I catch them in my melody
We wade together into the dream
And emerge with a new song.

The following is a section of a session transcript that illustrates the musical collaboration between Ann and myself. Ann had been talking about her brother and wishing they were closer. I asked her if she would like to explore this in the music. She says “yes”. I ask if she’d like to sing today. She says, “that sounds scary and exciting… yes.” She laughs. She’d like me to sing with her. We agree on using two chords. She suggests minor chords and we agree on D minor7 to A minor7. I begin to play the piano. I suggest we begin by breathing together (to enable her to relax and to help her feel centered). She begins singing and I join her.

Ann: Where’s the time gone? All our dreams. (She sings slowly over two measures).
Diane: (I repeat and echo back her words and melody). Where’s the time gone? All our dreams.

Ann: Where have they gone? (She comes in at the end of my phrase).

Diane: Where have they gone? (We sing in unison. Our voices swell and grow louder. It feels like a wave. We breathe together and repeat this phrase several times).

Ann: Where are you?

Diane: are you? (in unison)

Both: I tried to reach out to you (in harmony).

Ann: I search for you in other people cause I don’t know where to really find out.

Diane: I search for you cause I don’t know...

Both: Where to really find you...where to really find you... (I play the piano louder and faster. I sing more rhythmically and we continue to sing this refrain and create a kind of chorus).

Diane: Where are you?

Both: Where are you (we sing in unison. I add 9ths to the chords and use more open voicings. She is using a wider vocal range. There are more leaps in her melodic lines)

Ann: but I also wonder (softly and lightly)

Diane: but I also wonder (I match her tone and volume).

Ann: Do you want to find me?

Diane: Do you want to find me?

Ann: Do you need me?

Diane: Do you need me... do you need me... do you need me... need... me
Ann: Sometimes I feel I am just a sham.

Diane: Sometimes I feel I am just a sham.  
(She seems about to cry. I feel moved by her honesty and vulnerability. I feel a connection between us.)

Ann: I need you (I arpeggiate the chords and play more legato).

Diane: I need you.

Both: But do I have anything to offer you? (in harmony).

Ann: I feel

Diane: I feel (I sing a third below her).

Both: so far (in unison then Ann sings up a third to harmonize—we hold the note for two measures).

Diane: away

Ann: away

Both: fro-zen (I feel sad. I breathe deeply).

Diane: my tears are frozen

Ann: frozen (she is singing more sustained notes)  
I feel so far away from you

Diane: From me (this is really an interpretation on my part. I think her brother may be a part of herself that she is cut off from and misses — a feeling part. She could also mean that she feels far away from me).

Both: from all of life . . . from all of life (in unison).

Ann: from you

Diane: From you (I sing a third above. I wonder if she also feels far away from me)

Diane: Can I come in? Can I come in (I am singing as her double and asking to come in and also as myself and asking her to let me come closer).
Ann: Do you want me to come in? I can't believe you would want me.

Diane: want me (I lag behind a measure).

Ann: Am I real for you?

Diane: Am I real for you?

Diane: Am I real for me?

Ann: Am I real for me? (The music has a hypnotic, lulling effect on me. It is slower now. It has slowed down without my noticing it. I am playing a melody high in the accompaniment that sounds like a sad music box. It sounds similar to something she played once before).

Ann: You're my mirror

Diane: my mirror

Ann: I need you to tell me who I am.

Diane; Who I am (in unison).

Both: Am I real? (in harmony – I sing a third below).

Ann: Am I alive?

Diane: Am I alive? I want to be- I want to be . . .

Ann: Alive . . .

I am struck by the difference between her speaking voice and her singing voice. Her speaking voice sounds older and more self-assured. It is louder and more staccato. Her singing voice is more open, softer, more resonant and sounds younger. I feel she is being so honest, direct and vulnerable in the music, as if her defenses have melted. I enjoy singing with her and I feel compassionate toward her.
Therapist’s Self-disclosure

Even the most conservative psychotherapists cannot help but disclose things about themselves in the way they dress, their body language, facial expressions, the sound of their voice and their interpersonal style. We are at all times revealing some aspect of ourselves even when we are not providing specific information. As previously discussed, this is especially true for music psychotherapists who are also continuously revealing themselves in their musical choices and interactions. This is an implicit and inevitable process. Not only are we revealing things about ourselves but just as we are observing our clients, they are also observing us (Stolorow, Brandchaft & Atwood, 1987).

Self-disclosure, however, does not mean that therapists should reveal everything about themselves indiscriminately or provide answers to every question their clients pose without considering the client’s best interest from a theoretical perspective. Pearlman & Saakvitne (1995) believe the essential considerations when making decisions about self-disclosure are the therapist’s comfort sharing personal information; the length of time the client has been in treatment and the extent of the psychotherapist’s experience. More experienced therapists feel less compelled to work by the rules. Increased confidence and self-knowledge and an ability to sort out countertransference issues enables them to increasingly trust their own instincts. Like experienced musicians, they first master theory and technique before improvising.
I have found that conscious self-disclosure can be very effective in building trust and intimacy with particular clients. Sharing my experience with certain clients can also be genuinely helpful and supportive to them. One factor that influences my viewpoint is my client base and my research subjects. The three clients that participated in my research study all suffered in varying degrees from symptoms related to traumatic childhood experiences. Many trauma survivors need a real relationship in order to establish any degree of trust and intimacy. They need the therapist to be more genuine in the relationship. A distant or detached therapist is unlikely to provide them with the kind of experience they require in order to heal (Herman, 1992; McCann & Pearlman, 1990b).

Besides sharing my state of mind with a client who has accurately identified it (as when Marie questioned me, asking if I was alright and I told her I was feeling sad), I sometimes share my personal experiences with clients when it seems appropriate and in the service of the client. Of course, I have to be mindful of why I am doing this and whose need I am meeting. This issue speaks to the necessity for therapists to have a life outside of therapy. Having a family and/or friends and other interests enables therapists to lead a balanced life and helps to ensure that they do not use their clients to meet their own unmet needs. It is also important for music therapists to make music outside of therapy for the same reason (Turry, 1998).

I found that sharing personal experiences was sometimes connected to being a role model for my research participants. Since all three clients are
creative arts therapists we had many things in common. For example, when Marie was struggling to write her thesis and became extremely self critical because it was taking so long, I shared my difficulties writing my own thesis with her. She found my disclosure very supportive and “normalizing”. I also shared practical information with her about approaches and attitudes that helped me to complete my thesis.

Similarly, when Cindy was questioning her use of the voice as a primary instrument in music therapy, I shared that I had gone through similar doubts during my first year of private practice. At first it was hard for her to believe this but as we talked she recognized the feelings I shared as similar to her own. She said, “I don’t feel so isolated now…it’s just that I don’t know any other music therapists doing private practice with the voice but...wow, maybe I can do this!”

Sharing my personal experience illustrates the supportive, educative aspects of music psychotherapy. It did not however, prevent further in-depth exploration of the underlying causes of Marie’s or Cindy’s fear and self-doubt.

At times, answering information questions aids in the development of object constancy. For clients with abandonment issues, knowing where I am going to be taking my vacation often gives them a sense of security. I experienced this reaction with Ann, Cindy and Marie at different points in the therapy. Telling them where I would be seemed to help them to sustain a sense of connection with me and relieve some of their anxiety.
Sharing Countertransference

An important theme that emerged in the research was “sharing countertransference”. Although this theme did not appear frequently, when it did surface it was significant in the impact it had on the process and the therapeutic relationship. It also stood out because it is a relatively new and important aspect of my way of working.

Little (1951) and Gitelson (1952) were two of the first analysts to write about and strongly advocate for countertransference disclosure. Being in the minority, they failed to have a significant impact on the analytic thinking and technique of their day.

Today, there are more advocates of countertransference disclosure on a continuum from moderate (occasional disclosure with certain clients) to radical (extensive disclosure with most clients) (Pearlman & Saakvitne, 1995). The reasons cited for disclosing the countertransference primarily have to do with establishing the therapist’s honesty, developing intimacy and trust, allowing the therapist and the client to remain in an authentic relationship to one another, confirming the client’s sense of reality of the actual interpersonal situation as contrasted with the transferential situation and to clarify both the fact and the nature of the client’s impact on the therapist and people in general (Gitelson, 1952; Gorkin, 1987; Natterson & Friedman, 1995; Maroda, 1998; Pearlman & Saakvitne).

Davies and Frawley (1994) point out that with traumatized clients who have great difficulty symbolizing and naming their experience, sharing
countertransferential reactions can be extremely helpful. Many therapists come to know about aspects of their clients’ experience at a visceral level. If therapists are willing to share their countertransferential feelings and reactions, to name them, then a shared language can be created and clients can learn to identify their feelings and express them instead of self-destructively acting them out. As Alvarez (1992) concludes:

To discuss these observations with the patient and show her how these processes keep repeating themselves moment by moment in the sessions seems to be far more effective than simply resorting to elaborate detective-like reconstructions about the past causes of the patient’s beliefs about herself (p.3).

The research findings identified three ways that I share my countertransferential feelings in reaction to the clients and the clients’ music: verbally, musically and somatically. When I verbally shared my feelings with Marie, she was able to access her own feelings and to gain insight into her relationship with her mother.

Today’s session was difficult but exciting. I took a risk with Marie. I began to notice I felt very constricted and unusually self-conscious early on in the session. I felt like I was being examined under a microscope, stifled. Yuck! We were talking about her mother and her recent visit and how formal her mother is and difficult to connect with. I wanted to make a musical intervention but I couldn’t seem to break free. It was as if I was afraid of doing or saying the wrong thing – not at all my usual self. Then it hit me. I was feeling the way Marie felt around her mother – self-conscious, inhibited and shut down. She previously described feeling this way very intensely during her childhood and how she would go “flying off” into her own world probably to escape from her mother’s control and judgmental perfectionism. I decided to take a risk and tell her how I was feeling. At one point, I said, ‘I am having trouble being present – I feel very self-conscious and constricted – as if I am tied up and afraid to make a wrong move . . . I’m wondering what you’re experiencing.’ Marie
looked shocked. Her eyes grew wide, she opened her mouth and after a long pause she said, ‘how odd . . . that’s how I am feeling. I wondered if you were judging the way I handled things with my mother, my lack of self-assertion. I actually . . . I felt awful being with her, totally disconnected from her and myself – and, yes, self conscious around her – I’ve always been . . . I always feel I can’t be my real self that she won’t accept it’.

Revealing my countertransference proved to be a very effective intervention. Marie, like many of my clients, is often unaware of her feelings especially if the affects are intense and/or intolerable. Marie communicated with me unconsciously by projecting her feelings state. When I identified with her internal experience and openly shared my feelings with her she was able to access her feelings and together we could make connections in the present and to the past. Marie also provided me with an experience of what it was like to be her as a child so that I could understand in a profound way her early and current reality in relationships. She did this in the only way she could. She often had no words. Then she looked to me to provide them. Initially I helped her to translate her music, her gestures, her moods, and her silences, into something more tangible so that she could name her experience and make it known.

Sharing my countertransference to and in the music is something I do frequently. During the music my countertransference is often expressed somatically (shedding tears, getting chills, breathing deeply) or musically through my musical choices and interventions. Sharing countertransferential reactions verbally usually occurs quite naturally as part of the processing that follows a musical interaction.
These excerpts from Ann’s sessions illustrate some of the ways I shared my responses to her music both during and after the music making.

I shed a tear during the music. Afterwards I said the music felt sad to me. Ann said she could intellectually know it was sad but she couldn’t feel it. She felt disembodied-removed.

Ann played two drums and the cymbal and I played the drum kit. I remember getting chills at one point near the end of the improvisation. I was playing loudly and forcefully to encourage her to “let loose”. I realized at one point that I felt angry and was expressing my feelings in the music. I shared this with her. She said she felt very angry with her aunt and how she acted when she lived with Ann and her family but it was difficult to express this anger even in the music. She said she felt afraid that her anger could be destructive and could overpower her.

I felt moved by Ann’s singing. I found myself singing in unison with her more than I had before. I wanted to support the vulnerable sound I was hearing. After we sang together and Ann processed her feelings I told her I noticed a difference between the way she speaks and the way she sings. I shared my feelings of sadness during her singing and my sense that she needs to slow down and breathe more in session when she’s talking so that she can connect to her breath and her feelings. We ended by drawing her “hidden self”. It had no mouth. Her fear was that if she gave it a mouth all the stuff inside (yellow and orange) would come rushing out.

Sharing my musical countertransference with Cindy led to changing an intervention that could have been retraumatizing and replacing it with a safer alternative.

Cindy and I toned together to relieve the pressure she felt on her breastbone. Afterwards she said she felt her breath being taken from her. Her associations were to having to hold her breath during sex because she didn’t want to make noise and have her parents hear. I said, ‘Maybe this is too intense... it felt intense to me... we could tone above that area if you want to’. I told her I felt this intervention might be too direct. She decided to tone into her heart and I toned with her.
In this session I shared my feelings of sadness and anger to support and validate Cindy’s young feelings.

Cindy and I sang and played together (the piano). She sang about being a little girl and how lonely and isolated she was ... how helpless and vulnerable she felt. I heard myself breathing deeply several times. I was releasing some intense feelings that I was experiencing. Afterwards she said, “It wasn’t that bad – a lot of kids have it worse.” I told her I felt angry for her little girl and sad. Not only was she sexually abused but she was also emotionally abandoned by her mother.

During Marie’s music, I had an image of a young part of her and I got a sense of the private world she often retreated to.

Marie played the xylophone and I accompanied her on the piano. The music was soft and high pitched. The chords I played held her melody and added to the lullaby quality I felt in her music. I felt mesmerized. She said the music felt very comforting, like a blanket. I told her I had an image of a child in a cocoon at one point and then I had a sense that the music was sort of weaving a spell around us. She said it felt like the place she often goes to when she needs to comfort herself – her own special world.

When I revealed my physical sensations and my feeling of sadness, Marie was able to connect with the sad, lonely part of herself.

We sang to the frog. He represented the part of her that has no voice. His mouth is zipped up. He can’t express himself. I felt a chill. I told her I felt sad for the frog and that the music gave me chills. She started crying. I asked her what she was feeling. She said, ‘the frog is unhappy ... he’s very lonely.’ She wanted to unzip his mouth – so we did.

I found that sharing my countertransference to and about the music was experienced by the clients as less threatening than sharing my countertransferential feelings in direct relationship to them. Our music
making took place in a shared space, what Winnicott describes as the overlap of two play areas, where communication comes about through mutual experience (Davis & Wallbridge, 1981). Talking about and sharing feelings about this "third thing" is less direct and thus protects clients from feeling too vulnerable. When I shared somatic reactions, feelings, images and thoughts evoked by the music with Ann, Cindy and Marie, they were able to accept my responses without feeling invaded or criticized. I was usually sharing my experience of something we created together, something symbolic and real.

The clients I work with (my research participants and the rest of my client base) benefit most from having an authentic human encounter, a real relationship in music psychotherapy. This real relationship still allows for (as demonstrated in the case examples) important tenets of analytic theory such as transference reenactments and projections. A real relationship between client and therapist however, makes space for the possibility of the client getting honest reactions from the therapist, something that is not usually available in normal living (Lomas, 1987; Natterson and Friedman, 1995; Jung, 1975; Yalom, 2002). It also provides a reparative experience for clients who have never had this kind of intimacy in relationships with their parents.

An authentic relationship offers more opportunities for the therapist to model behavior for the clients. Some of this modeling is accomplished through therapist self-disclosure. The research revealed that I disclose personal information and countertransferenceal reactions when I think it will be helpful to the client. The degree and kind of disclosure varies from client
to client. According to Yalom, (2002), psychotherapy outcome literature strongly supports the view that therapist disclosure facilitates client disclosure.

For many traumatized clients, an authoritarian stance represents abuse of power. These clients feel safe and thrive when the therapeutic relationship is more mutual and reciprocal (Pearlman & Saakvitne, 1995).

As Jung (1961a) puts it,

> When important matters are at stake, it makes all the difference whether the doctor sees himself as part of the drama, or cloaks himself in his authority (p. 133).

I love being a part of the growth process both as an observer and a participant. It is inspiring to witness the courage exhibited by my clients as they struggle to separate from the familiar and the not-me and to connect with and integrate unfamiliar, unknown aspects of themselves. Whether we are talking, sitting in silence, singing a song, or improvising musically, the intimacy created in the mutual give and take of the therapeutic relationship offers an authentic human encounter and opportunities for healing and self-discovery for both the client and the therapist.

This encounter, the very heart of psychotherapy, is a caring, deeply human meeting between two people, one (generally, but not always, the patient) more troubled than the other. Therapists have a dual role: they must both observe and participate in the lives of their patients. As observer, one must be sufficiently objective to provide necessary rudimentary guidance to the patient. As participant, one enters into the life of the patient and is affected and sometimes changed by the encounter. In choosing to enter fully into each patient’s life, I, the therapist, not only am exposed to the same existential issues as are my patients but must be prepared to examine them with the same rules of inquiry. I must assume that knowing is better than not knowing,
venturing than not venturing; and that magic and illusion, however rich, however alluring, ultimately weaken the human spirit. (Yalom, 1989, p.13)
INTRODUCTION TO CHAPTERS VI THROUGH VIII

The following chapters examine the therapeutic process from three different perspectives. Chapter VI looks at the process through the lens of an overarching theme that emerged from the research data. This meta-theme, "connection" appeared frequently throughout the data and is one way to understand my approach especially the way I view the role of music in the therapeutic process.

Chapter VII considers reenactment and regression, two important aspects of my method of music psychotherapy, in terms of psychoanalytic and analytic theory researched in the literature. Three vignettes provide examples of some of the ways reenactment and regression appear and are worked with in the therapeutic process.

And Chapter VIII focuses on my research findings specific to the integration of music and words in the therapeutic process. Special emphasis is given to the music in spoken words, the words or meanings transmitted through improvised instrumental music and the fusion of music and words that occurs when singing improvised music and lyrics.
CHAPTER VI

THE THERAPEUTIC PROCESS: CONNECTION

Voice one: So much to tell you
Voice two: The words are hard to find
Voice three: There are no words to say it

Voice one: so good to breath
Voice two: to accept
Voice three: just to be here

Voice one: The music slows me down so I can
sense my body
Voice two: It turns something so ugly into something
so beautiful
Voice three: I find my voice

Voice one: The singing holds me close
Voice two: I find my feelings and a place to put them
Voice three: I'm safe inside a blanket of sound

Voice one: can you hear me
Voice two: can you see me
Voice three: can you help me find my way

All three: can I trust you

Voice four: I hear a small child playing the piano
I see a lonely little girl with only a tree
for a friend
I sense the words you need to name the feelings

Voice one: my heart is opening
Voice two: I'm connecting to my body
Voice three: I'm coming out

All: So many songs

Voice four: songs of longing and loss
songs of anger and fear
songs of rain falling on parched arid land
All: abandoned songs found within
Voice four: songs of hope
          songs of healing
All: songs of coming home...again

Introduction

"Connection" is the meta-theme that emerged from the analysis of the data relating to the therapeutic process. This overarching theme ran through all of the pertinent data and carries significant emotional and factual impact (Ely et. al. 1991).

