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MINDFULNESS IN MUSIC THERAPY CLINICAL IMPROVISATION:
WHEN THE MUSIC FLOWS

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CHAPTER I
THE RESEARCH OBJECTIVE

Personal Source of the Study

For the past seven years, I have been working as a Nordoff-Robbins music therapist, clinical supervisor and teacher. My clinical experience encompasses work with adults and children with a range of psychological, developmental, physical and emotional difficulties. As an inherent aspect of the Nordoff-Robbins approach, musical improvisation is the primary means of therapeutic interaction between client and therapist. Throughout my years of clinical practice, I began to notice that in these joint musical improvisations with clients there were moments and passages distinct in quality for the clients and me. There was a seemingly paradoxical sense of freedom and control, an intense involvement, and a heightened creativity in the music making.

When adult clients spoke of their experiences in the musical improvisations in their therapy sessions, their feelings, thoughts, and perceptions stimulated my research interest in these distinct experiences in clinical improvisation. Interestingly, the clients sensed a change or a shift, a sense of going beyond a former way of being while involved in the music, of breaking through a limitation or breaking out of a limiting perception of themselves, being
more expressive, more comfortable and confident, relating more easily and intimately, and of the music coming together almost effortlessly and in a personally significant way. The following paraphrased statements represent composite accounts of clients' reported experiences:

The music reflected a shift from thinking too much to letting the music flow and getting involved in the music itself; while playing, I listened to the story of the music, with its own existence, letting it live and breathe, letting it unfold on its own, and living fully within the music; surrendering to the experience, rather than trying to control it, I felt in control; I was fully present in the ongoing music; I found that I was giving the music a chance to develop and exist without getting in the way; I felt totally immersed in the evolving music; I felt free, more open, creative and comfortable with myself; the music was genuinely expressive, authentic; I was in the flow and letting the ideas and music come out without feeling self-conscious. (Fidelibus, 1998)

As I reflected on these clients' comments, my own experiences were similar in nature to theirs. As a therapist, I experienced a shift in my own playing, particularly in my ability to think and play in a spontaneous and unobstructed way, while maintaining a sense of the clinical situation. As therapist and client, we were creating music in a mutual manner and had unique experiences that were qualitatively different from other musical experiences in sessions. With adults who articulated their experiences during sessions, and with children who did not, I continued to be aware of these unique musical experiences. From my perspective,
the clients showed an unmistakable passion, vitality, intensity, and an absence of self-consciousness in the musical improvisations. With children, I could observe and hear the qualitative difference in their involvement in the music. I considered these engagements in improvising music as milestones in their therapy process. In many instances, adult clients themselves understood and expressed through words that these experiences were meaningful in their growth and development. Often, clients used the word "flow" when conveying their experiences. This word kept emerging in sessions and lingered in my own thoughts as I reflected on clinical improvisations. At some point in my reading of professional literature, I came across a theory called "flow" that seemed to describe some of the characteristics of these kinds of experiences.

Over the next few years, as I began to present my clinical work at professional conferences, I introduced Csikszentmihalyi's (1988, 1990, 1997) flow theory as a supportive theoretical construct. In essence, Csikszentmihalyi describes flow experience as a sense of inner harmony which is the result of the concentrated investment of psychic energy and leading to a sense of inner growth through intrinsically rewarding interaction with some aspect of the inner and outer environment (Csikszentmihalyi, 1988, 1990, 1997). At this time, his theory was well-suited to explaining the nature of clinical improvisation because its concepts resonated with my clinical experiences. In professional presentations, I started to highlight aspects of the music that occurred concomitantly to these kinds of experiences. These presentations represented my initial investigations into the relevance of the notion of flow to the clinical improvisation process.
Csikszentmihalyi’s theory of flow was helpful initially as a lens through which I viewed my own experiences in clinical improvisations.

Theoretical Origins of the Study

In the current music therapy literature, authors integrate the notion of flow and related concepts into music therapy theory. Music therapists mention aspects of Csikszentmihalyi’s thinking both explicitly and implicitly (Aigen, 1995, 1996, 1998, 2002; Amir, 1992; Ansdell, 1995; Kenny, 1989; Ruud, 1998). In related fields, Balara (2000) and Elliott (1995) relate Csikszentmihalyi’s ideas on flow experience to musical experiences. The following authors mention concepts closely related to Csikszentmihalyi’s ideas on flow, both in and out of the music therapy context. Formal references to Csikszentmihalyi’s ideas are differentiated from other descriptions of music therapy experience. The cited authors may or may not use the term flow but their descriptions present ideas that relate to the research topic or in how they use the term flow without explicitly referring to Csikszentmihalyi. These authors’ ideas provided me with a thinking tool at the onset of the study and are considered in Chapter VII in how the findings of this current study relate to their ideas as well as other frameworks as they arose in the study.

Csikszentmihalyi et al. (1988) studied people involved in a variety of human activities, including artistic, athletic and leisure endeavors, and identified a number of phenomenological characteristics and dimensions of the flow experience: merging of action and awareness (loss of self-consciousness)
transcendence of ego, centering of attention, feeling of competence and control, clarity of goals and immediate feedback, autotelic nature, transformation of time (Csikszentmihalyi, 1988).

According to Csikszentmihalyi (1988), in flow experience, people stop being aware of themselves as separate from their actions. While consciousness works smoothly, the self is fully functioning yet not aware of itself. The experience requires intense concentration, effort and skill, and it forces us to concentrate on a limited field of stimulus. There is a great inner clarity, and awareness is coherent and purposeful. There is a sense of mastery and a paradox of feeling in control while also experiencing a sense of letting go. The goals and rules of the activity may be explicit or negotiated through trial and error, and may remain below the participant's level of awareness. The goal of the experience is primarily the experience itself, rather than any future reward or advantage called autotelic nature. While involved in a flow experience, the participant's motivation is intrinsic. There is a distorted sense of time within the experience. Consciousness moves from disorder or psychic entropy, to order or negative entropy. The self undergoes differentiation which is seen as a movement toward uniqueness and separation, and integration as a union with other people, with ideas and entities beyond the self. After the experience the self re-emerges as more complex aptly named as the complexification of the self (Csikszentmihalyi, 1988, 1990, 1997).

Csikszentmihalyi's (1988) psychological studies of flow and optimal experience were in part outgrowths of his interest in Abraham Maslow's ideas in
the field of psychology that centered on intrinsic motivation. Csikszentmihalyi states that Maslow’s “distinction between process and product orientations in creative behavior, which led him to identify ‘peak experiences,’ was the conceptual framework closest to the phenomenon I was trying to understand” (1988, p. 5). Maslow (1965, 1968) postulated that humans were motivated by an intrinsic desire for self-actualization, explained as a need to discover one’s potentialities through intense experience. Csikszentmihalyi sought to understand and further develop Maslow’s ideographic and reflective formulation of these concepts through empirical research.

Clive Robbins (1998) introduced Maslow’s concepts of hierarchy of needs, peak experience, self-actualization, and intrinsic learning as a way to interpret and explain the clinical phenomena with which Nordoff and Robbins were familiar. The Nordoff-Robbins approach aims to engage and draw the client into a musical world as an inherent growth-seeking endeavor, transcending mental and physical human conditions. Similarly, Csikszentmihalyi (1988) states that “the flow experience is important to understand because it provides a key for understanding the strivings of the self and the quality of individual well-being” (p. 35). Historically and in present practice, Maslow’s concept of peak experience is shared between Csikszentmihalyi’s flow theory and as part of Nordoff-Robbins conceptual framework.