My research subjects suffer from varying degrees of developmental trauma. Trauma causes disconnection. The focus of my work is helping people connect with their authentic selves, people who have lived in a ‘false’ or adaptive persona or self, people who have fragmented, dissociated psyches, people who hide and isolate because they are isolated from who they truly are. These ‘self’ disorders or disconnections begin in early childhood when there is a rupture or series of ‘breakdowns’ in the mother-infant or mother-child relationship and they result in the lack of a stable, coherent sense of self and/or a diminished sense of self-esteem and self acceptance. So what happened externally becomes internalized (disintegration, splits in the psyche, self loathing).
The heart of my work is about connection and integration and I believe this is achieved primarily by having a reparative relationship. A dependable connection with someone (the therapist) who is perceived as safe enough and good-enough to provide a corrective emotional experience. This good-enough mother-therapist companions the client through the unconscious to retrieve and reconnect to lost or hidden parts of the self. The music helps clients connect to the therapist. It also provides access to feelings, memories and sensations so that splits (mind-body, thinking & feeling, conscious & unconscious) can be healed and clients can gain access to more of themselves.

Five core categories emerged from the meta-theme “connection”. They are:(a) the therapist’s need to connect, (b) the client’s need to connect to the therapist, (c) making connections: the therapist’s inner process (d) making connections: client’s insights and (e) disconnection and connection: musical interventions.

The Therapist’s Need To Connect

The importance of “connection” in music psychotherapy is not surprising, but the many and various ways it appears in the data is. First, there is my need to connect with myself and others, which relates to the theme of therapist as wounded healer. I now realize one of my unconscious motivations for choosing this profession was to intensify my own healing process. In order to be an effective music psychotherapist one has to experience and learn how to connect to his/her own feelings and inner life.
One also has to gain the capacity to connect feelings to words and words to feelings. After all, how can we help our clients do this if we cannot do this ourselves? When one has a sense of self connection, a consistent and coherent sense of identity, it is easier to maintain connections with others.

The intense, intimate connections I have experienced in therapeutic relationships is something I know I have craved. This degree of soul searching and truth telling does not occur frequently in the everyday world. I have learned and benefited from these experiences and from the therapy and supervision necessary to be of service to my clients, and I have been able to take what I have learned into my personal life.

Part of my researcher’s stance might be about my persistence to ‘get through’ to people. This has come up in the data analysis. I have a desire to connect or make contact with others that seems related to my personal history. My parents were difficult to relate to. I never felt a real connection to my mother (or I don’t remember having one). She was inaccessible for the most part. My father was somewhat more available. Mainly we connected through music. He played the piano and I sang with him. We also connected through humor and the arts, especially movies. Still, he was difficult to reach most of the time so my connections with friends became extremely important to me. Of course, I unconsciously chose friends who had some of my parent’s personality traits or boyfriends who were somewhat impenetrable but I was persistent in my desire to get through their invisible walls.
My personal experiences of feeling connected and disconnected inform and influence my clinical decisions and affect my ability to empathize with my clients.

What bothered me about the session was that I said I could ‘just’ listen – as if it isn’t enough to listen or that I’d probably prefer to participate. Is this countertransference? It’s something to think about. Would I feel this way with every client? I don’t think so – or at all times. Sometimes I feel fine listening and it feels important to listen and refrain from playing. My hunch is that I feel thwarted in my efforts to connect to her.

This is an important word for me (connection). When we connected in the music I felt empathy for her. I know how she feels- to be cut off and disconnected.

The session felt good to me – what does that mean? I felt we connected. I played the xylophone sound on the keyboard and we sang. It was interesting that it was non-verbal-she usually sings words. She sang on vowels and ended on ‘la’. I noticed how carefully I listened and how concentrated I was on really meeting her.

I enjoy my work the most when I feel connected and emotionally present and the music facilitates this connection to self and other.

There is a flow to the work when it’s going well. This seems related to intimacy. There is strength of contact and a sense of my total presence especially in the music and the singing in particular – an immersion in the creative process. Does singing help me connect to myself and to her?

She joins me and sings, ‘its OK to be afraid’. She sings in unison with me. She stops crying. I can identify and empathize easily with fear. It feels good to sing this. I feel connected to her. I feel connected to myself. I think this is probably also healing for me. It feels good to hear ‘it’s OK to be afraid’.
The role of the therapist, the therapeutic relationship and the therapeutic process are not discrete categories. They intersect and overlap. My desire to connect to myself and others is linked to my stance as a wounded healer-therapist and my belief in the mutuality of the therapeutic relationship, both of which affect my clinical approach.

The Client’s Need to Connect to the Therapist

The client’s need or desire to forge a connection with the therapist as a transference object or as a significant person is not usually directly expressed in the earlier stages of therapy. This desire is often revealed more subtly in the subtext of the conversation, in the client’s musical communication, body language, facial expression, behaviors, and the countertransference. The client is usually unconscious of this need until it is brought to a conscious level and then there is often ambivalence about having needs for closeness and connection with the therapist.

The more disappointing and damaging past relationships with significant others have been, the more unmet needs the client is likely to have. An accumulation of unmet dependency needs can make intimacy feel threatening or impossible. Clients tend to blame themselves for the deprivation they experienced. They often feel ashamed of being too needy and both yearn for and fear close relationships. There is a need/fear dilemma. They need connection yet they fear getting close to someone and being rejected when their true feelings and needs are exposed.
A positive relationship with the therapist offers a reparative experience; a chance to express feelings and needs and have them accepted and met.

Clients need to connect with the therapist; they need to be seen, listened to, understood and truly known. They need to sing and play and laugh with someone safe and supportive. These interactions lead to increased self-esteem, a more complete and realistic sense of self and an ability to maintain an intimate connection to themselves and others.

The way Ann looked at me suggested her desire for more personal contact.

Ann leaned forward and stared into my eyes. I felt as if she wanted something form me, probably to be finally seen for herself and not as an extension of her parents. As we talked and laughed together I felt we were making more contact than we had before. A connection was developing.

Marie expressed her needs for connection through sound, movement, music and words.

Marie started to move. She made a punching motion. I made the same movement. I suggested she add sound. She said ‘uh’ every time she punched. I did the same. We were perfectly in sync. I felt a chill run through my shoulders, and a twinge of sadness. I wondered if I was standing at a comfortable distance from her. I asked and she said she wanted to move closer to me. She began to cry and put her hands over her eyes.

I asked Marie what she experienced during the singing. She said, ‘it felt hypnotic but not empty like before . . . full . . . I felt contained and safe; I felt connected to you and that made it totally different . . . I was anchored. You were playing the music and the music lead me; it layed down a path.’
Cindy's body language and physical sensations revealed both the fear and the pleasure of increased intimacy with me.

Cindy turned on the piano bench to face me. Now we were directly facing each other. I asked how that felt and she responded, 'I feel relief and a ticklish feeling.' The feeling became pleasure and a fear of pleasure.

Ann was able to interact more with me and our growing connection was evident in the music of our conversation.

I can identify with what Ann is saying . . . it feels like she's leaving more breathing room, feeling room, room to interact a little more with me. Our conversation feels like music. Our melodies are overlapping and punctuated with phrases like 'yeah, yeah, right' on both our parts. The rhythm picks up and holds steady. We are in a groove. I feel present and engaged. It strikes me as funny that we're talking about her fear of intimacy.

After singing together, Cindy expressed a need to connect with me on a physical level.

Cindy is singing about her fears of changing and growing up. Her 'little girl' is afraid she won't be able to do what is required of her. The improvisation builds to a climax and ends with Cindy calling out to her mother. She says she'd never called out for her mother before, in therapy or otherwise. As she is leaving she says she wants to give me a hug. I ask her, "Do you need a hug?" She laughs and says, 'maybe . . . I never ask for hugs, I usually give them.' I hug her and she smiles shyly.

Clients need to connect to the therapist in order to get their needs met. These needs, such as the need for support, nurturance and understanding are met through the therapist's ability to attune to the uniqueness of each client
and listen and respond empathically in the music, in the words, through body language and physical contact and also through the therapist's capacity to provide the clients with a consistent, emotionally present companion who can help them contain, digest and make sense of their feelings. As their needs are met, clients come to trust and rely on the therapist and a partnership is forged between the therapist and the part of the client that is willing to do the work necessary to effect deep and lasting change.

Making Connections: The Therapist's Inner Process

As I listen to my clients' music, words and silence and observe their body language and actions, I make connections. These connections can occur in the form of thoughts, feelings, memories, sensations, images or intuitive flashes. I form hypotheses about the client's issues and then determine how best to intervene. At times the connections I make lead to interpretations. Some of these connections are between past and present, conscious and unconscious, characteristics and diagnoses, parts of the self and projections, music and feeling states, music and personal associations, music and parts of the self and music and relatedness.

An example of a connection I made in the music that led to an insight about an unconscious aspect of Ann occurred when Ann sang about her discord with a close friend. She sang about how different they are from each other and that maybe this difference creates distance between them. I sang with her as she described her friend as dramatic, open, earthy and sexual. I
made a connection (but did not share it) between these qualities and Ann’s “shadow” aspect, the unacknowledged, unconscious disowned parts of Ann’s personality that she seemed to be both attracted to and repelled by. This insight proved valuable in making further interventions with the intention of enabling Ann to begin to acknowledge and experience these aspects of herself.

When Marie and I sang together, I made a connection between Marie’s music and her psychic state (and probable diagnosis) as this example illustrates:

Marie and I sang about her invisible wings. The music we created had a dreamy, hypnotic quality to it. I made a connection between this music and her lack of embodiment and difficulty staying grounded in reality. Her voice also sounded light and airy. At one moment near the end I sensed her absence and wondered if she was present or in her own world. When we processed the music I asked her where she went and she said she didn’t know. I suspect Marie suffers from a dissociative personality disorder.

In this example I made a connection between Cindy’s behavior and the behavior of a former client who had post-traumatic stress disorder. This association led me to initiate a different and more effective intervention.

I made an association between Cindy’s behavior (wanting to force herself to scream) and another client I used to work with. This former client was also traumatized and liked to scream but in the end I don’t think it was always therapeutic or productive. When Cindy said it was ‘like giving birth . . . pushing’ my antenna went up. Her desire to ‘push out a scream’ made me think about (connect with) theories of trauma I have been studying that refer to the traumatized client’s tendency and pull to retraumatize herself.

Ann’s music evoked an image and a feeling in me that led to a musical intervention connecting her to her unconscious feelings.
The chords Ann chose (minor 7ths) and the sound of her singing voice (soft and plaintive) affected me. I began to feel sad. I had an image of a little girl who was given an impossible task, a task she could not help but fail. I wondered if she was also feeling sad and if I was picking up her feelings? I decided to use my countertransference to move the process along so I sang ‘I feel sad’. Ann responded and sang ‘and so alone’.

I realized there was a connection between Ann’s reluctance to make music and her fear of feelings associated with the young part of herself. This realization prompted my musical intervention.

We were talking about her fear of having needs and being perceived as needy. I said ‘do you have an image of a time in your life when you were aware that you were needy and it was scary to feel that way?’ I was thinking about an incident she mentioned when she was five years old. Ann said she didn’t have a particular memory but she thought she felt this way a lot when she was younger – ‘five or six comes to mind’. I ask, ‘do you think you could give a voice to that part of yourself and play or sing it?’ I sense she is avoiding the music, that there is a definite connection between resisting the music and her fear of the feelings associated with being a child and having her needs judged. At one point I say ‘the five year old is still alive. Can we give her space so she can get her needs met in the present and grow up?’ I am encouraging Ann to acknowledge and connect with this young part of herself to see that she has value and doesn’t deserve to be abandoned because she has unmet needs.

**Making Connections: Client’s Insights**

Just as I make connections between my clients’ past and present, their music and their affect, their visual and sound images and the underlying unconscious meaning of these images, so do the clients. These moments of connection or insight occur throughout the session but in keeping with my
theme I will focus on insights that emerged during and immediately following music making.

What constitutes an insight? In everyday usage we use the word insight to connote clear and immediate understanding of one’s own problems or a situation.

In psychoanalytic treatment, it may occur as a sudden flash of recognition and understanding, called the ‘aha’ experience, whereby the determining factors and connections of an idea or bit of behavior, or more global aspects of one’s way of thinking and feeling, are seen in perspective. (Moore & Fine, 1990, p. 99)

Usually, however, insight comes gradually as a result of self-examination and observation. A genuine insight can be viewed as a creative act in that it changes what existed before and creates a new awareness expanding a person’s self knowledge and/or knowledge of others. (May, 1975; Singer, 1970).

Freud’s (1913) concept of insight was synonymous with intellectual understanding. Today most therapists regard insight as experiential as well as intellectual and realize that cognitive awareness alone does not lead to therapeutic change (Jacobi, 1965; Neubauer, 1979; Kalshed, 1996).

Amir (1993) identified moments of insight that occurred to clients during music therapy sessions. Her qualitative study found that clients experienced insights in “four inner realms: intellectual, physical, spiritual, and emotional (p. 90).” Gaining insight and awareness into oneself and others is a crucial part of the growth process and is one of the goals of music psychotherapy.
The theme “Making Connections: Client’s Insights” appeared frequently throughout my research study. Through recursively examining my data, I have identified four ways in which insights occur for the clients as a result of the music process:

1. through projection onto the instruments and qualities of the elements of the music such as melody, harmony, rhythm, dynamics and timbre.

2. through transferential feelings in response to the musical interaction.

3. through symbols and images that emerge or are explored in more depth in the music.

4. through intentional musical re-creations of the past.

The first two examples illustrate insights that resulted from client’s projections onto the music (first category).

Cindy was playing the woodblock . . . Her playing had a relentless quality to it. She sped up the tempo and played louder. I felt like she was beating someone up. Then she stopped abruptly and said, “it’s like my father’s voice . . . he could be so critical of me, especially during my adolescence and now I criticize myself, I’m so hard on myself, not as bad as I used to be though.”

I comment on the ‘music box’ section of the piano improvisation. I ask Ann what she was feeling when playing this music. She smiles and says ‘young . . . like the part of me that doesn’t have words yet.’ I ask her if she’s aware that this ‘music box’ motif is a recurrent theme in her improvisations. She says, ‘yes . . . the music feels very small, I feel like I’m getting closer to the sadness in this music . . . I think it’s connected to the sad, hungry part of me . . . hmmm – I have been
eating a lot lately. I think I soothe myself with food when I feel this way.’ I ask her to say more about ‘this way’, ‘uh, sort of empty, sad I guess . . . needing something or someone to fill me.’

Transferential feelings that emerged in musical interactions gave birth to insights in the following two examples from category two:

Marie wanted to play the black keys on the piano. She wanted me to play with her. She was playing a ‘musical portrait’ of her mother. She began by playing a simple melody in the upper register of the keyboard. I played chords to support her melody. Gradually her hands descended down the keys until our hands were very close together. At one point we almost played the same note. Even though we were physically close, I felt a distance between us. When we processed the music, Marie said, ‘it felt odd . . . I could see my mother, I was picturing the last time she was here visiting, she, it’s confusing.’ I asked her about the music. ‘As I came closer to you I felt further away, I think that’s what it is. My mother seems to be coming toward me but she’s really pulling away. It’s a mixed message!’

Cindy and I have just finished singing together. We improvised acapella for quite a while. Our voices blend well and we both have jazz backgrounds so it is fun and easy to improvise with her. We sit for a moment in silence and then she begins to process the musical experience. She says, ‘at times I went to a very emotional place – really sung from my gut and then a few times I went into my head and started analyzing what we were doing from a music therapy standpoint . . . I have difficulty with the middle.’ At first I wasn’t sure what she meant but as she continued talking I understood. When she goes into her ‘emotional place’, it is a private world which sounds like a self-soothing cocooning kind of state. ‘I realized while we were singing that it’s hard to stay in my feelings and look at you – to stay connected to myself and you at the same time. I think that is the middle.’ Cindy’s insight led to a discussion of working to be separate yet related, something she never experienced in her family. ‘If I didn’t merge with my mother, I felt abandoned by her . . . it was basically all or nothing.’

In the next example, the symbol of the snowman that emerged in the music led Cindy to an important insight about herself (category three).
'I should be happy but I'm feeling sad.' Cindy tells me about all the good things happening in her life right now. 'Maybe it's just unfamiliar.' We talk about the difficulty of transition and change. She says her body feels 'frozen'. We decide to make up a song together. It turns into a song about a snowman. The music is medium tempo, in B flat major. It has 9ths in the melody and some dissonance. It feels sad to me. At the end of the song the snowman melts when the sun comes out. Cindy cries for several moments then blows her nose and says, 'I think I'm melting, thawing out... I'm letting good stuff in so I guess I'm feeling so much pain because I never had it until now.'

Ann finds relief when she returns to her past in an intentional musical re-creation (category four).

Ann and I were singing together. We were improvising words and melodies over two minor chords (Em, Am). We were going back to the first time she ever heard her voice 'as an alien voice.' She seemed scared but wanted to work on this issue. I set a time limit of 15 minutes to help her feel safer and contained and to leave time for closure. At one point she sang, 'How can she do this to me?' I repeated her words and melody. She seemed angry and sang, 'What is she thinking?' and then, 'Why do I have to go to the front of the room by myself... I'm only seven years old!' During the verbal processing Ann said, 'it finally got through to me... I always thought it was my problem. I cried realizing I was only seven years old and I needed support.'

In this last example, all four categories are represented. Marie projects what feels like an archetypal image of the Great Mother or the Self onto the drums. She works with images that emerge from the music and movement. She has positive transference feelings to me in the music. And there is an intentional musical re-creation of her past that becomes a developmental journey.

Marie wants to work with the image from her dream – a small child crawling along a dark corridor. I wonder if this is the same child who has been hiding and slowly making herself known to us. I ask Marie if
she'd like to sing, play instruments, dance or combine modalities. She wants me to play the drum and maybe sing and watch her dance. She wants a steady, continuous rhythm. I do as she asks. I play the conga drum. She begins on the floor huddled up with her eyes closed. Very slowly, she starts to open up and explore the space. She crawls and looks around with curiosity, her eyes wide open. I chant softly while I drum. Her dance feels like a kind of birth or rebirth and I want my music to reflect this. By the end of the dance she is standing tall with her arms open wide. She says, ‘I had no idea what I would do . . . I felt like I was emerging from a dark, quiet place into the light. The music grounded me and called me to stay in the room and not leave – not disappear. I realized that I needed to be called forth, invited out – I couldn’t just come out by myself . . . The drums held and called me and I needed you to witness so I would feel real.’ Marie began crying . . . the most amazing thing I realized was that if I stopped dancing that didn’t mean the voice of the rhythm would stop. It would continue to speak to me. It would keep calling.

**Disconnection and Connection: Musical Interventions**

Sometimes clients are ‘connected’ and emotionally present in the words and sometimes they are not. When they are not emotionally present, playing music often helps them to access their feelings. This can happen during the music or after playing or singing while talking about how the music affected them. Sometimes the music deepens feelings that are already surfacing. Sometimes the music brings clarity to feelings or an intellectual insight or triggers a memory or connects to some feeling, image or association from the past. Sometimes the music reflects resistance or mirrors the verbal process or reveals the latent unconscious content beneath the words. Sometimes music reveals the transference and countertransference or sheds new light on the relationship. Sometimes the music and the accompanying playfulness and
humor build rapport and a connection is formed or strengthened between the client and the therapist. And sometimes the music helps me connect to myself when I am feeling ‘off’, ‘in my head’ or overly identified with the client.