Aigen (1995), in arguing that “aesthetic considerations are central to clinical music therapy process,” (p. 235) contends that “a deep level of involvement in music therapy process --- incorporating enhanced expressive
freedom, confidence, insight, and personal power --- is simultaneously the vehicle and goal of the process” (p. 239). In further applying aesthetic theory to the clinical process, Aigen explains that music therapy treatment, “[rather than] a means toward some completely autonomous end,” can be understood in this way: “facilitating the ability of clients to live in the music is simultaneously the means and goal of Creative Music Therapy” (p. 239). There is a relationship between Aigen’s conceptualization and Csikszentmihalyi characterization of flow experience as having an autotelic nature, meaning that the goal of the experience is primarily the experience itself. Aigen (2002) advances the notion that “in music-centered work...the inherent rewards of musical experience are drawn upon and they provide the client’s motivation to music activity and experience” (p. 25).

In the field of music education, Elliott (1995) states that “musical experiences are a subset of that larger class of experiences that Csikszentmihalyi variously calls flow experiences” (p.126) --- creating the term *musicing* to capture the essence of these kinds of experiences in music. He contends that musical experiences and flow experience share some fundamental characteristics, but that there are unique conditions involved in flow experiences in music. He specifically cites focused concentration, absorption, and a match between musicianship and challenge as concomitant features of a flow experience in music. He argues that musical experience and flow experience share common outcomes: self-growth, self-knowledge, and self-esteem --- all of which he characterizes as the aim of music education. While his linkage of musical experience to flow experience
supports his philosophy of music education, his premise substantiates this research study by making a necessary correlation between Csikszentmihalyi’s ideas on flow experience and inherent characteristics of musical experience.

Aigen builds a foundational concept in music therapy by linking Elliott’s idea of musicing and clinical practice. Aigen (2002) asserts that Elliott’s construct of “musicing supports a music-centered notion of clinical practice where the essentially musical experience is a legitimate clinical goal because music exists primarily as a medium for the development of the self” (p. 22). He adds that “the client’s experience of himself in music can be so important on a basic human level that it need not be justified on anything outside of itself” (p. 33). In addressing the therapist’s clinical intention, Aigen (2002) states that “the therapist’s primary focus is to formulate strategies to deepen and differentiate the client’s musical experiences” (p. 24). From this perspective, clinical goals can be articulated as musical goals, and that benefits defined in nonmusical terms are “secondary consequents of the involvement in the musical experience” (p. 24).

Aigen (1996) found that a key foundational concept of Nordoff-Robbins music therapy is the achievement of “a state of being where both therapist and client are living as completely as is possible in the music” (p. 12). Aigen (1998) characterizes the process of Nordoff-Robbins music therapy as “the establishment of a musical world” and postulates that the work can be conceptualized as “an effort to draw a child into an experience of creating and/or living in an aesthetic form” (p. 258). These findings speak to a dimension of flow theory which recognizes a person’s state of total immersion in an experience. He further
explains that the “organizing entities of music --- and this includes intervals, melodies, chords, scales, styles, and idioms --- and their realization through specific song and compositional forms and improvisations contains the potential for creating liberating and healing experiences” (p. 258). The elements and forms of music are seen as essential to the establishment of a musical world and the reaping of its therapeutic benefits. The clinical purpose of creating this musical world can be viewed as a profoundly personal place in which a client’s immersion and deep involvement are made possible, and in which a client’s challenges and needs can be addressed. The idea of deepening personal engagement in an organized, interactive and dynamic musical world corresponds to a phenomenological characteristic of a flow experience: concentrated investment of psychic energy in some aspect of the inner and outer environments leading to psychic negentropy or psychic order. Similarly, aspects of the therapist’s orientation and involvement in the musical improvisation, identified as necessary to carry out the work, include “living totally in the moment,” “total concentration,” and “being poised in the creative now” (Aigen, 1998, p. 281) --- concepts closely related to attributes of flow experience elucidated in Csikszentmihalyi’s writings.

Ruud (1998), in his investigation of improvisation in music therapy, describes the experience as liminal and joins the ideas of flow and void in a complementary fashion. He defines flow strictly according to Csikszentmihalyi but further postulates that when boundaries are liberated and there is a clearing of old meanings and perceptions, a void is created out of which new perceptions and
meanings can come forth. In this way, flow and void are complementary phenomena: as a consequence of flow, a state of nothingness (void) ensues. The interplay of these concepts are in service of the greater idea of liminality that Ruud defines as a state characterized by ambiguity and confusion. Flow is construed as a necessary component in the liminal experience as a whole. The flow aspect of the liminal experience is understood as a means to an end, the creation of a void. While bringing the flow concept into musical improvisation, his ideas lack the empirical underpinnings that could further explain his ideas in the context of music therapy practice, and lend understanding to the conditions, contexts, and strategies involved in this experience.

Kenny (1989) developed a music therapy theory, the field of play, that contains four interactive fields: ritual, a particular state of consciousness, power, and creative process. Specifically and related closely to flow experience, a particular state of consciousness, is conceptualized as “a field of focused relaxation and intense concentration, yet playfulness” while creating musical form (p. 106). She further explains that this state of consciousness, a self-motivational state, “allows one to travel in the dimension of consciousness into a fluid reality which is not contingent upon circumstance, e.g., disability” (p. 107). Kenny’s theory speaks to aspects of flow experience quite directly: intrinsic motivation, focused and intense concentration, and a fluid quality of consciousness that transcends incapacitating situations.

Balara (2000) enlisted Csikszentmihalyi’s flow theory in a tripartite theoretical construct in his qualitative study of jazz improvisers’ involvement in
creating collective jazz improvisation. His recommendations speak to aspects of the music therapy situation and certainly warrant the study and expansion of flow theory in creative realms. While his study confirmed the experience of flow in all its dimensions, he looked uniquely at the flow experience within an interactive and dynamic environment of a group of improvising musicians. Thus, his investigation addressed social dimensions of creativity, and emphasized the need to stretch flow theory toward more contextual situations when studying a creative process. He concluded that several dimensions of flow experience, such as autotelicity, were highly dependent upon qualities of the social environment. His study clearly focused on social structure and experience and concluded that these are key to further understanding flow theory. While extending flow theory to address socially creative milieus, he determined that “the interplay of the conscious and nonconscious,” and the “contextual characteristics” need further investigation (p. 328). He recommends that the life-worlds and personal histories of the individuals need to be taken into account as a way of understanding intrinsic motivation, and that the states of “comfort” and “security” contribute to the characteristic dimension of transformation of time (p. 328). He suggests further study of flow theory in a number of areas: “listening,” “the relationship among skill levels within a group,” “the multiple levels of feedback,” and the “interconnection of environment and self-perception” (p. 329).

Amir (1991) investigated “meaningful moments” in the music therapy process, and discovered several categories of these significant moments. In her findings, she explains that, in these moments, the therapist and client were
"completely absorbed, fully there, yet lost in a state of timelessness" and that the experience was "self-validating and was felt as an end in itself" (p. 194). She further reports that when the therapist's participation is full and there is a sense of "being what is happening," these are healing moments in the process (Amir, 1991). Her findings speak to aspects of the flow experience and, as she acknowledges, to Maslow's peak experience as well. The pervasive qualities of timelessness, absorption, and full involvement are particularly similar to dimensions of flow experience. She attributes the occurrence of these moments to the "intrinsic power of music" and to its inspiration for these moments (p. 195). She urges the further investigation of the conditions that allow such moments to occur (Amir, 1991).

Ansdell (1995) cites Csikszentmihalyi's studies in a footnote for further reading about flow as optimal experience. Ansdell states that "the flow and integration of music is a compensation for the scattered, the incoherent and the discontinuous" (p. 140). He adds that "it is this sense of flow of both the music and the self which is often an unusual and fulfilling experience for our clients" (p. 27). To further explain his understanding of flow in the music therapy experience, he quotes Zuckerkandl's statement that "to hear music is to be flowing with time, is to know the past and the future only as characteristics of the flowing present, as its two directions, away from and toward" (cited in Ansdell, 1995, p. 140). Ansdell's frequent use of the term flow takes on various meanings: a sense of physical and psychological movement, continuity, connectedness --- relevant to Csikszentmihalyi's (1975) statement that a person in the flow state "experiences it
as a unified flowing from one moment to the next” (p. 36). Ansdell posits that “when music involves, and improvisation seizes the present, there can emerge the opportunity for a person to experience themselves differently from their habitual state” (p. 27). This speaks to the aspect of Csikszentmihalyi’s writings on flow experience in which one experiences a sense of transcendence.