The research revealed that the majority of my musical interventions were motivated by moments of disconnection in the client and between the client and myself. Sometimes words were not connected to feelings, sometimes emotions had no connection to meaning, sometimes the conscious mind had little or no relationship to the unconscious realm and sometimes clients simply lacked a connection to their real selves.

My awareness of these instances of disconnection came primarily from my countertransferential feelings: feeling or sensing the client’s lack of feeling or inauthenticity of feeling, feeling bored by their words or music, feeling confused and unable to focus, feeling a sense of emptiness and/or a lack of energy, and sensing moments when the clients “left” (dissociated) and were no longer present and in the room with me. When appropriate, I would check out my feelings and hunches with the clients. Sometimes clients were aware of their inability to connect with their feelings and with themselves and volunteered this information.

Disconnection and Connection: Feelings

The following examples illustrate musical interventions geared towards enabling clients to connect to their feelings so that they can experience being more spontaneous, fully alive, authentic and effective. Music has the ability to
directly access feelings and to provide a safe space in which to fully experience them. In the process of relating to their feelings, clients begin to integrate resources that were previously unavailable to them. In the words of Paul Nordoff and Clive Robbins (1977), "A new emotional stream begins to flow, nourishing a new awareness of self and of expressive capability" (p. 56).

In the first example, Marie was disconnected from herself and from me. I had seen her in this kind of dissociated state before. Music usually helped her to connect to her feelings. Singing was especially effective in that it required Marie to breath deeply. Breathing brought her into her body and put her in touch with her feelings.

Marie complains about feeling numb. She doesn’t talk much but she periodically looks at me as if searching for something. I feel a void-emptiness. I ask her if she feels like playing or singing. She says, “oh, I brought that song in, we could sing it.” We sing a song about surviving and afterwards she seems somewhat more present. I ask her if she’d like to sing it again and this time I slow down the tempo so that she can feel the effect of the words and the music more intensely. We begin by breathing together several times. By the middle of the song, Marie is crying and I feel she is in the room with me and no longer dissociated.

Cindy’s words were not connected to her feelings. In the music, she was able to express her anger and feelings of empowerment and reconnect with her life energy.

Cindy said she felt tired. She seemed depressed. She talked in a monotone without much energy. She had spent the weekend at her mother’s and felt drained. ‘She’s so needy and clingy and yuck... she has no boundaries, she sucks up all the air.’ I wondered if she was sitting on her anger. Anger was a difficult feeling for her to express and she usually turned it against herself. I asked her if she'd be willing
to explore her feelings in the music. She moved over to the conga drum and I took the African drum. She beat out a powerful rhythm in 4/4 time. I played with her and at times created a polyrhythm by playing eighth note triplets. She began to yell ‘back off’ and I gathered she was yelling at her mother. I joined her and the yelling became chanting – ‘give me space’ and ‘I am here – here I am-this is my space’. Afterwards she said we were singing a lot of harmonies using thirds, fourths and fifths. ‘I felt angry at first but it turned into energy, it was empowering – especially when we sang those harmonies’.

Marie’s music felt disconnected. I made a musical intervention that helped her to connect to the music and her feelings.

Marie had a dream. She had to work late and called her boyfriend to tell him but she couldn’t get a clear connection and he couldn’t hear her. I asked her if she would like to explore the dream musically and she said ‘yes . . . but I’m not sure what I want to play’. She began playing the steel drum then moved on to various percussion instruments. Her rhythms were erratic and the music did not flow. I began to play a dissonant melody on the piano that felt right somehow. The melodic line seemed to pull the improvisation together and we got into a groove. When we processed the music, Marie said she felt panicky when she began playing. Her boyfriend is leaving town for a week and the last time he was away that long it was very difficult for her. She realized she is feeling anxious about the upcoming separation.

Disconnection and Connection: Parts of the Self

Music has the ability to mediate contents from the personal and collective unconscious to the conscious mind (Austin, 1996). The collective unconscious is a concept widely applied by Carl Jung to refer to the inherited, universal and primal aspects of the personality that transcend personal experience. The energies contained in the collective unconscious can create
images independent of conscious experience. These images appear in dreams, myths and creative expression and their central themes are believed to be similar in all people and all cultures. Jung clustered the images into archetypes. An archetype is a transpersonal, universal pattern of psychic experience and meaning and is comprised of emotion, image and sound. It contains the most primitive form of the affect (Austin, 1996; Edinger, 1972; Jung, 1959).

Jung was a pioneer in observing and documenting the psyche’s tendency toward dissociation. He believed it was an essential, natural process in the differentiation of the personality and that dissociation extended along a continuum from “normal” mental functioning to “abnormal” mental states (Jung, 1959).

Jung believed that we are born in a state of unconscious unity. The ego is identified (or merged) with the Self (the central archetype of wholeness). As one moves toward consciousness, there is a breaking up of the original unity. Parts of the personality that are never seen and related to, withdraw from consciousness. These part personalities get left out in the course of one’s ego development and in the process of adapting to parental values and expectations and remain unintegrated. Parts of the self are directly related to complexes. A complex is an emotionally charged energy center comprising a number of associated ideas and images. At the core of the complex is an archetype (Edinger, 1972; Jacobi, 1942; Kast, 1992).
According to Jung, complexes are psychic fragments that have split off as a result of traumatic experiences or incompatible tendencies. The contents of the unconscious first present themselves to the ego in the form of complexes. If the complex is not made conscious it will surface as a projection. On the other hand, when we identify with a complex, our emotional reactions are exaggerated and we lose our center. We are controlled by energies we cannot influence. We react not only to the present situation that triggered the fear or grief but also to all similar situations we have experienced throughout our lives (Austin, 1996; Jung, 1969; Kast, 1992).

Healing involves reconnecting with lost or disowned aspects of the personality as well as differentiating feelings and dis-identifying or separating from qualities that do not belong to us, for example, realizing you are living out your parents’ unlived life and not your own life. Music is invaluable in this healing process. It can give us access to the invisible world, the world of imagery, memory and association. Music can function as a bridge over which aspects of the self normally not heard from can cross over and make themselves known to us. Music allows the image and the feelings associated with the complex to be channeled into a concrete form, for example, “the needy part”. The ego can then relate to a previously unknown aspect of the unconscious and begin to integrate it into one’s self-image. The energy tied up in the dissociated part then becomes available for conscious use and the personality becomes more complete.
We all have un-integrated parts of the self. Our inner cast of
characters have their own goals, their own emotions and their own music. In
music psychotherapy, their songs can be heard and brought into awareness.
Then the life force contained in the music can be used to enlarge and enrich
the conscious personality.

_A Song in Three Parts_

**Hopeful voice:** I want to be free. I want to unwrap all the feelings
trapped inside of me.

**Wounded voice:** But what will happen if I do? It sounds too risky and
too good to be true.

**Critical voice:** It's too late to change. You're too fragile. You'll break.
Just stay where you are. You don't have what it takes.

**Hopeful voice:** You're wrong about me and it's never too late. You try
to destroy all I try to create.

**Critical voice:** You're wrong about me. I'm your friend. I don't want
to see you disappointed again.

**Wounded voice:** It's true. I keep getting hurt. When will it end? My
heart is broken and will never mend.

**Hopeful voice:** But now we have someone to listen and guide us. We
can stop hiding what's deep down inside us.

**Wounded voice:** Why should I trust her? Why should I let her in? What
makes her any different from the rest of them?

**Hopeful voice:** I'm sick of pretending I'm doing OK. Your way hasn't
worked, why not try it my way?
Wounded voice: If I come out, there's no guarantee. Will I be safe? Who'll take care of me?

Critical voice: I'll take care of you. I'll never stray. Once she gets to know you, she'll never stay.

Hopeful voice: I won't be your captive any longer. I have a voice now and it's getting stronger.

Critical voice: You don't even know what you feel.

Hopeful voice: I'm learning to trust that my feelings are real.

Critical voice: You don't even know what you need.

Hopeful voice: I know that my spirit needs to be freed.

Critical voice: You don't even know who you are!

Hopeful voice: If I listen to you I won't get very far.

Wounded voice: I'm scared that you'll leave and won't take me along, that I am a burden, I'm worthless, I'm wrong. I'm filled up with sadness and rage and despair. How could anyone love me? How could anyone care?

Hopeful voice: It's true I've ignored you and wished you weren't here. I hated your neediness, hated your fear, but your pain is my pain, it's something we share. Come with me. Forgive me for being unfair.

Wounded voice: I'll gladly come with you out into the light, if you will protect me when it gets too bright.

Critical voice: I'm still in control here. It's foolish to run.
Hopeful & wounded voice:  Divided, you conquered.  
But now we are one.

The research revealed three categories that describe the process involved 
in enabling clients to connect with and eventually integrate parts of 
themselves that had been previously dissociated from consciousness. The 
categories are:

1. Awareness/Access
2. Understanding/Acceptance
3. Relating/Integrating

The first category refers to the use of the music to gain access to the 
unfamiliar, unknown, aspect of the self that is ready to emerge into conscious 
awareness. It can emerge in a symbolic form, such as Marie’s dolphin, or as a 
part-personality, such as Cindy’s scared child. The client may already have an 
intellectual or emotional awareness of this self-aspect but difficulty accessing 
it or may not even be aware of its existence. In either case the musical 
intervention can provide the necessary bridge to the unconscious inner world 
where clients can meet lost parts of themselves. Vocal and instrumental 
improvisation is extremely effective in this undertaking as it can be regarded 
as free association in music (Austin, 1996, 1998, 1999, 2001; Streeter, 1999), 
loosening boundaries and bypassing defenses that keep the unconscious at a 
distance. Songs that are meaningful to the client may carry feelings related to
specific parts of the self and can help the client become aware of and/or gain access to parts of the personality left out in the client’s development (Rolla, 1993).

In this example, Ann became aware (intellectually) of a part of herself she had ambivalent feelings about.

Ann played a song I had never heard before. It was very rhythmic and lively. She said it was a song sung by one of her favorite singers. She described the singer as very earthy and sensual, not the way Ann thought of herself. Afterwards we talked about these qualities she had ambivalence about – this sensual, free part of herself that felt very foreign to her. She said she could only connect to it sometimes in the music.

Marie gained access to a young child-part that was not ready to relate to her.

Marie and I are playing the piano. I am playing chords in the key of C and she is playing the melody. She begins singing “ah” up a third and back down again. I sing unison and then harmonize with her . . . she tells me she saw a small child. The child was hiding because she felt ugly and ashamed and didn’t want anyone to look at her. She was not ready to come out of hiding.

Marie became aware of and made an emotional connection to a part of herself that seemed dead.

Marie and I sang “The Rose” together. She brought in the sheet music because the song touched her when she heard it on the radio. By the end of the song, Marie was crying . . . after a few moments I asked her what she was experiencing. She said she was aware of a dead part of herself, or maybe it wasn’t really dead, just sleeping because the song woke it up.

Ann became aware of a critical part of herself and made a connection to its source.
‘I feel like I can never do enough, no matter how hard I try something goes wrong’. I sense that Ann has a very harsh inner critic that needs depotentiating. I invite her to play or sing what she is feeling. She picks up the cowbell and hits it over and over again... it sounds so loud, so harsh and cold to me... I ask her what it felt or sounded like. Ann says, ‘I had a fleeting image of my mother looking very angry. She gets so critical of me. Sometimes I dread seeing or even talking to her on the phone... I guess, yes, it sounds kind of like her voice, that disapproving voice she has sometimes.’

The second category refers to the part of the therapeutic process when clients begin to understand and accept the newly emerging aspects of themselves. The music can help them understand the origins of these parts (the previous example illustrated this) through the musical associations they make to significant people or early experiences in their lives. They can hear the truth in the music without the therapist’s interpretation. The past can be called up and the “scene of the crime” can be recreated through the sensual and aesthetic properties of music such as melody, harmony and rhythm. As clients begin to understand these previously unacknowledged or unaccepted parts and the reasons behind the rejections, they begin to experience compassion for themselves. Compassion leads to acceptance. The therapist’s empathy, understanding, and emotional availability in the music can provide a reparative, emotionally corrective experience.

The following examples illustrate moments in the music when clients have an experience of understanding and begin to accept more of themselves.

I asked Marie if she could sing to or as the sick dolphin in her dream... during the singing she regressed to seven or eight years old, a time when she felt depressed and wanted to die. She sang about stillness,
not being able to reach out and feeling isolated. She said, ‘the dolphin couldn’t connect to the other dolphins so she gave up.’

‘I felt like I was starting to disconnect from myself while playing the piano’ . . . Ann is telling me about her performance anxiety. I ask her if she’s ever felt this kind of fear before and she describes how she felt as a young girl when she moved to a new city and had to enter a new school. We decide to return to that experience in the music. We sing together over two minor chords that she has picked out. Ann is able to recreate the school, the atmosphere, the fear she felt having to speak in front of the class. Her voice sounds different to me. It becomes higher pitched and softer. I feel like she is becoming a young scared child in front of me. Afterwards Ann cries and says ‘I felt so humiliated, like I was so strange, but it wasn’t my fault!’ ‘No, it wasn’t your fault,’ I respond.

The song turns into play. We are playing in the sandbox, building castles and knocking them down. Cindy says her little girl is happy. Then we are both in the imaginal realm singing as her little girl . . . we play hide and seek, we run and skip. When we process the experience Cindy says, ‘I didn’t realize that playing and being a little girl was also a part of healing . . . I think I like this part of myself, this fun-loving part.’

Parts of the self can make themselves known through projections onto people, places and objects (including music and musical instruments) and through the symbols that emerge in dreams, fantasies, movies (our modern myths) and creative expression. They can also communicate with us through our bodies in the form of sensations and physical symptoms.

They can both emerge in the music and be worked with in the music. Acceptance increases as these part-personalities are interacted with. Through time, a relationship can be built with parts of the self that were hated and feared or simply unfamiliar and unknown. Clients can dialogue with these
parts and come to know them through instrumental or vocal improvisation, with or without words.

The examples that follow depict clients in the process of relating to and beginning to integrate parts of themselves.

Marie said she felt tired and disoriented. I asked her if she felt like doing some breathing exercises that involved moving . . . I led her in an exercise. We moved our arms and bodies up on the inhalation and down on the exhalation. She laughed and said, 'I feel like a bird'. I then suggested we add sound and take turns changing the movement and sound . . . Marie seemed to be enjoying herself. I was enjoying the flow and exchange of energy between us. We ended up stamping our feet and saying 'No'! When we finished, Marie laughed. She said 'I'm here now . . . More of me. I loved stamping and yelling 'No' and I'm not feeling as afraid to say it now. We talked about how helpless and passive she felt growing up, how afraid she was of her father's anger and that she would have the same aggressive tendencies. Now she saw the value of using her anger to protect herself and make boundaries. She said this assertive aspect of herself was new and she wasn't used to it yet but it made her feel very hopeful and less depressed.

Cindy begins to cry. She says, “I can see my little girl . . . she is scared.” We continue to sing to her to comfort her and let her know she is not alone. I feel I am providing Cindy with a reparative experience through the music.

Cindy said she had been singing “Happy Birthday” to herself all morning. I asked if she’d like to sing it . . . I played “Happy Birthday” on the piano and we sang together. Cindy laughed afterwards and said, “My little girl is happy now . . . I felt a little funny needing to sing that but this part of me needs to be acknowledged too.”

Through the music and lyrics, clients can experience not only the destructive elements but also the creative aspects of various parts of the self. They can be fully present to feelings, memories and associations related to part-personalities and begin to heal the wounds that caused these aspects to
split-off in the first place. The therapist usually takes the lead in this process by modeling acceptance, compassion and by helping clients view devalued self-aspects from a non-judgmental vantage point.

Images that are painful become easier to relate to when they are put into a musical form. Writing a song or listening to an audio-tape of an improvisation are examples of ways to simultaneously look at and work on a difficult issue, to create some distance in order to enable clients to dis-identify from an aspect of themselves they may be ashamed of. Realizing this part is not the whole of who they are often gives clients the courage to relate to it; then they may discover it has something of value to contribute to their developing sense of self, something that is worth integrating

REUNION

Child
Secret sleeping in the snow
Frozen in time
Wrapped in a lullaby
Of longing and loss
Waiting for her to notice you are missing
Waiting for her to want you back
Waiting till she is strong enough to make the journey
Down the long winding corridors
Through the thick still night
She begins to remember where she hid you so long ago
Now with each breath
She comes a little closer
So close that somewhere between dream and wakefulness
You can hear her calling you
You can hear her calling you
Home.
CHAPTER VII
HAUNTING MELODIES

Introduction

"Haunting melodies" is a metaphor for two major themes that surfaced during the research, the themes of reenactment and regression. These themes, along with transference and countertransference (covered in Chapters IV and V), view significant findings about the therapeutic process from the perspective of theories and terms from analytic and psychoanalytic literature. This chapter will discuss these themes as they appear in the related literature and will provide examples of reenactment and regression that emerged from the research study. Vignettes will illustrate some of the ways in which music was used to enable a therapeutic regression so that early traumas and critical issues could be worked through and the cycle of painful reenactments could eventually end.

Replaying and Returning

Reenactment is related to the client’s compulsion to continuously repeat critical experiences that express core issues. These issues, or critical wounds, became apparent during the therapeutic process as they repeatedly emerged in the words and the music and had to be worked through with the client time and time again. Freud addressed the client’s need to reenact
traumatic events with his concept of the "repetition compulsion" (Freud, 1914, 1920). The "repetition compulsion" relates to the repression of significant feelings and memories and the client's unconscious impulse to reenact these painful emotional experiences repeatedly in an attempt to finally master them (Loewald, 1971; Greenson, 1967; Winnicott, 1989).

In order to end this cycle of suffering and defeat, the client must rediscover and experience the external distressing situation as it was originally perceived. Fairbairn (1952) accounts for the client's need to repeat and re-experience painful situations over and over again by stressing the child's striving for contact with the parent (the original love object).

The emptier the real exchange the greater his devotion to the promising yet depriving features of his parents which he has internalized and seeks within . . . these internalized object relations are also projected onto the outside world . . . love objects are selected for or made into withholders or deprivers so as to personify the exciting object, promising but never fulfilling (Greenberg & Mitchell, 1983, p. 173).

Fairbairn (1952) also points out one of the reasons it is so difficult to end this destructive cycle. The client (unconsciously) feels that seeking out new and fulfilling relationships will be a betrayal of his/her parents and therefore, change carries with it the childhood terror of abandonment. The resistance to giving up the familiar, painful though it may be, for the unfamiliar and therefore unknown, is great. Relinquishing the illusion of
control, the illusion of finally being able to get what one missed, if one is
smarter, prettier, more caring etc, requires accepting one's powerlessness in
the original situation and grieving the loss (Austin, 1991, 2001).

Jung (1968, 1969) connected the repetition compulsion to the
constellations of ever-returning complexes and the intense emotional reactions
accompanying them. Narcissistically injured people, for example, may
overreact to criticism because they are reacting not only to the current
situation but to all similar situations experienced within their lifetimes

In analytic theory, deep characterological change requires a
therapeutic regression so that clients can remember, fully experience and
make sense of the feelings and sensations that were overwhelming as a child,
intolerable because no one was present to help the child contain, understand
and metabolize the intense affects. During a therapeutic regression, clients can
turn back the clock and return to the “scene of the crime”. They can grieve
what was and what never will be, make meaning out of false beliefs and old
confusions and accept and integrate the past so that they can live more fully in
the present.

The vignettes that follow are a composite of sessions that took place
during the fourth through the sixth month of music psychotherapy. They
illustrate the two major themes of this chapter, reenactment and regression.
From A Distance

Ann suffered severe performance anxiety Saturday night. Her eyes are glued to mine as she tells me "I felt like I was starting to disconnect from myself while playing the piano." She was at a party and a friend asked her to play the piano. She said she didn’t feel comfortable playing but her friend was insensitive to her feelings and insisted. Ann speaks calmly, in the middle range of her voice and without much feeling. She wonders why she keeps finding herself in situations where she feels “on the spot”. As she continues to talk I hear what seems like resignation in the music of her voice.

This is not the first time she has spoken about her fears of performing or speaking publicly or of her tendency to dissociate when overtaken by extreme anxiety. I think her anxiety is related to an unconscious pressure to be perfect as a defense against the fear of being seen and judged. I think she feels that who she really is isn’t good enough. She often expresses shame and anger at being criticized by her family or teachers as well as fear of being misperceived and judged. Her expectations of herself are unrealistic, so she often feels disappointed after a performance of any kind. As she talks, I think about the "gifted child" (Miller, 1981) who feels she must be perfect to win her parents love and acceptance. I can identify with the pain of having to hide one's true self and my empathy makes me feel closer to Ann.

Diane: Have you ever felt this kind of fear so intensely before?
Ann: When I was around 8 years old, we had just moved to a new city and it was 3 months into the school year. I
didn't even have a school uniform yet. I felt awkward and embarrassed. The teacher called me to the front of the room to give a speech about myself.

Diane: To introduce yourself?

Ann: Yes, and everyone was staring at me and I didn't know anyone. I felt odd, alien, I, umm, saw myself from a distance... sort of like what happened Saturday night.

Diane: It sounds very scary.

Ann: I remember a pink dress I wore that day. I can hear my voice wanting to break into tears but I fought through it.

Diane: You had to hide your feelings?

Ann: Yes! I had to stay in control.

Trauma literature emphasizes the inevitability of unconscious reenactments, specific repetition of traumatic relational paradigms and/or events (Davies & Frawley, 1994; McCann & Pearlman, 1990b, van der Kolk, 1989). Instead of viewing the repetition compulsion as an attempt to master the original trauma (for example, finally attaining the love of a rejecting parent), the aforementioned trauma theorists and other depth psychologists such as Kalsched, 1996; Kohut, 1977; and Winnicott, 1963 take a stance that I embrace as well. Clients unconsciously repeat painful relationships and events in order to remember (re-member), the original loss or trauma, remember not just with the mind but also with the body and the whole self. Within a safe therapeutic container clients can allow for a creative regression to occur. The feelings that were once too overwhelming to be felt and processed can now be safely re-experienced, mourned and seen from a different perspective (Herman, 1992; Perrera, 1981; Woodman, 1982, 1985). The original traumatic
event can acquire a new meaning that allows for the healing of old wounds.
A reparative experience is possible in which the client's feelings and needs are acknowledged, understood, accepted and met (symbolically or literally).
Mind, body and spirit can be reunited and a new relationship to self and others can be integrated into a more unified sense of self. At that point, the client can let go of the past and move forward with his/her life.

Ann tells me that she sometimes experiences her voice as "disembodied" and "unreal". I notice I am breathing deeply. I feel tears welling up in my eyes. The tears feel connected to fear. Ann is sitting slumped on the couch. She looks sad and defeated. I wonder if I am feeling her feelings or my own. I ask her what she is feeling and she says, "nothing- umm – kind of numb". I make an intervention toward the music. I suggest we return to the classroom she has just described. I offer her choices. We can play instruments or sing. I also suggest we set a time limit of ten minutes. The time limit is to provide more structure and safety as well as allowing for time at the end of the session to process the music if necessary.

Ann wants to sing. She wants to work with the “vocal holding technique”. “Vocal holding techniques”, a method of vocal improvisation I developed and codified, promotes a therapeutic regression in which unconscious feelings, memories, and associations can be accessed, processed and integrated (Austin, 1998,1999,2001,2002). I feel this is what Ann needs.

I ask Ann to choose two chords. She picks E minor 7 to A minor 7. She approaches the piano, sits down and takes a breath. She says, "I don't
know why this should feel so scary but it does . . . I want to do it, though." I suggest we sing to, or as the young part of herself. I begin playing softly and steadily and suggest we begin by breathing together.

Ann:  (Singing) I am looking out the window at the flowers and the trees

Diane:  (Singing) I am looking out the window at the flowers and the trees

Ann:  at the flowers.

Diane:  at the flowers.

Ann:  I wish I was with the flowers.

Diane:  with the flowers.

Ann:  I am scared here. I am frightened.

Diane:  I am frightened.

Ann:  I don't know where I am.

Diane:  Where are you?

Ann:  I am floating somewhere up above . . . I can see everything from here.

I mirror her and sing as her double (inner voice). Then I shift from her double to myself with my question. I match her vocal quality, dynamics, and phrasing. At times we sing in unison, "How will I get through this?"

"Everything is so new" or we harmonize. I notice her singing voice is quite different from her speaking voice. It is soft and open and higher pitched. I believe she is experiencing a therapeutic regression. I notice how easy it is
for me to connect with her in the music while she is singing from this young vulnerable place.

I sing, "I don't want to open my mouth", referring to the speech in front of the classroom. She seems to take off from my phrase and sings "I don't want to open myself . . . how can she do this to me? What is she thinking?"

I continue to sing with her in unison and harmony. Her melodies are simple with few leaps. She sings slowly. There seems to be more feeling coming through in her singing. I feel willing to take risks, perhaps because I feel I understand her experience so well, the feeling of being exposed as inadequate. It feels familiar to me. I consciously slow down the tempo and sing "Doesn't she understand what it's like to be new?"

Ann:  To be 8 years old!
Diane: To be 8 and new. Doesn't she understand . . . to feel so strange and so different.

Ann:  So different.
Diane: Doesn't she know?
Ann:  It must be me who's wrong if she could ask this of me.

Tears fall from Ann's eyes. This is the first time she has ever cried during therapy. I feel she is beginning to trust me more; she is letting me in and letting herself "in". I feel touched by her courage to connect with this wounded, young part rather than to stay distanced from it. I think about the way children blame themselves when painful things happen to them. I feel it
is important to help Ann realize she was not responsible for her teacher’s insensitivity just as it was not her fault that she did not receive the empathy and understanding she needed during her childhood and adolescence. Otherwise she will keep finding herself in situations where she feels misunderstood and misperceived.

I feel protective toward her. I switch from singing as her "double" to singing as myself/her therapist. We sing the following.

Diane: It's not you. She doesn't understand - you're just eight years old and scared.

Ann: I'm scared (still crying softly) . . . I'm far away.

Diane: So scared and far away . . . and you need someone there who can understand your fear. It's not your fault.

Ann: Why do I have to go by myself to the front of the room by myself? What am I going to say? (Her voice becomes softer)

Diane: (singing softly) You don't have to have to go up there right now. Just come back to your body right now. Take a breath. It's OK now. Come back to this room. Come back to the present.

We breathe together while I continue playing the piano. I synchronize my breath with hers. My playing becomes softer, slower and more arpeggiated during the last part of the vocal improvisation. I also play in the upper register of the piano. These musical interventions are intended to support her singing and to meet her where she is emotionally. My lyrical interventions are intended to offer empathy, understanding and to help Ann
put words to and make new meaning out of a painful childhood memory. I want to alleviate her anxiety and work with her tendency to dissociate. I hope to provide her with the beginnings of a reparative experience. I am also aware that our time is coming to an end. I want to be sure to allow her time to emerge from the altered state she is in (the regression) and process the experience if she needs to. I feel it is very significant that Ann is accessing feelings she couldn't express in the past and that she is not alone this time. I am there to companion her.

During the breathing, Ann stops crying. I slowly bring the music to a close and we sit in silence for a few moments. Then Ann looks at me and says, "I was shocked that sadness and terror came up. It happened when I sang about only being eight years old and that she didn't understand what it's like to be eight years old . . . I felt like it was me who had to be strange, but the teacher was asking such a big thing!" I look Ann in the eyes and say "much too big for an eight-year-old girl who had just come from another city and didn't know - it was three months into the term . . . much too big." My tone of voice is very soft and slow, almost as if I am talking to a child.

Ann asks me, "Why did the teacher do that?" She sounds angry now and genuinely perplexed. I say gently, "She didn't understand . . . she didn't understand how exposed you felt . . . She didn't see you.

Healing childhood injuries requires revisiting past traumatic events in the present. Clients need a dependable, empathic "other" that is capable of companioning them through the unconscious realm. Transforming patterns of
behavior and defenses that were once useful in protecting a fragile sense of self but now stand in the way of growth, can be a slow and difficult process and one that requires the courage to let go of the familiar and step out into the unknown.

_Safe Enough to Play_

In the following case example Cindy experiences a therapeutic regression in which she encounters a playful, young part of herself. She is able to connect with this young girl and undergo a corrective emotional experience.

Cindy tells me about her dream. All she remembers is that she was a little girl all alone in the house and couldn't find a way to get outside, She woke up feeling anxious. I ask her if she has any idea of how old she was in the dream. She says "around five." I ask what she remembers about being five years old, what was it like?

Cindy: I was a victim as a kid... a target... I cried all day the first day of kindergarten.

Diane: Were you scared of school?

Cindy: I was scared all the time... I had so much responsibility at five... I was alone a lot. I had to take care of myself.

She laughs when she tells me how bad things were. It doesn't sound like an authentic laugh. Her voice lacks energy as she talks. She speaks in a monotone with little affect. I ask her what makes her laugh about this subject. I say, "What are you really feeling when you describe your childhood? What
are you experiencing in your body?" She pauses for a moment, then takes a few deep breaths and says, "a lot of anger . . . rage." I ask if we can make space for her rage and "be with it". She says, "maybe". A few moments pass and she says, "It's like the sound of fire when it's raging through the forest".

Diane: Where is it located in your body?
Cindy: In my belly.
Diane: Let's take a deep breath and if you feel like it, try releasing some of the sound.

We breathe together several times and then Cindy lets out a long, loud "Ahhh!" I notice that her face looks very tense and tight. I ask her what she is experiencing in her face and body.

Cindy: I am stopping the sound from fully coming out.
Diane: Can you relax your face? Take in another breath, now let's sigh out the tension.
Cindy: Ah – mmmm . . . I feel like a little girl in my backyard looking at the sunset. (Her eyes are closed.)
Diane: mmm
Cindy: Yet part of me wants to burn the house down.
Diane: What are you experiencing now?
Cindy: Rage again . . . It's too much . . . I'm scared . . .
Diane: I am with you. Would you like me to help you carry the rage?
Cindy: Can you hold my hand?
Diane: Yes.
Cindy wants to scream again. I yell with her. We pause in between each scream and breathe deeply together. The sound gradually changes to an "m-m-m" and then a series of moans and groans. Cindy says, "its like labor—part of it feels like wonderful energy and part of it feels difficult".

I suggest we try drumming while toning together, that we make a safe space and not push so hard. I am thinking that I don't want her to push feelings that aren't yet ready to emerge. We talk about the "labor" metaphor and that perhaps the "baby" is not yet ready to come out. I tell her that there is a tendency for many traumatized people to push and rush themselves in an attempt to get to the root of the trauma. It is often difficult to be patient with oneself and the process. I don't want Cindy to re-traumatize herself unnecessarily.

Cindy gets teary while I'm talking. She says, "the little girl is very scared. I usually don't listen to the little girl . . . my adult part wants to hurry up and get it over with." I continue to encourage her to go slowly. I tell her we need to make it safe for the little girl to come out and get her needs met. I also think about the latent content of her words, the possible sexual reference. I ask if she would prefer to sing or play to the little girl to comfort her. Cindy likes the idea of singing together while we drum.

We each take a conga drum. Cindy begins playing a simple rhythm at a medium tempo. I play with her and she syncopates off of my basic beat. She begins singing "ah-ah uh" and I join her in unison. We then harmonize
and sing a simple descending melody line. We sing the following words in unison.

Cindy: Little girl.
Diane: Little girl.
Cindy: Ah -h little girl.
Diane: Ah- h little girl.
Cindy: I'm here.
Diane: I'm here.
Cindy: I was pulling you.
Diane: (I repeat her words and melody, mirroring her) I was pulling you.
Cindy: Making you run very fast.
Diane: (mirroring) Making you run very fast.
Cindy: Very fast
Diane: I need to listen to you.
Cindy: Try to breathe and stay with you.
Diane: (mirroring) Try to breathe and stay with you.
Cindy: This is new for me.
Diane: This is new for me. (in unison)
Cindy: To open up my listening ears.
Diane: (mirroring) To open up my listening ears.

We continue singing about taking time and listening and being patient.

The melody remains simple but has more variety. I sing unison, harmonize with her and mirror her. At other points, I sing as her double (inner voice) and add feelings or thoughts she may not be aware of yet or have the words for.
When I am accurate Cindy repeats what I have sung or responds directly to my words.

Diane: We don't have to do anything we don't want to.
Cindy: We don't have to make a happy face.
Diane: We don't have to make a happy face.
Cindy: We've got time to be a little girl ... you didn't have that before. You had to grow up fast cause no one took care!
Diane: Cause no one took care!
Cindy: Of your precious feelings.
Diane: Of your precious feelings.

Our phrases overlap in this last section of the "song". Cindy stops drumming and I continue. We sing for a few more minutes and then Cindy begins to cry. I keep singing but change the words to sounds (m-m-m- and ah-h-h). I often sing up a third or fourth and descend to a minor third or fifth. I slow the tempo of the drumming and play softer. When I notice Cindy has stopped crying I sing, "time to breathe".

Cindy: Time to play . . . play in the sandbox.
Diane: In the sandbox.
Cindy: Build a castle, then we knock it down.
Diane: we knock it down.
Cindy: then we laugh.
Diane: then we laugh.
Cindy: She's saying, "look at me mommy, I'm playing!"
Diane: Look at me, look at me!
Cindy: I'm pretty. I'm pretty when I smile.
Diane: I'm pretty when I smile and when I cry and even if I'm angry, I'm still pretty.

Cindy: Look what I can do. I'm skipping, la, la, la, la,

We continue to sing phrases using "la" then we switch to "li" and sing in unison and harmony. Cindy is singing playfully with the full range of her voice. I attempt to match her melodies and vocal quality. I use the drum and cymbal to accent and support our playful singing. We are now both in the imaginal realm singing as her little girl, allowing for a reparative experience to occur. I feel that Cindy's "little girl" is getting a need filled that was never attended to in the past.

Cindy begins singing, "are you sleeping, are you sleeping?" and I recognize the lyrics and melody to "Frere Jacques". I play it on the piano and join in the song. Cindy sings, "Why should I get up? There's nothing much to get up for." I respond, "What would you like this morning; what would you like to eat?" She laughs. We continue in this make believe musical world. We sing about playing hide and seek. We have sung to Cindy's child-self, as her child-self, and now I am singing as her "good mother" while she continues to play out the role of her inner child; only this is a childhood Cindy never had.

After the session, I sit and write. I write about the process. I feel happy that I stopped Cindy from pushing herself and unwittingly creating a traumatic re-enactment with myself as the perpetrator. I haven't always been
as conscious of this particular dynamic that is especially prevalent with sexually abused clients. I think about the progression of the session. Once again, I am amazed by the creative, unpredictable nature of this work.

I recall Cindy's words when we processed the music; "Playing took me by surprise!" She went on to say, "I thought healing my abuse meant feeling a lot of pain every time I came to therapy. I didn't realize that playing and being a little girl was also a part of healing . . . I think I retrieved another lost part of myself as a little girl, the fun-loving part."

A Small Voice

Creative or therapeutic regression is an essential aspect of my method of music psychotherapy. Balint (1968), associates therapeutic regression with the opportunity for a new beginning, a chance to go back to a point before the "basic fault" or childhood trauma occurred. This basic fault results from inadequate mothering, a lack of fit between the mother and child during the early formative periods. A positive transference can provide the opportunity for a different kind of experience. The therapist becomes the new primary relationship and the client has the chance to discover and explore new and different ways of relating which can lead to healing of the basic fault.

Machtiger (1992), places great emphasis on regression in the transitional space of the transference/countertransference relationship with clients who have experienced chronic and repetitive parental failures during
infancy and early childhood. "In the blurring of boundaries the gulf is bridged, and the analyst can incarnate earlier parental figures" (p.128).

Machtiger could have been describing Marie when referring to clients who had been emotionally abandoned during childhood. Such clients if untreated, end up continuously reenacting their early experiences by pursuing unavailable partners or by unconsciously abandoning themselves.

"I have been feeling angry all week and I don't know why." Marie describes her week and we discuss the possible source of her feelings. "Here I am commuting again . . . I get so frustrated with all the waiting, for the train, then the bus!" Marie is referring to her internship site. She says, "Here I am again in a situation where I feel unsettled." We have been discussing her pattern of living in one city and working or going to school in another and how this triggers painful associations from childhood.

"Would you like to explore your feelings in the music?" I ask. Marie wants to play the piano with me. We go through the various settings on the keyboard and she selects the organ sound. We laugh together at how loud this sound is and the significance of picking such an obviously loud sound. I sit at the lower end of the piano and she sits beside me on a separate bench. We begin by breathing together and I say, "When you feel ready, just let your hands lead you. Marie is not a pianist and we rarely play piano together.

She begins tentatively by playing clusters of notes on the white keys. I mirror her by playing similar patterns. After a while she adds the black keys and the dissonance increases. I feel a rhythm pattern developing and I accent
it to provide structure and grounding. The music becomes slightly louder and somewhat faster. I add syncopation in order to introduce a new rhythmic element and expand the musical form (Turry, 1998). The melodies become more defined and playful. There are isolated moments in which she appears to be randomly jumping all over the piano. We make eye contact a few times and she smiles.

Gradually our playing becomes softer and slower. There is a hymn-like quality to the music that reminds me of "Amazing Grace". I play chords and a moving bass line that emphasize this quality.

We gradually come to a close, ending together. The silence feels peaceful to me. A few minutes pass then Marie says, "The anger left." I question her about the music and the way it changed and she says, "I felt something was underneath the anger... I heard a small voice.

Diane: What did it sound like?
Marie: Sort of crying sounds.
Diane: Crying?
Marie: Yes, but the anger was drowning it out.
Diane: When the anger left could you hear it better?
Marie: Yes, at the end of the music it said, 'listen to me...you really have to listen hard.
Diane: Is the voice very quiet?
Marie: Where it lives is very quiet... it has been shut up for a long time and needs to be heard.
Diane: Yes.
Marie: The music provided a place where it could speak... because I was listening to the music it knew I would
hear It . . . my head is usually filled up with so many thoughts.