The writings and studies of musical and clinical improvisation cited in this literature touch upon the research topic of when the music flows. Some writings were for the most part theoretical endeavors, while most of the research studies relied primarily on verbal recollections of musical experiences, excluding the actual music as pertinent data and as references linked to the text. Aigen (1998, 2002) and Ansdell (1995) were the sole researchers who included musical excerpts in their works, connecting their findings to the music itself. Aigen provided and examined the music as foundational data from which he developed his concepts.

It became evident through professional communications with other music therapists that they have their own unique understanding, interpretation, and meaning of clinical improvisations. Music therapists, as part of their role in the therapeutic process, are directly involved in, reflect upon and interpret the musical experiences that take place between therapist and client. Therefore, they have a unique perspective of the musical experiences in the therapy dyad that will be essential in this study. As clinicians they are able to articulate their understanding of the interaction from a therapeutic perspective, and as musicians from a musical perspective. Essential to this study, their musical and clinical proficiency are well-
suited to yield multiple levels of meaning of their experiences in clinical improvisations.

When therapists have access to audio or video recordings of clinical improvisations, they are able to review the musical interaction from yet another perspective, one in which they are not directly involved in the musical experience. From both observational and participatory standpoints, therapists can construct meaning and understanding of clinical improvisations as they review and refer to a musical interaction from an archived session. As part of their usual practice, music therapists understand clinical improvisations within the context of the therapy relationship and process. This study relies upon therapists’ experiences and perspectives of clinical improvisations with clients garnered through qualitative interviews in which archived taped clinical improvisations were reviewed and discussed.

The Context of the Study’s Focus: Clinical Improvisation

Just as musical improvisation has existed in many ways, shapes, forms, and for a multitude of reasons in diverse cultures throughout the history of humankind, musical improvisation in the music therapy clinical setting, known as clinical improvisation, has been adopted and adapted in a number of varied approaches congruent with particular theoretical orientations. Clinical improvisation has been used in psychiatric, medical, educational, and private practices, and with an extensive range of client groups to address psychiatric, psychological, developmental, medical, and geriatric issues.
In clinical improvisation, the therapist and client(s) play musical instruments and/or sing to make music spontaneously without the use of a musical score, predetermined musical direction or instruction. The substance, form and character of the music are created and determined by the therapist and client(s) through the musical interaction. Clients play percussion and melodic instruments that require no necessary education or skill to play, such as the human voice, drums and xylophones, allowing ready access to making music. The therapist usually plays an instrument (piano, guitar, voice, percussion) on which he or she has attained an advanced level of proficiency.

Bruscia (1987) defines *improvisational music therapy* as any approach that uses improvisation as its “primary therapeutic experience” (p.5). He codified numerous models of improvisational music therapy that use clinical improvisation. He classified these models according to the role of clinical improvisation in the therapy process, and the practitioners’ approaches and orientations working within specific settings and client groups. His detailed descriptions and labels encompass the diversified applications of musical improvisation in the clinical setting: Creative Music Therapy (The Nordoff-Robbins Model), Free Improvisation Therapy (The Alvin Model), Analytical Music Therapy (The Priestley Model), Experimental Improvisation (The Riordan-Bruscia Model), Orff Improvisation Models, Paraverbal Therapy (The Heimlich Model), Metaphoric Improvisation Therapy (The Katsh & Merle-Fishman Model), Adult Improvisational Music Therapy (The Stephens Model), Musical Psychodrama (The Moreno Model), Vocal Improvisation Therapy (The Sokolov
Model), Integrative Improvisation Therapy (The Simpkins Model),
Developmental Therapeutic Process (The Grinnell Model) (p.xiii). He explains
that the theoretical orientations of a model “determine how improvisation is used
and the rationale for emphasizing certain aspects of improvising over others”
(p.11). The models are closely identified with the practitioners, and their
particular use of clinical improvisation. There is considerable overlap of salient
features, and adaptability of their application amongst all of the models in
Bruscia’s categorizations.

A number of theoreticians and pioneers in the field of music therapy have
investigated and articulated various music therapy approaches that use clinical
Austin, 1996; Boxill, 1985; Kenny, 1989; Lee, 1996; Nordoff & Robbins, 1968,
1977; Priestley, 1984, 1994; Ruud, 1998; Pavlicevic, 1997). I cite the following
authors to create a composite, practical connotation of clinical improvisation for
the purpose of portraying the context of this study’s focus: Boxill (1985) defines
clinical improvisation as “the spontaneous, extemporaneous expression of music
and its components, vocally and instrumentally, for therapeutic purposes” (p.96);
Ansdell (1995) describes improvisation as “the main tool the music therapist has
to involve someone immediately in a creative musical experience” (p.22); Aigen
(1998) explains that “an essential component of the Nordoff-Robbins approach is
the direct participation in creating and experiencing aesthetic forms” (p.236);
Bruscia (1987) defines “a characteristic feature of analytical music therapy as
clinical improvisation that is “often stimulated and guided by feelings, ideas,
images, fantasies, memories, events, situations, etc., in which the client or therapist has identified as an issue needing therapeutic investigation" (p.116). Taken together, these definitions encompass and articulate features of clinical improvisation that are relevant to this current study in how from an historical perspective they delineate the context of this study’s focus.

The context and role of clinical improvisation in the therapy process varies according to the therapist’s theoretical treatment orientation. For the purposes of this study, clinical improvisation can be broadly defined as a therapeutic medium through which the therapist and client interact and relate using musical elements to spontaneously create musical forms and structures, some of which may be associated with specific idioms and styles. The previous passages are an initial portrayal of the context of this study’s focus. Clinical improvisation is a complex and involved therapeutic medium, and the analysis and findings in this study further illuminate its multiple facets.

**The Evolution of the Study: Research Questions – Then and Now**

Stemming from my clinical experiences, the current writings in music therapy, and the reasoning presented thus far, my initial research question was:

What characterizes flow experiences in clinical improvisation in music therapy?

Some sub-questions were:

What role does the therapist play in flow experiences?

What role does the client play in flow experiences?
What qualities of the music accompany flow experiences?

Are there discernible stages and parts of flow experience, and what characterizes them?

How does the substance of musical flow experiences compare and contrast to the structures and thinking systems proposed by Csikszentmihalyi?

The design of the study entailed interviews with therapists during which we listened to musical examples from their clinical work. The focus of this study shifted as I interviewed the therapists and analyzed the data. As the participants described their experience of a shift in the clinical improvisation, the study’s focus shifted from the therapists’ roles to a sole focus on the therapists’ experiences. Therefore, the central research question changed:

What are therapists’ experiences as the music flows in the clinical improvisation?

As the study progressed, the therapists’ conscious process in the musical interaction became the central focus, and the client’s role no longer remained part of the study’s focus. The musical qualities that accompany the participants’ experiences remained a related aspect of the inquiry as the therapists discussed the qualities of the music as they saw fit to flesh out their descriptions of their experiences in the musical interaction. The final sub-question can be re-stated as two separate questions:

How does the substance of the therapists’ experiences compare and contrast to current music therapy literature?
What structures and thinking systems relate to and support the findings of the study?

Csikszentmihalyi's concept of flow experiences became part of a broader scope of thinking systems that relate to and support the findings of this study.