Marie and I talk about the small voice. I ask her what makes it safe for this part to emerge. She says it needs a receptive attitude on her part and no expectations. Music and singing help it to come out. Anger makes it retreat. We speak about the way she sometimes uses her anger as a defense and that there is often grief underneath the anger.

She tells me she was going to bring her pig to therapy today. Her pig is one of her stuffed animals. It is shy and is the "youngest and neediest" of all her animals. She looks over at the shelf where I keep stuffed animals, dolls and other objects and asks me if my stuffed animals have names. I tell her they don't and ask if she would like to look at them up close. She says, "yes!" gets up from the bench and goes over to the shelf. She picks up and examines the different stuffed animals and puppets.

Marie: I like the moose; he reminds me of my pig. They are the same color and size.

Diane: You can bring him over if you want to.

Marie brings the moose to the piano and sits him on top of the keyboard. I ask her what the moose is thinking. She replies, "that his horns are so big, how could they not be seen?" I believe the pig and the moose symbolize the very young, vulnerable part of Marie, the "small voice" and I wonder if the horns represent unmet feelings and needs. She continues, "He
feels ignored and invisible." Her eyes fill up with tears. I talk to her about the importance of looking in your mother's eyes and seeing yourself reflected back. I say, "If you aren't seen or heard, if your early needs aren't met, it is hard to feel valued, to know you exist." My words seem to touch Marie and she cries softly. I feel very moved by her and filled up with sadness. I know what I am saying is true for myself as well as for Marie. Marie looks into my eyes and says quietly, "The saddest thing is waiting, waiting to be seen."

And Returning

The significance of reenactment or repetition and therapeutic regression in analytic and psychoanalytic theory is documented throughout this chapter. These aspects of the therapeutic process are essential elements of in depth music psychotherapy as I practice it. Controlled regression within a therapeutic reenactment allows clients to return to earlier stages in their development to rework unresolved conflicts, address unmet dependency needs, and repair early injuries to the self. Music can easily penetrate the boundaries between the conscious and the unconscious layers of the psyche providing access to young, encapsulated parts of the self. Music can melt through rational defenses and speak to, as, or for regressed parts of the personality. Music speaks in the language of dreams, the language of emotions, the language of the unconscious. Music travels through time effortlessly. A repetitive chord progression and the sound of lullaby-like singing can relax ego boundaries and enable an adult client to revisit
childhood. Through the use of music and words within the therapeutic relationship, adult "children" can have corrective emotional experiences, let go of the need to repeat the past and experience the joy of becoming their true selves.
CHAPTER VIII
THE MARRIAGE OF MUSIC AND WORDS

Separation

I am in Germany. The year is 1996. I am attending the 8th World Congress of Music Therapy. I am seated in a room full of music therapists from all over the world who have been arguing about the value of "music as therapy", music as the primary stimulus for the client's therapeutic growth, versus "music in therapy" (Bruscia, 1987, p.9), music aids the process but the therapeutic relationship is the primary stimulus for change.

The argument somehow boils down to music versus words and I have the distinct impression that music as therapy carries more status than music in therapy. I feel the adrenaline flowing through my body and realize my face is flushed. Someone has just spoken about all that music can accomplish in therapy that words cannot. I am on my feet speaking passionately in defense of words.

"Sometimes clients can reach deep feelings and bring tears to my eyes through their use of the language and sometimes clients can play music and avoid feeling anything at all. It isn’t about music or words, it’s about being emotionally present and embodied!"

I have also observed this tendency toward polarization in the split between some music centered music therapists who feel that basing music therapy on a psychodynamic approach or including theories and methods from
psychoanalysis in the music therapy process distorts how therapists view and relate in the music and interferes with the response to music as pure experience (Ansdell, 1995; Lee, 1996). On the other side are the analytical or psychoanalytically informed music therapists who feel strongly that psychodynamic theories and approaches enhance the depth of the music therapy process. Streeter’s (1999) implication that it is unethical to practice music psychotherapy without a working knowledge and awareness of unconscious dynamics and how they affect the music therapy process provoked strong responses from some music centered music therapists because of a belief that Streeter was elevating a theoretical preference to an ethical necessity. (Aigen, 1999; Ansdell, 1999; Brown, 1999; Pavlicevic, 1999).

After listening to colleagues speak about this issue for the past several years, it seems that the deeper issue underlying the music /words debate is whether musical experiences in music therapy are a self contained psychotherapeutic form or whether the music has to be interpreted or analyzed and used for conscious insight to be considered psychotherapy.

**Synthesis**

Jung (1969) believed the psyche structured itself into polarities such as consciousness, unconsciousness; reason, instinct; masculine and feminine. The interchange of differing points of view and the tension of the opposites
generate life energy and influence one's degree of creativity (Edinger, 1971; Kast, 1992).

Jung (1969) also believed that the psyche had a tendency to reconcile its polarities. "The wholeness of the self is built up from the reconciliation of these opposite psychic poles, but not from their fusion, because the tension of the opposites remains the source of life's energy and the dynamism of the self" (Ulanov, 1971, p. 63).

I am not suggesting that music and words are opposites but I am instead responding to a perceived polarization between two ways of working as a music psychotherapist: one in which all the work is done and processed in the music and another in which there is verbal processing before and/or after the music. The significance of examining these two approaches is to clarify my method of music psychotherapy.

The research findings highlight the integration of music and words that occurs in my approach. Because of the way I view both music and words and because I frequently work with improvised music and lyrics, the categories "music in therapy" and "music as therapy" are not relevant to my method; my work is simultaneously both. The music is doing something necessary and the words are doing something necessary. For example, many of Cindy's sessions and a few of Marie's took place entirely in the music. Music and lyrics were the catalyst for therapeutic growth; they opened the doors to the unconscious and provided a container for in depth processing to occur.
Some of the sessions I studied were entirely verbal yet much was revealed about the client’s emotional and psychological state through the musical elements of rhythm, melody, timbre, dynamics, tempo and phrasing in the client’s speaking voice, breathing patterns, silence and body language. From this perspective, the clients, themselves are music. We have “the prototypes of rhythm, melody, harmony and form in our physiological and psychological processes” (Ansdell, 1995, p. 9).

My approach is neither formulaic nor prescriptive. I regard the whole music psychotherapy session (and series of sessions) as an improvisation, a creative process for both participants. There is an organic flow between the music and the words, a partnership between equals. The words take the music to a deeper level and the music takes the words to a deeper level.

The “chord structure” that I improvise over is composed of my musical knowledge and preferences and my theoretical knowledge based on theories and techniques from depth psychology, trauma theory, twelve step philosophy, psychodrama and of course music therapy. The “chord changes” are chosen from my knowledge of the clients I work with, their particular wounds, strengths and needs and our working relationship at that moment in time. My intention is to create a safe environment that facilitates the emergence of the client’s spontaneous self.
Spontaneity and the Improvisational Attitude

Spontaneity plays a dynamic role in most forms of psychotherapy, for when clients are able to be spontaneous they can allow for the natural flow of their impulses and express themselves from an authentic center of being. In a spontaneous moment, healing can occur because clients are able to connect with their true voice, their true feelings and thoughts. They are able to experience themselves freed from the tyranny of “shoulds” and “oughts” and access and release authentic feelings, thereby opening a channel to the self.

An improvisational attitude frees the clients and the therapist from old frames of reference and ready-made responses and allows space for the creation of new ways of being to emerge from feelings and impulses we are experiencing in the moment. There is a sense of flowing with time and our evolving consciousness and a feeling of being enlivened when we can create our own form (music, sounds, words) instead of “con-forming”, duplicating someone else’s way of being or acting.

The more knowledge and experience we have working within different modalities, the freer we are to leave the limited framework of the familiar and comfortable and to follow the flow of the improvisation into uncharted territory. For example, when Ann’s words led quite naturally to drawing, it was important to trust the process and the direction it was taking. In this way, Ann was able to experience an intervention that was the most effective for her at that moment.
The heart of improvisation is the free play of consciousness as it draws, writes, paints and plays the raw material emerging from the unconscious . . . the real story is about spontaneous expression and it is therefore a spiritual and psychological story rather than a story about the technique of one art form or another (Nachmanovitch, p. 9, 1990).

The improvisational attitude in the therapy session creates room for the unexpected and the instantaneous creation of new behaviors, ways of relating and concepts of the self. Like a jazz musician, the therapist learns the theories and techniques and then “lets go” of knowing. This attitude encourages deep listening and immersion in the unique “music” of each client at each encounter. It requires grounding yourself in your training but not allowing theories and techniques to blind you to the person who is sitting in the room with you.

The key is this: we must be able to let things happen in the psyche. For us, this becomes a real art of which few people know anything. Consciousness is forever interfering, helping, correcting and negating, and never leaving the simple growth of the psychic processes in peace (Wilhelm, p. 46, 1931).

The music and the words within the context of the therapeutic relationship facilitate the process. The verbal and musical interventions interweave, overlap and complement each other. The interventions are determined by the therapist’s and the client’s perception of what is needed or missing in the moment and the therapist’s sense of what type of intervention will best serve this particular client at this particular point in the therapeutic process. When the work comes from a spontaneous or playful place, the
interventions are more likely to evolve naturally out of the process and to take
on new and inventive forms.

Marie’s fourth session illustrates an intervention I had never used
before, that combines music and words in a different way.

Marie seemed to be having difficulty describing what occurred over
the weekend. She spoke haltingly and left half finished sentences
hanging in mid-air. Without thinking, I began to play the piano pacing
the music to match the rhythm of her words. The music seemed to
help her to relax. I noticed she began breathing more regularly and
soon she was speaking more easily. Her words began to flow naturally
and there was more energy in the way she was speaking.

Playing underneath her speaking was an intuitive response on my part but in
retrospect it made sense. The music helped Marie to connect her words to her
body and subsequently to her feelings so that she could be more fully present
to herself and genuine in her responses to me.

Layers of Listening

“Layers of Listening” is a core category that emerged early in the data
analysis and refers to the multiple facets of the listening process. When
clients talk, move, make music or are silent, I listen and gather information
from what they say and don’t say, the sound of their voices, the music they
play and their body language.

I process this information on a variety of levels: I listen to my
thoughts, I listen to my feelings in response to the material as well as to
feelings evoked by the clients and their music (countertransference), I listen to
my body and my physical sensations and I listen to my reactions that emerge
in the form of imagery and intuitive hunches. After processing what I have heard, I form a verbal or musical (or combination) intervention. The client responds to the intervention and the whole process repeats itself.

It is a circular process that is ongoing and continually deepening with each go round. Sometimes each step in the process is lengthy and sometimes it all seems to happen in one creative leap. As each client’s story continues to unfold, intuitions can be verified, observations can be confirmed or corrected and patterns can be recognized and made conscious. Then emotional conflicts and psychological issues that stand in the way of change can be experienced and worked through.

Being a “good listener” does not come naturally to everyone, some have to work hard to develop this skill. The ability to listen with the whole self is an essential aspect of being an effective music therapist. I listen with what feels like an inner ear and what Reik (1948) refers to as “the third ear” (p.144).

Of the many and diverse competencies required of a music therapist, listening is the most fundamental and unique to the discipline. It precedes, shapes and monitors how the therapist responds to the client . . . Because no other therapeutic modality is defined by the use of music, no other modality depends so entirely upon the therapist’s listening abilities in nonverbal as well as verbal modes of expression. And for this reason, no other modality can provide clients with such opportunities to be heard so fully (Bruscia, 2001, p.7).

By listening with the whole self I mean tuning in not only with our ears, but also with our bodies, minds, feelings and intuition. I mean listening to the manifest as well as the latent content (Freud, 1910), the subtext as well...
as the text, what is not said and played as well as what is said and played by the client, the inner as well as the outer music. I also mean listening to ourselves and the inner voices that arise from our unconscious depths, listening to the thoughts, images, associations, feelings, hunches and physical sensations we have while being with and observing the client. If we are able to listen in this way, we will hear messages which

if deciphered lead to psychological insights that cannot be reached by any other means. If the therapist does not get these messages — if he cannot make out what they mean . . . he must dig deeper and deeper into himself, until he reaches the source of all psychological understanding that is in himself (Reik, 1948, p. 67).

In music psychotherapy we listen to our client’s words, silences and music, what they tell us, and what they conceal. We tune into subtle levels of communication to hear the elusive messages that travel from the client’s unconscious to our own. We receive sounds and listen to their reverberations upon our psyches in order to decode the possible meanings. We are required to listen actively and with concentration in order to catch transient impressions: fleeting tones, turns of phrase and rhythmic and dynamic changes that occur in both the client’s music and words.

Besides listening to our inner voices we also need to listen and become more attuned to our own speaking and singing voices. What are we communicating with our sounds and our music about our overall physical, emotional, mental and spiritual states? (Warming, 1992).

The research revealed that I listen in layers with my whole self, body, mind and spirit. I listen to what is being said, sung or played, what is
manifest. Then I listen to what is beneath the surface of what I have just heard. I listen to the unconscious messages I am receiving.

For example, a client may tell me how well she is doing, and I hear her words. However, on a deeper level beneath the words, the tone and quality of her voice suggests that she is sad. I listen to my feelings and they tell me that I feel sad. I receive another clue. I continue to listen and I hear that she is speaking with a voice that we have both associated with her “inner child”. I hear a part of her related to unresolved feelings and issues. She continues speaking and I hear a destructive behavioral pattern being repeated with her new boyfriend. I hear that she is not aware of this. She plays the piano and I hear loud, thick harmonies with a lot of 11ths and 13ths in the chords. She is playing with a lot of force and changing tempo frequently. I listen to our interaction and I hear distance between us. I listen to my body and I am aware of chills running down my back. I hear some sadness and anger in the music. I listen to all of the information I have heard and I listen to my thoughts about it. I hear grief and rage surfacing related to a childhood pattern that is being reenacted in which she feels abandoned and then isolates, unable to reach out for help.

Between The Lines

She says, “I’m very self sufficient ... I hate needing anyone.”
I hear, “Can I depend on you?”
She says, “I like to be alone ... that’s when I feel the safest.”
I hear, “Will I be safe with you?”
She analyzes everything,
She has it all figured out.
I hear a lonely little girl,
Lost somewhere on her way to feeling.
She fills every single space
And leaves no room for a reply.
I hear the emptiness, the fear,
I hear, “tell me I’m not too much!”
I sing a song that has no words,
Our voices meet then move away,
She hears, “I understand your pain . . . I’m not afraid . . .
I’ve suffered too.”
We sing a lullaby, a dream,
Our voices meet, then move, then touch.
She hears, “I’ll walk you through the dark . . . I will not leave . . .
I’ll stay with you.”

The Music in the Words

Two major themes emerged from “Layers of Listening”, “The Music in the Words” and “The Words in the Music”. These themes appeared most frequently, are related and also felt most significant. I have been aware for quite some time that I am very sensitive to the sound of the speaking voice. In an early analytic memo I wrote

I learn so much when I listen to Ann’s voice on the tapes. The melody, tempo, dynamics, rhythm, pauses, reveal another dimension, the subtext to the text . . . I often pick up nuances of meaning when I listen to people speak, even on the answering machine. The inflection in the voice on certain words can reveal hidden feelings.

I received quite a bit of “self-supervision” from listening to the sound of Ann’s speaking voice and my own on the audiotapes. In these initial sessions I often heard judgment and sometimes self-contempt in the tone of
Ann’s voice. The feelings I picked up from her did not always match her words.

What was somewhat surprising and difficult to look at (and listen to) however was the judgment and impatience I sometimes heard in my own voice. I would have missed some significant countertransference feelings if not for the fact that I continued to return to the audiotapes and session transcripts and study them. I heard moments where I was inwardly judging Ann for being so judgmental. I also became aware that her voice quality (when it was loud) sometimes annoyed me. With more time and reflection I realized this vocal quality seemed indicative of repressed anger. Perhaps I was picking up her split off feelings and identifying with them (projective identification). Ann had great difficulty both expressing anger and experiencing anger directed towards her.

These realizations were very helpful to me in examining and working through my countertransference to Ann and her speaking voice. The sound of my voice alerted me to my unconscious feelings and some important questions emerged as a result.

She’s not letting my observations sink in or affect her. I wonder if I felt annoyed. I don’t feel conscious of it but my voice sounds like I could be . . . I sound impatient here, as if I want her to get to the point.

And from another session:

She sounds stuck and unaware of what she needs. Why should this annoy me? I don’t sound empathic when I question her, more like I’m impatient with her. I don’t usually feel unempathic when a client is stuck. Maybe some of this is about the research, maybe we are both feeling self-conscious about being studied, maybe I have performance
anxiety? After all she is my first research participant! Time for supervision . . .

In the early stages of our work together there were moments when I felt as if we were engaged in a power struggle. I could feel tension in my body and I could hear the dynamics play out in the tonality, rhythm, texture and phrasing of our conversation. We would frequently interrupt each other. Her voice sometimes had a harsh aggressive edge to it. My voice would take on a “know it all” lecturing tone.

During these times our verbal music conveyed unrelatedness, competition versus “trading fours”. At points, Ann would take a long “solo”. At other points I would talk too much. (I wrote a few observer comments in my data log such as “shut up Diane” and “what am I talking about?”). Ann would often intellectualize and if I joined her we would end up lost in the words together.

I wondered if I was colluding with Ann’s resistance to the music by unconsciously joining with her on an intellectual plane. At one point during the fifth session I wrote in the margins, “why don’t I stop talking and get to the music?” An important shift occurred during this session, however, when I realized we were not connecting and I needed to slow down my speaking rhythm and ground myself in my body in order to help Ann slow down and feel. I wrote in an analytic memo:

She is not breathing. Am I? If I slow down the pace and leave more space it might help her to speak slower, breathe and feel the things she is talking about. I think some of this wordiness is due to anxiety and
perhaps some is nervous excitement that finally she can talk about these things with someone and feel listened to!

Knoblauch (2000) writes of similar experiences with clients in “The Musical Edge of Therapeutic Dialogue”. His emphasis is on the musical elements of speech and how these elements are a major source of information about unconscious communication and action between client and therapist and can greatly influence the therapeutic process. He uses improvising and accompaniment in jazz as a metaphor for clinical technique in psychotherapy. He could have been describing aspects of Ann’s, Cindy or Marie’s sessions when he wrote,

Therapists employ the rhythmic dimension in their accompanying responses to patients, often unconsciously, as they shape the non-verbal contours of their turn with a slowed down pace . . . or an acceleration (p. 38).

I found that whenever I started to intellectualize too much, joining or partially merging with Ann, if I focused on my breathing I would relax and sink down into my body. My listening improved. I became more present to myself and to Ann. I felt more empathy for the anxiety Ann was experiencing and realized again that intellectualization was a defense she employed and that she would need time to feel safe enough to begin to trust me and the process. Then she could gradually allow herself to express her deeper feelings and needs. An excerpt from the fifth session describes a particularly musical verbal exchange between Ann and myself that deepened our connection.
During this session, I spoke less but what I did say seemed to punctuate and support Ann’s words. I found myself becoming more interested in her story as it unfolded before me. As I became more emotionally attuned we began to “play together” with words and pauses and the process of releasing and expanding feelings and meanings resembled a soloist and accompanist when they get into a “groove” together. At times we each provided tonal and percussive accompaniment to one another’s words and there was a call and response feeling to the interchange. We laughed together, our eyes met frequently and there were moments when I felt I understood her and I think she felt understood. I could hear important themes coming through the words, themes to return to, and return to, and return to.

The music in Marie’s words was airy, light and breathy like a wind instrument. It was slow, hesitant and contained many “rests”, many moments of silence. As I have described before it was initially “spirit music”, disembodied and often detached from the everyday world of reality. I could sometimes hear her drifting off into space, as her voice got softer and softer.

Where did she go? In Marie’s words:

A place it is hard to describe . . . soft, like a blanket or a cloud, dreamy . . . magical . . . I can’t remember when I started to go there, it seems like it’s always been there for me.

We gradually reconstructed enough of her childhood to help us understand her need to “fly away”. She could not physically leave so she left psychically. The lack of security, the constant moving from place to place and her parents’ unhappy marriage were contributing factors in her need to escape to safety.

A recurring theme of Marie’s music was “a small voice”. Once while sitting and breathing together she heard it whisper “listen to me…you really
have to listen hard”. The voice told her it lived in a very quiet place and had been shut up there for a long time. It needed to be finally heard.

Listening to audiotapes of our sessions was often difficult because it was hard to hear Marie’s voice – both speaking and singing. Many of the words got lost, which felt symbolic to me but not surprising. I also found myself losing interest partly because of the flat affect and monotonous melody of her words. It took great concentration especially when listening to the earlier tapes.

During sessions I sometimes found myself feeling sleepy when she talked, a typical sign that the client is repressing feelings. In Marie’s case, however, I think her feelings were often dissociated more than repressed. Attuning my speaking voice to hers in order to meet her seemed to make matters worse. An analytic memo from the fourth month of working together addresses this topic:

We both sounded depressed or caught in some kind of trance-like drone. I decided to break out of our rhythmic and melodic pattern. I worked to engage her more. I leaned in and became more active. I allowed my own varying melodic patterns more freedom. My laughter, my faster and varied rhythms entered our verbal improvisation and she responded sometimes with laughs or smiles. I noticed her voice did not trail off as much as it used to. There was more energy in the room now and Marie seemed to be positively effected by this new music.

Alvarez (1992) makes the point that within a safe reliable relationship (environment) dissonance, change and even disruption may not always be experienced as traumatic but may bring surprise and opportunities for play.
and enjoyment. "A mother’s speaking voice cannot be said to fit itself precisely to a baby’s need for sound... the mother’s speaking voice is, to my mind, a cause for positive wonder, if not amazement" (p. 78).

The sound of Cindy’s speaking voice sometimes contrasted with the message her words conveyed. For example, during her eleventh session she said, "I’m doing really well right now." The music of her voice however, sounded depressed. The tone was fairly uniform with little melodic variation and dropped in inflection at the end of the sentence. As it turned out, there was sadness buried inside that her voice conveyed. The sadness was connected to her fears of being abandoned if she succeeded.

At other times the music in her words sounded like muffled percussion. I often had the sense that she was stifling her anger using her energy to squash intense feelings. Her singing voice in contrast was flexible and emotional. She possessed and made use of a wide vocal range. Perhaps she felt more permission to release intense feelings while singing. Many singers feel this way. It can be an aesthetically pleasing experience to sing and songs are vehicles and containers for emotion. The structure of a song or a chord progression can give one a sense of safety, of being held.

Sighs and deep breaths initially accented the music in Cindy’s words, and her tempo was usually slow. Her voice conveyed the sounds of someone who had seen a lot and survived — the sound of the blues. I often sensed a disconnection between her words and her feelings, unless she was singing. There was also a noticeable difference in her speaking voice right after
singing. Her voice sounded more embodied, enlivened, and more connected to her feelings.

In the initial phase of therapy, I often detected a defeated quality in her voice, like a slow, soft current running underneath her words. As the therapy progressed and she was able to express her grief, fear and anger through the music her speaking voice gradually took on more of the qualities of her singing voice. She became more playful and spontaneous. There was more of a connection between her words and her feelings. The more often she was able to express her feelings and needs, not just to me but to other people in her life, the more powerful and free she felt. Her speaking and her singing voice mirrored this change.

The Words in the Music

From an analytic or psychoanalytic music therapy perspective, music is often regarded as a language that gives symbolic expression to unconscious contents and intra psychic processes (Diaz de Chumaceiro, 1996 b, 1992a: LeCourt, 1991; Priestly; 1994; Tyson, 1981). When I speak of “words in the music”, however, I am referring to something more encompassing. Sometimes while improvising with clients or listening to their music, I do feel the music is operating on one level as a form of symbolic communication. The instruments clients choose and the ways in which clients use all the elements of music, for example harmony, rhythm and melody can be viewed as metaphors for the client’s psychological,
emotional and spiritual state. They are "speaking" to me, communicating something about their experience through the language of music. The melodic element of music in particular evokes concurrences between speech and music (Nordoff and Robbins, 1977).

The client’s music may be reflecting the transference – countertransference dynamics or expressing feelings, memories and associations to the past that are not yet available to the conscious mind. At other times, the music may be saying something that relates to the here and now, something that is conscious or unconscious, something not being expressed verbally but being communicated through the music. The "words" I hear may be "I feel more alive today", "I want to play alone", or "Can you help me get to where I need to go?"

Robbins and Robbins (1991) believe that the therapist’s musical interventions are posing musical questions. "Every time the therapist creates a musical idea, or offers a musical phrase, it is an invitation for the child to respond—a question for the child to answer" (p.57).

The therapist’s music can mirror and support the client’s communication and encourage the client to "say" more, reminiscent of the way a mother stimulates her infant’s expressiveness through vocal-musical interactions. And just as an empathic, attuned mother comes to understand the essence of her child’s non-verbal language, an attuned therapist can often interpret aspects of the client’s musical expression and come to recognize the unique musical language specific to each client.
An example of this phenomenon is when I began to notice that Marie played a particular kind of music when she was going off into her own world (dissociating). It was always slow and minor and in the upper register of the piano. The melody had a repetitious, circular quality that felt hypnotic to me, as if Marie were wrapping herself inside of a musical cocoon. This music spoke to me of Marie’s anxiety. It usually announced the arrival of a feeling that felt threatening to her. When my musical interventions were able to break through this trance-like state so that I could connect to Marie and help her return to her body, she usually returned with a feeling.

When I listen with my whole self to all the nuances of the music, the music speaks to me, sometimes in metaphor and sometimes on a visceral level. I hear both the text and the subtext. The music conveys a meaning and carries a message that sometimes requires interpretation but at other times is complete in itself. The message may be conveyed in the form of a feeling, a thought or a sensation. It can also be spoken through imagery, for example when I saw Marie’s little girl hiding in the corner (and she saw the same image).

When Cindy and I sang together for the first time we communicated through sounds. The sounds covered a wide range of expression from moans and growls to playful childlike utterances and soaring melodic phrases. I felt like she was asking, “Can you go with me? Can you handle all of my feelings?” When I reviewed the audio-tape, however, I felt a visceral reaction to the more primal sounds, the harsh growls and the loud, gruff vocalizations.
The angry sounds seemed more authentic. When we talked about the experience during the next session and I shared my reactions with Cindy she said, “I was thinking if she can’t listen to the ugliness of my annoyance, how can she possibly listen to my rage?” No one had ever been present for her feelings and singing was the only outlet she’d had. At the end of our discussion Cindy said, “I was communicating I am here to sing. Are you here to listen?”

Langenberg (1988, 1993, 1996) made a similar point about the ability of music to communicate meaning. In her research, she found that listening to an audiotape of a clinical improvisation is not unlike reading a transcript of a verbal psychotherapy session. She studied a client’s musical improvisation to validate the ability of the music to communicate symbolically, to resonate with the therapist. She examined the patient’s, the therapist’s and outside listeners’ associations to a tape of a patient/therapist improvisation and found that when the music was translated into verbal accounts the listeners heard similar things. There was an opportunity to “look at the full range of possible associations with music, such as connecting music with some vivid images, with emotional states or with particular events in people’s lives” (Langenberg, Frommer & Langenbach, 1996, p.151).

The clients also hear “words” in the music in many of the same ways I do and sometimes quite literally. For example Marie often heard a small voice speaking to her when we vocally improvised together at the piano. She would tell me what she heard when we processed the musical experience.
Cindy also heard different parts of herself (the child, the critic, the adolescent) coming through the music.

When Cindy and I played together during the following session, her music communicated valuable information about her feelings and the transference.

Cindy wanted to sit on the floor today. I got pillows for us and we sat facing each other. She decided to pull out a lot of instruments so that we could play together. She began playing the gato drum and I played the wood block, and then switched to the conga drum. It felt like every time we were in a groove together she changed the tempo and rhythm so that it was difficult to connect musically. Next she picked up the umbira and began playing a melody (in the key of C). I accompanied her on the metallophone and again noticed that she switched rhythms and it was hard for me to follow her. I felt like I was chasing her. Was she running away from me? Was she angry with me? She began singing a simple melody with the umbira. I decided to stop playing and just sing quietly with her. She sang louder and I noticed with some amusement that I felt drowned out. It was as if she were saying ‘shut up’. I thought about our last session and how intense it was. We worked on her feelings about her mother’s intrusiveness that made it so hard for Cindy to trust her and to make boundaries with her. Cindy had difficulty expressing her anger directly toward her mother because she also felt sorry for her. My hunch was that today I was receiving some negative mother transference. Perhaps she was practicing with me. ‘Okay’ I thought, ‘I think you need more space’.

Ann’s music spoke to us about a young alienated part of her.

Ann felt unsafe at work. She didn’t feel her boss really heard or understood her. She protected herself by withdrawing and holding back. I asked her if she could play or sing what it felt like being at work. She looked a little nervous but agreed. She slowly looked over the instruments and selected the small metal metallophone. I decided to play the xylophone setting on the piano. I felt I could support her most effectively this way. She began by slowly hitting various notes. She then began playing the ‘A’ over and over again, very softly. I supported her by playing chords of two or three notes. I felt like I was holding something fragile in my hands. I ended up playing in A
minor, which felt right to me. Her ‘A’ kept resonating softly, slowly but persistently like a melancholy young child who was doubtful yet determined to be listened to. It was as if she was saying, ‘hear me, hear me’ with her music. I felt very connected to her. When we processed the music it became clear that this part of her (the ‘A’) is quiet and vulnerable. She said, ‘it does not feel safe and doesn’t trust that it will be heard the way you heard me in the music . . . it feels like an alien, that’s how I felt growing up – I had to make myself presentable so I would look human but I didn’t feel that way.’

The Complementary Relationship Between Music and Words

Music and words work together in a natural way. This is very obvious when I’m making interventions. Sometimes the words lead to music; sometimes the music leads to words. Words and music often occur at the same time or are interwoven into the tapestry of the session in an organic way. Sometimes my interventions are intuitive – fast – obvious to me. It is staring me in the face, some issue ripe for exploring in the music or the words- peeping up calling for attention ‘here I am; look at me’. Sometimes there is a feeling of resistance that I pick up and I sense the music will help work it through. Other times the client suggests it – like ‘let’s start with music today’ or ‘there’s a song that’s been going through my head all week.’ Today I have the image of a ball of different colored yarn and several strands that catch my eye. Some are brighter than the others, throbbing with color, so I choose one of these. Sometimes the color is so intense I feel cautious. Perhaps it is too soon to ask that question or suggest she play that feeling – too quick – she might unravel too fast. Then the best intervention is to wait, to listen, to sit still in the unknowing and be open to being surprised and then sometimes a strand I didn’t even see falls loose and changes the shape of everything (Analytic memo, 12/8/2000).

As I listen to the client’s words and music, I am gathering and processing the information I receive. This information informs my interventions. The client responds or reacts and I listen in order to assess the effectiveness of the intervention. I gather more information by tuning in to the client and myself and processing what I hear. I may then change or
expand the intervention to make it more effective or I may form a new intervention.

This example briefly describes a session with Marie in which we began with talking, moved to drumming, went back to talking and ended up singing.

Marie had a bad week. She was angry that once again she found herself in a situation where she spent all of her time rushing from one place to another. She wanted to express her frustration by playing the drums. We set up the drum kit and she sat beside me at the piano. I accompanied her on the conga and the cymbal. She began playing very fast and loud but I could see she was not playing with her whole body. She did not seem fully connected to the music and quickly lost momentum. I asked her what she was feeling and she stopped playing and said 'I don’t think I’m ready to express my anger—I just couldn’t get into it.' I felt she was afraid. She was not comfortable expressing anger. My perception of her emotional state informed my next intervention. I asked her what she needed to hear right now. She replied 'I can take my time.' I asked her if she felt like singing and she said yes, I asked her what chords she’d like and she said 'something major.' I began playing Bb major7 to F major. I played slowly in the beginning and we began with some deep breaths. I started singing 'I can take my time' and after several moments she sang 'I don’t have to rush so fast' and I joined in. She began to pick up the tempo and sang 'I don’t have to hurry up' and I added a chorus of 'No I don’t, no I don’t, no I don’t!' The mood of the song became lighter and more playful. I began playing Bb major7 to Eb major to F7 to Eb major to add more support to her melody. Marie laughed and said it sounded like 'Feeling Groovy.' Afterwards Marie said it was nice to remember that she has a choice and she can change her rhythm if she wants to.

There are occasions when I receive a strong impression of what kind of intervention a client needs. In these moments, and depending upon the client, my intervention might be very directive, as in the example above when I felt Marie would benefit more from singing self-affirming statements than
from drumming. The interventions may be toward the music and/or in the music or words. For instance, when I said to Ann ‘Why don’t you come to the piano and play that?’ or when Cindy was telling me how excited she was about a recent accomplishment and I noticed that her words were disconnected from her feelings. I asked her what she was experiencing. When she said she didn’t know I suggested she take a deep breath and tune into her body. She noticed tension in her chest, which led to a discussion about her fear of success. We then played her anxious feelings together at the piano and she was able to assess memories of her fear of her mother’s envy.

At other times, the interventions are more collaborative. Even when I initiate the intervention, I am informed directly or indirectly by the clients in the sense that they continue to teach me what is helpful and effective and what is not. While singing with Marie, she had an image of a moose. He was hiding in a corner of her bedroom. The following excerpt is taken from the processing after the music:

Diane: What would help the moose to come out?
Marie: If he felt welcome
Diane: How can we help him feel welcome?
Marie: Maybe some more music
Diane: We could sing to him
Marie: Yes
Diane: Should we sing welcome?
Marie: We could start with hello and see what happens.
I frequently offer choices to the client. I might say, "We could sing or play. What instrument would you like to play? Would you like to do music, draw, dance or something else? Do you want me to play with you? What would you like me to play?" I sometimes offer choices in terms of risk-taking. An example is when I asked Ann if she would like so sing as the dog, to the dog, or about the dog. In cases like this, singing as the object or part of the self is usually the more difficult choice in that it is the most revealing.

There are also times when the client initiates or directly or indirectly leads a musical intervention. The following examples illustrate this. Marie brought in a song she wanted to sing that directly related to issues with her father we had been working on. We sang it through once and then Marie wanted to sing it again. The second time she changed some of the words to more accurately depict her situation.

Cindy started a session by saying she wanted to scream then began making loud sounds. I moved to the piano to accompany her in an atonal improvisation. Her sounds became more varied and eventually she began singing about her anger at her mother.

Ann was doodling on the xylophone while talking. I began playing with her on the metalophone and we engaged in a musical improvisation that felt connected to her feelings and to me.

Each intervention has an intention. In the earlier example of Ann singing to the dog, the intention was to help her connect with and relate to a
split-off aspect of herself with the goal of eventually integrating this part and the valuable energy it contains. As previously stated, the research study revealed that the vast majority of my interventions both toward the music and in the music were motivated by moments of disconnect in the client or between the client and myself. It follows that my intentions were primarily concerned with enabling the clients to connect to or to deepen the connection to themselves (their feelings, memories, sensations, images and parts of the self that contain these resources) and to me.

After examining my musical interventions, I once again thought of the ball of yarn metaphor. Sometimes the yarn is knotted up and needs to be slowly and gently untied. Then a strand can be teased out and unwound. Sometimes the client and I are very secure in the choice of color and design and our words and music become the knitting needles that the two of us use to connect and combine the yarn in creative ways.

**The Singing Voice**

An important area of inquiry that emerged from my data on interventions is “the singing voice”. The themes “the voice” and “singing” appeared frequently and also felt significant in terms of effectiveness as an intervention. It is important to reiterate that my preference is toward the voice since it is my primary instrument. Another possible factor in the predominance of this theme is that two of the research participants, Ann and Cindy, knew of my specialization in vocal improvisation and Cindy came to
music psychotherapy with the intention of focusing on the use of the voice in therapy.

Why is singing so effective as an intervention? To begin with when we sing, our voices, our bodies are the instrument. We are intimately connected to the source of the sound and the vibrations. We make the music, we are immersed in the music and we are the music. Our voices resonate inward to help us connect to our body-selves and they resonate outward to others. The self is revealed through the sound and characteristics of the voice. The process of finding one’s voice, one’s own sound, is a metaphor for finding one’s self.

On a physiological level singing facilitates deep breathing. In order to sustain tones, one has to take in more air, thus expanding the belly and diaphragm and then has to fully release the breath in order to continue the process. This kind of deep breathing slows the heart rate and calms and nurtures the nervous system, stilling the mind and the body. It relaxes the musculature and can create a deep experience of grounding and centering. The relaxed state that results is beneficial to everyone but especially helpful to anyone in a state of panic or extreme anxiety who is hyperventilating or breathing in short, shallow bursts (Austin, 2001).

There is reciprocity between the physiological and the psychological effects of breathing. By restricting the intake and release of breath, we can control our feelings. This was obvious when I watched Marie and Ann often hold their breath after revealing an emotionally charged issue. When I
encouraged them to exhale fully, they often came in contact with a feeling they had been suppressing. Likewise, the inability to take in nurturing or other kinds of experiences and information is mirrored in restricted inhalation. The way we breathe influences how we feel and what we feel has a direct effect on how we breathe.

Singing is also a neuromuscular activity and muscular patterns are closely linked to psychological patterns and emotional response (Newham, 1998). When we sing we produce vibrations that nurture the body and massage our insides (Keyes, 1973). Internally resonating vibrations break up and release blockages of energy allowing a natural flow of vitality and a state of equilibrium to return to the body. These benefits are particularly relevant to clients who have frozen, numbed off areas in the body that hold traumatic experience. According to Levine (1997), this residue of unresolved, undischarged energy gets trapped in the nervous system and creates the debilitating symptoms associated with trauma.

The voice is a primary source of connection between mother and child. The human ear is fully functional four-and-a-half months before we are born. The sounds we hear in the womb, our mother’s breathing, heartbeat and especially her voice fire electrical charges into our cortex and stimulate our brains. This stimulation aids in the development of the brain and the central nervous system. The mother’s voice is like a cord that connects the child to its life source and provides the positive intrauterine and post-birth experiences so essential in fostering the child’s ability to bond with others (Minson, 1992).
The vocal interaction in speech and song between infant and mother is critical to the child’s continuing development (Newham, 1998).