The exploration of the flow phenomenon provided an entry point to an investigation that shifted the study into a broadly different direction. The scope of the therapists' experiences changed the direction of the study into areas of therapeutic presence, mindfulness, meditation and spiritual tenets in clinical improvisation. I found theoretical writings from various fields that became increasingly relevant to the findings. My analysis of the data, and the theoretical constructs that I brought into the study influenced one another as the study progressed. This bi-directional influence occurred as a seamless and intensive research process. The progression of chapters leads the reader through the evolution of the study. I developed the structure and shape of the report to reflect the therapists' experiences, to portray in a parallel manner their conscious processes in clinical improvisation, and to make explicit the research process from the presentation and analysis of data, to the presentation of the findings, to the development of a model, and finally to the integration of the findings into a conceptual context.
CHAPTER II
DISCUSSION OF RESEARCH METHOD

This study was designed to learn about therapists’ experiences as the music flows during musical improvisation between therapists and clients. The research method incorporated the gathering and analysis of data gleaned from therapists’ reports of their experience in clinical improvisations in music therapy sessions. The therapists’ reports included their interpretation and understanding of their experience of a discernible shift in the therapy dyad musical improvisation.

The challenge of this inquiry was in describing and delineating a phenomenon of multiple dimensions and of a complex nature. This required a method that could capture the essence of the lived and subjective nature of experiences in clinical improvisation. With this in mind, I constructed meanings from the therapists’ impressions, thoughts, feelings and perceptions of musical experiences. Naturalistic, constructivist inquiry was the basis of the method and data analysis in this study.

This approach was suitable in collecting and making sense of data gathered through qualitative interviews that included listening to recordings of musical improvisations that occurred between music therapists and their clients in music therapy sessions. During the interview process, the participant and I
listened to exemplars from music therapy improvisations with a former client in
music therapy sessions. These musical excerpts were chosen by the therapists as
their illustration of their notion of flow in their clinical work. The therapist and I
focused on salient aspects that were determined by our interaction as we listened
to the recording together. Lincoln (1990) explains that the position of
constructivist inquiry dictates that “the interactivity between researcher and
researched be recognized and utilized in the teaching and learning process
between the two…. focussing on the social processes of construction,
reconstruction, and elaboration, and must be concerned with conflict as well as
consensus” (p. 78).

The musical components and foundational elements were considered as a
means to better understand the intricacies of the music making process within the
therapy process. Lee (2000) contends that connections between music theory and
clinical intent are imperative to the understanding of music therapy improvisation.
Ruud (1998) concurs in stating that there is “the necessity of developing some
tools of interpretation for reading the interplay among musical structures, the
client’s experiences, and the therapist’s intervention” (p. 110). He further suggests
that “one possible strategy for deconstructing this triadic process would be to
postulate that the whole music therapy situation is a ‘text’” (Ruud, 1998, p.110).
The relationship between the musical aspects and the reported experiences of flow
received attention in the research process.
Finding and Selecting Participants

The participants selected for this study were music therapists who utilized musical improvisation as the primary means of therapeutic interaction between the therapist and client. I selected participants who demonstrated through personal communications, professional publications or presentations, that they could reflect upon and describe their experiences in clinical improvisations.

The participants’ music therapy experience using clinical improvisation as the primary means of therapeutic interaction ranged from six to forty years, after their master’s degree education. All of the participants had attained or were pursuing post master’s education in music therapy, including doctoral degrees in music therapy, certification in Nordoff-Robbins Music Therapy, and psychoanalytic, creative arts, and expressive arts institute training. The participant group included published authors in the field of music therapy, lecturers, instructors, clinical supervisors, and music therapists who were music performers as well music therapists. I selected five female and five male participants to balance the gender ratio, which was recommended by the Human Subjects Committee.

Collectively, the participants used piano, guitar, voice, percussion, and wind instruments in their clinical improvisations with clients. All participants were especially skilled on at least one instrument which they considered their primary instrument in clinical improvisations. This I hoped would have allowed their levels of musical improvisation skills in a clinical setting to be substantially developed through clinical experience, and that they had developed an
experienced understanding of therapeutic processes, and that they were able to
discern and describe in detail musical aspects of their work in the musical
excerpts. Lincoln and Guba (1985) propose that through this process of
“purposive sampling” the researcher “increases the scope or range of data
exposed… as well as the likelihood that the full array of multiple realities will be
uncovered” (p. 40).