As Moses (1954) points out, children go through a period of identification, imitation, borrowing and eventual acceptance while finding and becoming themselves. The vocal process, he says, reflects these same stages. Likewise, when emotions are blocked and/or inhibited by the intellect the voice reflects this blockage. There is no longer direct contact with emotional impulses.

As we grow and become ourselves, our voices reflect the changes we undergo. The sounds we make, the language we use and the music in our voices reveal much about who we are – the different aspects of our personalities, our emotional and psychological blocks and our comfort or discomfort in our bodies (Austin, 1999).

Singing can enable clients to reconnect with their essential nature by providing them with access to, and an outlet for, intense feelings. Singing offers a way for the disembodied spirit to incarnate for some clients because the way home can be pleasurable and the painful feelings can be put into an aesthetically pleasing form. Cindy explained it this way: “When I sang just now, I took something ugly that happened to me and made it beautiful.” The structure inherent in songs and present in vocal improvisation can shore up a weak inner structure in the psyche and help contain strong emotions thus making it safer to express them (Austin, 1986).
Singing can provide clients with an opportunity to express the inexpressible, to give voice to the whole range of their personality. This includes sounds not taught in traditional vocal classes, screams, sobs, moans and more primitive forms of self-expression. Claiming and giving voice to these stifled, repressed sounds is reclaiming aspects of ourselves that have been silenced or inhibited in our families and/or society in general.

Singing is powerful. "The voice not only releases power but direct energy through the body" (Gardner, 1990). The act of singing is empowering; sensing the life force flowing through the body; feeling one's strength in the ability to produce strong and prolonged tones; experiencing one's creativity in the process of making something beautiful; having the ability to move oneself and others; and hearing one's own voice mirroring back the undeniable confirmation of existence. Owning one's voice is owning one's authority.

**Vocal Holding Techniques**

Vocal Holding Techniques is the name ascribed to a method of vocal improvisation I have been developing and refining since 1994 (Austin, 1996, 1998, 1999, 2001). During the research study, I discovered ways in which I had expanded and amplified these techniques. The research also revealed their effectiveness as an intervention with a variety of clients and for a variety of symptoms and psychological issues. I also became aware of how frequently I used them as interventions. I often improvised with Ann, Cindy and Marie using these techniques. Numerous examples can be found throughout this
document whenever I refer to vocally improvising with or without words over two chords.

Vocal holding techniques involve the intentional use of two chords in combination with the therapist’s voice in order to create a consistent and stable musical environment that facilitates improvised singing within the client therapist relationship. This method provides a reliable, safe structure for the client who is afraid or unused to improvising; it supports a connection to self and other and promotes a therapeutic regression in which unconscious feelings, sensations, memories and associations can be accessed, processed and integrated. These unconscious experiences are directly related to parts of the self that have been split off and suspended in time due to traumatic occurrences. When contacted and communicated with, these younger parts can be reunited with the ego and the vital energy they contain can be made available to the present day personality. Developmental arrests can be repaired and a more complete sense of self can be attained.

This improvisational structure is usually limited to two chords in order to establish a predictable, secure musical and psychological container that will enable clients to relinquish some of the mind’s control, sink down into their bodies and allow their spontaneous selves to emerge. The simplicity of the music and the hypnotic repetition of the two chords, combined with the rocking rhythmic motion and the singing of single syllables (sounds, not words initially) can produce a trance-like altered state and easy access to the world of the unconscious. The steady, consistent harmonic underpinning, the
rhythmic grounding and the therapist's singing encourage and support the client's vocalization. Within this strong yet flexible musical container the client can explore new ways of being, experience the freedom of play and creative self-expression and allow feelings and images to emerge. (Austin, 1996, 1998, 1999) The client's voice, feelings, and emerging aspects of the self are all held within this musical matrix.

This method is especially useful in working through developmental injuries and arrests due to traumatic ruptures in the mother-child relationship and/or empathic failures at crucial developmental junctures (Austin, 2001). After vocal holding Ann said she felt accepted. "I didn't have to do anything amazing, sing louder or better . . . I was enough!" This was very therapeutic for Ann who grew up with critical, perfectionistic parents who expected so much from her. This perfectionism often prevented her from enjoying her own music.

Interpretation and illumination of psychic conflict is of minimal value in working with adults traumatized as children, until the link between self and other is rebuilt and the client's capacity for relationship is restored (Herman, 1992; Hegeman, 1995). Cindy felt she couldn't hide in the simplicity of the music "I felt you really saw me. I was shy at first but then it felt so reassuring. I wasn't alone and you felt safe... I could hear and feel you singing-you were really there with me and for me, just for me."

Improvised singing seems ideally suited for this reparative work. Babies begin to vocalize at around five weeks of age and the attachment
between the infant and its caretaker develops slowly over the baby’s first year of life through physical closeness and an ongoing dialogue of cooing, babbling, gazing and smiling. The gaze between mother and infant contributes to the vocal rapport between the two (Bowlby, 1969; Winnicott, 1971). Vocal interaction in sounds, song and later speech are critical to the child’s development (Newham, 1998). Tomatis (1991) has even suggested that the mother’s voice is just as important to the child as the mother’s milk in providing adequate relational bonding. The importance of the voice and vocal holding in building and repairing the connection between self and other has significant implications when working in depth with clients suffering from the consequences of pre-verbal wounds to the self. In Marie’s words, “I felt safe, connected to you physically and musically, and when I looked into your eyes it was almost like you were feeding me. I could imagine soup, hot soup.”

Vocal holding techniques are not meant to be a prescription or recipe and are not necessarily used in the order that follows. For the sake of clarity, I will describe the process as it appears to complement the developmental stages. As with any therapeutic intervention, however, the client’s history, diagnosis, transference reactions and unique personality and needs should determine the approach taken to accomplish therapeutic goals. For example, when improvising, Ann initially felt more comfortable using words and may have experienced vocal sounds as more regressive and associated with loss of control. Marie felt more comfortable in the open realm of non-verbal singing in our earlier sessions perhaps because she had difficulty finding words to
express herself and because she often regressed to a preverbal place. At other
times, she seemed to need more structure so pre-composed songs were more
effective.

In the initial "vocal holding" phase the client and I sing in unison.

Singing together on the same notes can promote the emergence of a
symbiosis-like transference and countertransference. This was important for
Marie who never had a satisfactory experience of merging with an
emotionally present, attuned mother. In our initial vocal holding experiences,
Marie preferred singing in unison with me. When I moved to another note to
harmonize with her, she followed me. Over time, she allowed me to leave her
note and sing in harmony with her and gradually she began to explore more of
her vocal range and create more expressive melodies. The second stage,
harmonizing creates the opportunity for the client to experience a sense of
being separate yet in relationship.

Marie’s music mirrored her psychological growth. Through a
replication of early mother-child relatedness, she began to internalize a stable
sense of self and then gradually renegotiate the stages of separation and
individuation.

Marie and I sang together at the piano. She picked out chords to
improvise over – A minor7 to G major7. We sang on “ah” in unison
and in harmony. Her melodies now had more variety than in the past.
I also noticed that her voice had become more resonant and less
breathy. Her voice sounded stronger and I thought about the way it
mirrored her psychological growth. Marie had grown stronger as well.
She seemed more solid and three-dimensional to me. I felt some
sadness in the music. I had a sense that her inner child was around. At
times she sang up a minor 3rd and a minor 6th. I mirrored her melodies.
They had a yearning quality to them. When we stopped singing we sat quietly for a while. Then she said, 'That was very powerful . . . I had a deeper awareness of something, it's hard to find words, to pin down because it comes through the feelings but the image is the most important thing. I saw my child. She feels left and I suddenly felt sad for her, for leaving my own child, for leaving the dark place, the floaty place . . . I think she feels sad because I don't need to go there anymore. I don't want to . . . 'Marie began crying. 'I feel some loss, some relief, so many things - after so long finally there's this change-that place, the quality of being there was so beautiful.' I asked her what she replaced the dark floaty place with. Marie said, 'I guess the real world, being able to find it with real people, being here and finding it here with real people.'

Singing in unison can be very soothing and useful when clients need comforting or closure at the end of an emotional session. It is also a way to encourage clients to improvise. They may feel safer because they are not alone or exposed and they can draw on the therapist's voice for support.

Today while singing with Ann, I was enjoying the unison singing - it felt so right- the way our voices fit and soared together but I was aware of this and moved to harmony at one point quite consciously for fear that it might be my need for unison . . . Afterwards she said the unison was the most powerful part of the singing for her. 'I felt so much support, so much freer to sing and take chances.'

*Mirroring* occurs when a client sings her own melodic line and I respond by repeating the client's melody back to her. I often used mirroring with Cindy to support her in finding, strengthening and staying grounded in her authentic voice (for example when she confronted her uncle). Mirroring also helped her to hear and accept new parts of her personality, like the happy child, when they emerged. This musical reflection provides encouragement and validation. *Grounding*, when I sing the tone or root of the chords, often provided a base for Cindy's vocalizations later in the process. She would improvise freely and return to "home base" whenever she wanted to check in.
This musical intervention is reminiscent of a typical pattern of interaction between the child and the maternal figure that occurs when the child begins to move away from the mother to explore the environment. In the ideal situation, the mother stays in contact with the child and supports and encourages her increased efforts to individuate. Cindy expressed it this way: "It felt like time and space were being stretched and opened. I could take as long as I wanted to get out what I wanted to get out and go as far out as I needed to but if I wanted to return I could...the music never left."

All three clients in the study benefited from vocal holding techniques, sometimes for different reasons. The following categories derived from the research describe the kind of clients with whom this intervention is most effective:

1. Clients who want to vocally improvise but have little or no experience - The predictable repetitive chord structure frees these clients from over thinking and worrying about scales that fit with the more complicated and rapidly shifting harmonies of jazz and other forms of vocal improvisation.

2. Clients who are very skilled improvisers but are disconnected from their emotions - These clients can hide in their technique and take cover in complicated rhythms, melodies and harmonies, thus remaining in their heads and avoiding feelings.

3. Clients who have difficulty being playful - The two chords and the therapist's voice and presence create a safe, musical playground where
they can let go, surrender to the music and allow their spontaneous
selves to emerge. They can experience the pure sensation of singing
and the pleasure of making all kinds of sounds, something they were
often not allowed to do as children because of direct or indirect
messages to be quiet, good or to suppress their feelings. The musical
environment and the therapist’s encouragement can ameliorate the
internalized judgment of being childlike, silly and emotionally
expressive.

4. Clients who have early attachment or bonding issues and need to
experience a direct involvement on a sensory and feeling level with a
positive (mother) therapist - This technique facilitates a therapeutic
regression and creates a space for a reparative experience to occur.

5. Clients who experience the repetition of the two chords in combination
with the rocking rhythmic motion and the singing of single syllables as
a stimulus for the spontaneous flow of imagery that uncovers
unconscious contents - These clients respond to vocal holding
techniques much like they respond to the “Bonny method of Guided
Imagery and Music” (1986), in that they are able to relax the body and
mind and allow the images to unfold at their own pace in a stream of
consciousness reminiscent of a waking dream.

6. Clients who experience dissociation—These clients are often able to
“return to their bodies” through the combination of deep breathing that
is necessary to sustain tones and the vibrations that resonate deep
inside and increase body awareness.

The research also illuminated my intentions for using vocal holding techniques as interventions in the clinical process.

1. to build trust and create a positive mother transference
2. to soothe and comfort clients
3. to offer an experience of being seen and deeply listened to
4. to encourage vocal play and spontaneity
5. to work through resistance to feelings
6. to create an opportunity for the client to undergo a therapeutic regression in order to re-experience and repair early developmental injuries
7. to access unconscious feelings, images and associations
8. to release feelings
9. to lead into and out of free associative singing (vocal holding with words)

**Free Associative Singing**

Free associative singing is the term I use to describe a technique that can be implemented when words enter the vocal holding process. It is similar to Freud’s technique of free association (1938) in that the client is encouraged to verbalize whatever comes into her head with the expectation that by doing so, she will come into contact with unconscious images, memories and
associated feelings. It differs from Freud's technique in that the client is singing instead of speaking, but more significantly, the therapist is also singing and contributing to the musical stream of consciousness by making active verbal and musical interventions. The accompaniment (two-chord holding pattern or repetitive riff) and my singing, continue to contain the client's process, but the emphasis now is not only on "holding" the client's emerging self and psychic contents but on creating momentum through the music and the lyrics that will propel the improvisation and the therapeutic process forward. The progression to words and the more active role I take on generally promote a greater differentiation between the client and myself. When I begin questioning, reframing and adding my own words to the improvisational dyad, the transference and countertransference can become much more complex. The client may experience me not only as the "good-enough" mother, but in other roles as well (figures from the client's interpersonal and intrapsychic world).

In its simplest form "free associative singing" involves the client singing a word or phrase and my mirroring or repeating the words and melody back to them. The vocal holding techniques of singing in unison, harmonizing and grounding add additional support and variation. There are many examples of this intervention throughout the study. What emerged from the research however is the ways in which this technique has evolved since its inception.

I begin the process of vocal attunement by breathing in unison with the client.
Ann and I begin by taking a few deep breaths.

I ask Cindy to breath in deeply as if sipping through a straw and exhale on an f-f-f-f sound. I join her.

Marie and I breathe together before singing. I notice how shallow her breathing is.

As we sing together I attempt to match the client’s vocal quality, timbre, dynamics, tempo and phrasing.

It is often hard to distinguish my voice from Cindy’s.

Marie’s voice is so soft. I feel like I’m almost whispering when we sing together.

Cindy said, ‘I felt like our voices were weaving and melding together. When we sang loudly I felt an intense vibrational sound connection with you. Maybe because our voices are similar.’

The research revealed that with the movement to words there is often a need for more variations in the music. The two chords remain the basis for the musical improvisation but changes in the client’s feeling states and emotional intensity often require a broader musical palette. Variations in dynamics, tempo, voicings, arpeggiation, rhythm, accents, rests, alternate chord substitutions and chord extensions (adding 7ths, 9ths, 11ths, 13ths) enable me to reflect and support the client’s experience. In this way, I use not only my voice and the lyrics but also the music to deepen the vocal improvisation and the therapeutic process.

The following example is taken from the session in which Cindy was working to integrate her feelings about being sexually abused. It was
challenging for me to musically intervene in ways that both contained and encouraged the intensity of Cindy’s emotions.

I felt like I was standing in the room with Cindy and her uncle. She was there to confront him about the abuse. I was playing in D minor but somewhere it became very modal and polyrhythmic. I wasn’t singing much but occasionally mirroring back her words. I felt riveted to each word she sang and I supported her musically with lots of rhythmic variations and chord alterations, 9th, 11th, 13th - as if the chords expanded as the scene expanded. She was yelling at him for what he did to her ‘little girl’. I felt the adrenaline rushing through my body as she told him what he did and how it affected her. My playing grew louder and more syncopated. At one point she sang, ‘this is my body’ and I was right there. I started singing a chorus ‘my body is my body.’ I moved my left hand and played lower in the bass of the piano to support the intensity of our singing. I played eighth note triplets in my right hand to match her energy. She joined me in this chorus that felt like a gospel choir. I felt her coming out of the victim and into a sense of empowerment. I felt we were joined in this anthem for all women who had been victimized. Then I had to pull back a bit to get clear where we were and where we needed to go. She needed to ‘cool down’ so that there would be time for her to reorient herself before the end of the session and to verbally process the experience if she needed to. I gradually slowed the tempo down and began singing “oo” and “ah” in a soothing way. Later she said ‘Sometimes I felt like two of me was singing. I didn’t think I’d be able to express myself but your music helped me to share my experience. It helped me to let those feelings out. I could face my uncle because you were right there beside me. I could draw on your strength’.

Throughout the improvisation I am making critical decisions about when, how and what to sing with the client. This is especially true when I move beyond simply mirroring the client’s lyrics and music and begin to vocally provide empathic reflection, ask questions, use repetition to emphasize important words and musically role play significant people in the client’s life as well as parts of the self as they emerge in the therapy. By
taking a more active role in musically facilitating the therapeutic process and with the singing of words, I can help the client understand and make meaning out of what she is experiencing in the present and what she experienced in the past and how these events affected her sense of self. Old, unrealistic self-concepts can be replaced by new, realistic ones resulting in self-acceptance and increased self-esteem.

**Psychodramatic Singing**

Psychodrama has interested me for years. I have a background in theatre that led me to take courses in drama therapy and psychodrama during my graduate studies at New York University. I returned to it six years ago after attending a workshop and learning that many psychodramatists are working effectively with trauma survivors (Bannister, 2000; Dayton, 1997; Hudgins & Kiesler, 1987; Kellermann, 2000).

One discovery I made while analyzing my data is the relationship between “free associative singing” and psychodrama. I realized a technique I use frequently and find invaluable that I had always referred to as an “alter-ego” (Austin, 1998,1999), was actually a musical version of the psychodramatic “double” (Moreno, 1994). Following is an analytic memo I wrote when I had this realization:

I am Ann’s musical double! A lot of my work with her has psychodramatic elements. Today I was role-playing her little girl, doubling her and switching roles. Doubling deepens the process and
can easily lead into expression of feelings. It also helps her connect to parts of herself.

The “double” is the inner voice of the protagonist (client). The director or someone the protagonist chooses to play the “double” speaks in the first person using “I” and expresses feelings and thoughts the protagonist (client) might be having but either has no words for or is unaware of feeling. The words can be protested or confirmed by the protagonist. Hearing the words spoken aloud supports the protagonist and enables him/her to name the feelings, express them and process and integrate previously repressed or dissociated emotions (Dayton, 1994, 1997).

Free associative singing could be thought of as a form of musical psychodrama. When I “double”, I sing as the inner voice of the client and use the first person (“I”). Drawing on induced countertransference, empathy, intuition as well as knowledge of the client’s history, I give voice to feelings and thoughts the client may be experiencing but is not yet singing, perhaps because the feelings and thoughts are uncomfortable, unconscious, or the client has no words for, or ability to conceptualize the experience. When the doubling is not accurate it still moves the process along as the client can change the words to fit her truth. When it is accurate, it provides the client with an experience of being truly seen and understood. It also encourages a bond between client and therapist and over time strengthens the client’s sense of self.

This intervention was especially useful for the clients in this study,
people working to integrate thinking and feeling or a mind/body split. Doubling offers an effective way to breathe feelings into words and supply words for feelings. In addition, the naming or labeling of unprocessed trauma material can aid in preventing uncontrolled regression and retraumatization (Hudgins and Keisler, 1987).

Besides singing as a double, I may take on (sing) roles from the client’s story as it unfolds in the improvisation. Following is part of an excerpt taken from my log and an audiotaped transcription. It illustrates “free associative singing” and the interventions I now refer to as “doubling” and “role-playing”.

I ask Cindy ‘was there anyone you could talk to (as a child) that you felt safe with?’ She shakes her head and says ‘no’. ‘Did you have a pet or a favorite stuffed animal?’ Again she says ‘no’. I am feeling sad for her and trying to think of what might have helped her to survive when she says, ‘there was a tree’. I ask her to tell me more about it and she says ‘it was huge and beautiful and right outside my bedroom window . . . I guess the tree was my friend growing up.’ I asked Cindy if she would like to sing as the tree, to the tree or about the tree. My intention was to put her in touch with a resource she had, an image she could return to when she felt unsafe. She wanted to sing as the tree and asked me to play something ‘soft and warm’. I tried a few chords and she chose C, F/C, G/C. She liked the pedal tone sustaining throughout. I suggested we begin by breathing together several times. My intention was to help her relax and ground herself in her body. She began by singing ‘ah-h-h’. I joined her briefly in unison and then in harmony. She begins to cry softly and sings:

Cindy: Sweet little girl I hear your tears
Diane: I hear your tears
Cindy: I see you crying
Diane: I see you crying

Cindy: and I wish my arms could hold you – reach around and hold you close

Diane: and hold you close – reach around and hold you close

Cindy: but my arms can’t move that way and my arms can’t give you touch

Diane: but I’d like them to – reach around, reach around, reach around you

Cindy: maybe you can look at me and see you’re not alone

Diane: maybe you can look at me and see you’re not alone

I have been repeating her words and melodies – echoing them back to her but when I sing “I’d like them to” I am offering a reparative experience as the mother-tree. At the end of “you’re not alone” my melody resolves the phrase and feels comforting to me and I hope to her.

Cindy: Maybe you can see my arms reaching up, reaching out, maybe you can see my strength, maybe you can see me connection to the earth (her singing becomes stronger, her melody soars up, building and she sustains the last note for two measures).

Diane: the earth (I join her in unison).

Cindy: can you see me?

Diane: can you see me? See my arms?

Cindy: I’m just staring at the bedspread (she’s now singing as her little girl).

Diane: staring at the bedspread.

Cindy: the spread turns into different patterns, what a bore, what a bore staring at my bedspread
Diane: wouldn’t you like to play says the tree, wouldn’t you like to play with me, climb up in my branches, put your arms around me? (I decide to sing as the tree, the nurturing, positive mother figure that offers her support. I also sing an entirely different melody. Her melody consisted of three repeated notes, the sound of boredom. I sang of play and my melody reflected that by jumping up to a fourth, then a sixth and creating a singsong effect).

Cindy: I’m afraid (she cries).

Diane: we could just sit then, it’s okay to be afraid, it’s okay, it’s okay, it’s okay (she cries and blows her nose).

Diane: I will stay here outside your window and you can cry if that’s what you need to do (my singing has a lullaby quality to it, both my voice and the melody. Again, I am offering a reparative experience – an empathic mother-tree who is accepting and empathic).

Cindy: but what if lightning strikes you down?

Diane: (I pause here – stuck for a moment, how do I answer that, I wasn’t expecting it but she needs to know I won’t be destroyed by the lightning or the intensity of her needs). My spirit will always be here with you.

Cindy: you’ll be here with me?

Diane: I’ll be here with you. (I feel relieved that I came up with an acceptable answer. I feel very close to her – very moved by her).

Integration

Music and words can do the same things in the therapeutic process:

Build trust, offer support, clarify issues, stimulate insight, access feelings,
uncover unconscious material, contain and hold the client’s psychological
process and help the client integrate new experience. The effectiveness of either depends on when, how and with whom they are used. The clients’ strengths, vulnerabilities, defenses and needs have to be considered as well as the aspect of the client that is being worked with.

The three research participants are a representation of my client base; people with early injuries to their sense of self. Cindy, Ann and Marie all utilized dissociation as a means of coping with a traumatic event or events in their childhoods. They all experienced difficulty being emotionally present due to mind-body splits. Ann often had an intellectual understanding of what she was experiencing but could not feel it. Marie often had feelings but no words for them. Cindy sometimes experienced a fragmentation of consciousness in which different parts of herself wanted different things or one part would take control and she would lose touch with the other aspects of herself. All three clients needed to become more aware of the different facets of their personalities, learn to listen to them and work to integrate them in order to establish a more cohesive, vital sense of self.

The combination of music and words and having the comfort and flexibility to move and flow from one “language” to another, gave me more avenues of access to the clients so that I could reach them at whatever developmental stage they were working through. The verbal and musical interventions overlapped and supported each other. Over time, the words and music within the context of the therapeutic relationship, helped the clients connect with, relate to and gradually begin to integrate encapsulated parts of
the self that had been rejected, lost, or hidden away. The stream of sound, sensation, feelings and energy exchanged between the client and the therapist in the music, the words and the silence, provided the clients with an opportunity to have a corrective emotional experience and to renegotiate crucial junctures when the relationship with the primary caretaker was ruptured. The music and the words worked together to weave a connection, a bridge back to the self.
The Clinician/Researcher Revisited

Studying my own work was a difficult, exciting, stressful but ultimately valuable endeavor. It was difficult and stressful for several reasons. Because of the problematic nature of dual roles, I took extra precautions to ensure the trustworthiness of this study. I analyzed the data recursively and utilized a variety of methods to do so: poetry, song, vignettes, art and several different kinds of charts in addition to the customary logs, field notes, analytic memos and tape transcriptions. I also discussed aspects of the data in conference presentations and received valuable feedback from colleagues around the world. Needless to say, the data collection and analysis took a long time.

I had several ongoing forums where I could discuss and receive feedback on my work as it progressed; personal psychotherapy, supervision and a peer support group. Although I received much needed support and useful feedback, at times I felt raw and exposed presenting work I am so intimately connected to. The document at times felt like a mirror and in its reflection I did not always look my best. Qualitative research, when done in depth requires extensive and honest self-examination and self-reflection (Ely et al., 1991). I had to face myself and question aspects of my work, at times in agonizing detail.
Because I was studying my own clients who were undergoing in depth music psychotherapy, I was determined to conduct the research as unobtrusively as possible. When I realized the research process was initially affecting Ann’s therapy I was very concerned. An analytic memo I wrote after her first session describes the way I dealt with this issue.

I discussed this session yesterday in my supervision group, which is comprised of a Jungian analyst/psychologist (leader) and two other psychotherapists. What became clearer to me is the effect of the research process on both of us (Ann and myself) during the first session. My supervisor said we were in a ‘participation mystique’, a shared feeling state of anxiety, performance anxiety due to the third thing in the room – the research process as represented by the taping of the entire session. The anxiety we both felt was heightened. Ann speaks quickly anyway. During this session it seemed her anxiety caused her to speed up her tempo even more. I am studying my work and a part of that is how, when and why I use interventions so it makes sense that I would feel pressure to get my interventions in. My anxiety caused me to feel somewhat dissociated. If I had been grounded and centered, I probably would have commented on what was occurring and explored the ways the research process was affecting us. Then I could have slowed things down in a number of ways and helped Ann focus. My supervisor felt that until we ‘metabolize’ the effects of the research, the first few sessions would probably reflect some heightened anxiety due to performance pressure and fears. I agree with him. The groups I attend are essential to the trustworthiness of this research process. It is not possible to see my own blind spots.

My supervisor was accurate. By the fourth session both Ann and I were impervious to the tape recorder. By the time I began working with Cindy and Marie, I was comfortable with the situation and being taped never seemed to pose a problem for either of them.

Another challenging aspect of studying my own work was knowing when to stop and what to leave out. Intellectually, I know that you stop
collecting and analyzing data when the data starts repeating itself and there are few, if any new categories or themes (Ely et al., 1991; Higgins, 1996; Lincoln & Guba, 1985), but it was difficult because I did not want to leave anything out. After all, this is my method and I felt invested in giving readers a total picture of how I work including all the interventions I use and all the different ways I use them and why. My support group was very effective when it came to this issue. I heard “you have enough data”, “start writing”, “this isn’t a book”, several times before I finally relented and realized I could not (and should not) include everything related to my work in this document.

Researching my own work was rewarding because it gave me the opportunity to study what I do in detail and gain greater clarity about the essential elements of my method of music psychotherapy. It was beneficial not only to me but also to the research participants because of the extra time, energy and attention I devoted to their case material. I wrote about this in an analytic memo.

Doing research on my own work is akin to self-supervision. This is a positive side effect of doing research on the therapeutic process. I spend an enormous amount of time listening to the tapes, transcribing them, writing my impressions, thoughts, questions and then returning to the notes after time has passed to see if my perspective has changed or if I have missed something.

In another memo about interventions I wrote:

I have been thinking about using this kind of intervention more with her – having her slow down and breathe. My research has increased my awareness so that before the session I sometimes have certain goals or interventions in mind as if I’d just had supervision on Cindy. The research is improving my work! The vagueness and indirectness I often detect in the way she speaks seems to be a defense against
feeling her feelings. As I write this, I see some parallel process in that this issue of being indirect and talking associatively came up in my own therapy yesterday. I sometimes talk this way, usually to avoid feelings . . . Now I'm thinking of a line from a poem, 'to see the world in a grain of sand' and Jung's idea that if we keep free-associating we will always return to our core complexes and issues. This is great—to have an excuse to write like this, to think deeply about my work and to explore how it's connected to my own personal journey.

As I recursively examined the sessions and experimented with different methods of data analyzation, more layers of meaning emerged. I gathered some valuable clinical information as a result of continually returning to the tapes, the transcripts, the analytic memos and the logs. This information was similar to the kinds of things I might learn in supervision such as what was occurring in the transference, countertransference, and when and how I was making musical interventions. For example in an analytic memo I wrote after Ann’s fourth session, I stated:

I felt much better today in the work. I had more energy and felt more present and grounded. I also think listening to last week’s session tape made me want to get to the music earlier. We had barely any time for music last week . . . I also felt aware of her resistance to the music and my irritation at her defensiveness. I felt pushed away (my countertransference). On reflection, I think it is her defense that was difficult for me. Listening to the tape and writing about it was very helpful. I came to realize it is not me she pushes away but her feelings. What therapist has the luxury of time and energy to listen and transcribe sessions? There’s so much to learn from this process.

After listening to the audiotape of Cindy’s session several times, I had a realization about her behavior:

The music seemed to mirror or parallel the verbal part of the session. I remember having a sense-intuition during the session that Cindy really wanted to sing the song by herself and have me listen to her but
perhaps felt uncomfortable saying that. I have found that clients, clients who are music therapy students in particular, often feel reluctant to say they would prefer to play or sing alone especially if they feel the therapist wants to participate. If clients have care-taking tendencies this is especially true. They want to please the therapist and try to anticipate what the therapist needs/wants . . . the music felt like the rest of the session. I felt that Cindy was trying to take care of me, and sacrificing her own needs, a pattern that occurs in the rest of her life, especially with her mother. This pattern was being played out during the session.

I feel fortunate to work with many music and creative arts therapists in my practice and to have had three of them as my research participants. My client-participants often had the ability to articulate what they experienced in the music and the therapeutic process in more depth and detail than those clients in other vocations. Because of this, I was able to learn more about the effectiveness of different kinds of musical interventions and gain greater clarity about my method of working. For example Cindy told me she read about vocal holding techniques and thought they were more for a beginning singer but that she would feel bored or confined by them.

I didn’t think two chords would be stimulating enough for me but I’ve learned to depend on the constancy of these two chords. I think they represent the symbiotic bonding I never had. I didn’t have to guess where you were going because the chords were predictable, they made me feel secure and held . . . I can trust them in a way I can’t yet trust a person.

After a session that consisted almost entirely of free associative singing,

Cindy said:

I thought I wouldn’t be able to hear myself when you started reflecting my words but it actually helped me to hear myself more . . . I felt encouraged to let my feelings out and safe to share them with you.
The way you matched my timbre, pitch and phrasing made me feel like two of me was singing. It felt empowering.

Ann often mentioned a musical intervention when it was particularly effective. "When you changed to a minor key I was able to get involved in the music on a deeper level. It expressed my mood more accurately." And Marie also commented on the musical interventions. "I’ve noticed that when you sing the same note I’m singing, it helps me to feel stronger and to take more risks."

Through the feedback I received, often during the verbal processing of the music, I learned a great deal about what worked and what did not work and why. The process of data collection and analyzation led to insights that enhanced the quality of my work. My belief in the power of the voice to reach clients on a deep level and to enable them to integrate body, mind and spirit was confirmed.

The research study also helped me to fully understand and validate the effectiveness of vocal holding techniques and free associative singing in facilitating a therapeutic regression, integrating dissociated aspects of the self, and healing early injuries caused by insufficient or inadequate parenting. The research process led me to the realization that I was extending these techniques and combining them with other creative arts modalities like drama therapy and psychodrama. These research findings about my work helped me to further define and fully value techniques I have been developing and refining for years.
Studying my own work was an invaluable experience, an opportunity to learn more about myself as well as my clients. For instance, the data analysis relating to the role of the therapist took me to a place deep inside of myself where I revisited my own childhood wounds, the genesis of my development as a music therapist. I learned how profoundly my own healing process influenced my approach to music psychotherapy.

When I began Jungian analysis years ago, I needed to find words and a context for the intense and confusing feelings that sometimes overwhelmed me. My analysis helped me to express, understand and integrate emotions connected to painful childhood experiences and to comprehend the effect these experiences had on my present day life. It was here that I learned first hand about therapeutic regression in service of the self and the powerful hold the past has on us. I filled dozens of journals with feelings, insights, dreams and poetry. I became acquainted with the wisdom of the unconscious and its relationship to creativity. I was singing professionally at the time and found it was extremely therapeutic to express myself through my own lyrics and music. I began writing songs that chronicled my inner journey, a process that spanned at least twelve years. I needed both music and words to explore, express and make meaning out of my life experience.

I studied object relations theory because of a need to gain a greater understanding of the infant-mother relationship and its impact on the child’s development. By this time I knew I suffered from pre-verbal injuries to my
sense of self so theorists like Winnicott, Miller, Klein and Fairbairn fascinated me and helped me to better understand my clients.

My inner journey also led me to Al-anon, a program for relatives of alcoholics and drug addicts. What I learned there got integrated into my clinical work along with a new respect for cognitive-behavioral tools as a resource for people with addictions or addictive behavior.

My analysis and supervision taught me that the stronger people become, the deeper they can delve into their own process because they have the ego strength to contain intense affects without being overwhelmed by them. This was certainly true for me. About seven years ago I became interested in trauma work including generational trauma. I studied and experienced various ways of working with developmental trauma, again as part of my own healing process. This work, especially somatic experiencing and psychodrama, along with the traumatized clients I was attracting in my practice, greatly influenced my way of working. This became evident when I analyzed the data on the therapeutic relationship and the therapeutic process.

As I sit here writing the final pages of this dissertation, I am struck by the significance of completing this document. All the anxiety, the resistance, and the stress of the past several months make sense. This is a rite of passage. Giving birth to this dissertation, which is so intimately interwoven with my own life’s journey and letting it go out into the world is a major step in my individuation process.
Recommendations for Future Research

When the research study ended, all three clients continued in music psychotherapy. Now, almost five years later, two of the three are still deeply involved in the therapeutic process. Originally, I hoped to study clients in various stages of the therapeutic process but unfortunately this was not possible due to restrictions imposed by the human subjects committee. I think a study of in depth music psychotherapy with clients in different stages would be extremely valuable in tracking the evolution of the clinical process. It could answer questions about the long-term use of music with verbal clients. Do the clients use music less, more or differently as the process deepens? Are there periods of resistance to the music or words or stretches of time when clients feel the need for something else and turn toward art or other forms of creative expression?

Researchers interested in studying clients at different stages in the process need to search for creative ways to accomplish this. One idea is for researchers to ask new clients for advanced consent. They could do this a year or two before they start their research.

I was able to learn quite a bit about my method of in depth music psychotherapy in this study. Having clients who could articulate what they were experiencing in the music and the therapeutic process was extremely advantageous. For this reason I would encourage music therapists to endeavor to include clients capable of expressing themselves both musically and verbally in their research studies.
More research on music psychotherapy interventions is still needed, for just as several analysts looking at the same client would intervene at different times and in different ways, the same would most surely be true for music psychotherapists. The “when” and “how” of musical interventions is a rich area still fertile for exploration.

I think ultimately the benefits of studying one’s own work outweigh the difficulties. Besides learning more about my own method, I gathered valuable information about my clients that helped me to work more effectively with them. The research provided me with the opportunity to immerse myself in all the facets of my work for a prolonged period of time. As a result, I also learned a great deal about myself as a person and as a clinician. I do think, however, that therapists studying their own work should be involved in personal psychotherapy and supervision not only to ensure the integrity of the research but also to enable them to look deeply and unflinchingly at themselves.
Two Voices

A look, a sound
A feeling that's never been spoken
A word, a touch
A rhythm that will not be broken

You name the fear
And something so cloudy becomes so clear
Two voices are better than one
No stopping the music once it's begun

Some time, some trust
A treasure once lost is recovered
A smile, a song
What's hidden inside is discovered

A laugh, a tear
And someone so distant is soon so near
It's never too late to be free
Let go of what never will be and sing with me
Two Voices

Bossa Nova feel

Diane Austin

Intro  C  D/C  Fm/C  C

look, a sound A feeling that's never been spoken A

word, a touch A rhythm that will not be broken You

name the fear And something so cloudy becomes so clear

Two voices are better than one No stopping the music once

it's begun Some time, some trust A
Treasure lost is recovered. A smile, a song. What's
hidden inside is discovered. A laugh, a tear. And
someone so distant is soon so near. It's never too late to be
free. Let go of what never will be. and sing with me.

Cmaj7/C Cmaj7/C Cmaj7/C Cmaj7/C Cmaj7/C Cmaj7/C Cmaj7/C
REFERENCES


Herman, J. (1992). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror.* New York: Basic Books.


the power of sound (pp. 199-216). Albany NY: State University of New York Press.


APPENDIX A

CONSENT FORM
CONSENT FORM

I, __________________ agree to participate in a music therapy study conducted by Diane Austin as part of her research for her doctoral dissertation in Music Therapy at New York University.

I understand that Diane will be audiotaping and studying 12 to 16 of my music therapy sessions with her to gain insight into analytically oriented music therapy. I understand that my participation in this study is voluntary and that I may withdraw from the study at any time. I further understand that I may withdraw from the study but continue as a client in music therapy and, if I decide to withdraw, Diane will not use any information pertaining to me in her study.

I have been assured that my confidentiality will be protected. My name and specific identifying details such as geographic information will be altered to protect my anonymity. As a participant, I have the option to review the tapes and ask that all or any portion of them be destroyed.

Diane has answered any questions I have about the study. I understand that if I have further questions I can contact her at her office: 28 Willow Street, Brooklyn, New York: 718-722-7910.

_________________________  ______________________
Participant Signature     Date

_________________________
Participant Name (Print)
APPENDIX B

THE TREE
APPENDIX C

CHART ONE
Breathes more space
She is singing longer phrases - leaving
I don't know myself
I'm also aware of the session time
Support her by matching
I feel we are coming to the end
I slow down tempo - I feel we
Lots of counterpoint, repetition
Music slows - rocking motion
Play more melody in accompaniment
Builds in intensity
Presses in motion and harmony
Use of repetition of musical

"Can I come in?"
I sing as auxiliary ego
My tears are frozen
I sing as auxiliary ego

Intention
Musical Intervention
Client Response
Permits deeper processing
She does not repeat "my tears" - just
APPENDIX D

CHART TWO
APPENDIX E

CHART AS ART