Some participants’ clinical experiences were exclusively with children,
others exclusively with adults, while others worked with a broad range of age
groups. Throughout their years of clinical experience, each participant had
worked with a range of client groups with developmental, psychological,
rehabilitative, medical, geriatric, and palliative issues. Some participants were
currently working with specific client groups in medical institutions, community-
based centers, and private practice.

I had known some participants for ten years as colleagues in the music
therapy field, and others I had met over the past few years through my
interactions with music therapists in educational and supervision settings, and
doctoral coursework. My familiarity with many of the participants ranged from
having spoken to them frequently about various aspects of clinical work, to
having listened to recordings of their clinical improvisations as part of
professional presentations, to more intermittent meetings and conversations at
conferences and workshops on a number of topics.

Through my professional interactions with these participants, I had
witnessed their capacity to articulate their understanding of their work, including
both the musical and clinical aspects. In our initial conversation about this study, or through my previous professional interactions with the participants, I found that each of them valued musical improvisation as the primary therapeutic medium in their music therapy approach. I had witnessed and considered their high level of musicianship and clinical knowledge as attributes that I had hoped would allow for in-depth discussions on clinical improvisation that would include their musical and clinical perspectives. In all instances, I felt assured that these participants used their artistry as well as their clinical and musical expertise in service of their clients’ therapy process in clinical improvisation.

Potential participants were required to have access to audio or video recordings of their sessions, so that we would be able to listen to these musical excerpts during the interview. I asked them to choose clinical examples that demonstrated a shift in the clinical improvisation to when the music flowed. I purposely used the terms shift and flow in a generic sense, so that the open-ended nature of my initial inquiring statements about the study could allow for the participants’ interpretations of what flow and shift in clinical improvisation meant to them.

The clinical work in the musical examples in this study were conducted with children, adolescents and adults in an individual music therapy setting. The individual setting was chosen so as to limit the focus to one therapist and one client in the musical interaction. The therapist and I listened to recordings of musical improvisations that took place in music therapy sessions, with the understanding that “realities are wholes that cannot be understood in isolation
from their contexts” and that “the phenomenon must be studied in its full-scale influence (force) field” (Lincoln & Guba, 1985, p.39). I observed the musical interaction between therapist and client as it occurred in its natural setting through archived recordings. In this way, the therapy situation was not altered for the purpose of this research: “There is a belief that the very act of observation influences what is seen, and so the research interaction should take place with the entity-in-context for fullest understanding” (Lincoln & Guba, 1985, p.39).

**Collecting and Analyzing Data**

I met with each participant for an initial interview of approximately ninety minutes, and a subsequent interview for about an hour with five of the participants whom I needed to pursue further exploration or clarification of ideas presented in their initial interview. The number of participants and length of the interview allowed an in-depth interviewing process with sufficient time to listen to musical excerpts and to discuss aspects of the musical experience in a detailed and thorough manner.

The participant-therapists and I listened together to the musical example that they had chosen as an illustration of when the music flowed in their clinical work. During and after our listening to the examples, I asked the therapists to discuss their understanding of these experiences in clinical improvisation, as well as musical aspects including structures, forms, specific musical elements, and therapeutic considerations that were relevant. The following questions were considered and asked when appropriate to open up related areas of inquiry: What
role do you as the therapist play in these experiences? Please describe any aspects of the music that you feel are relevant in these experiences? The interview/listening sessions were audio recorded and transcribed.

Arnason (2002) and Lee (2000) suggest repeated listening of the improvisations in order to discern salient features of the music in the therapy process. In this study, I was highly attentive to the therapist’s focus on musical structures and components that he or she found relevant to their experience. If, for example, the therapist found the harmonic structure to be a salient feature in the exemplar, then a more thorough and detailed discussion of the harmonic aspect of the music ensued to see whether insights and meaning could be constructed from this type of discussion. Ferrara (1991) worked to link formal analysis and musical reference or extrinsic meaning. In his footsteps, Arnason (2002) and Lee (2000) have developed approaches to analyzing musical improvisations that include multiple layers of listening which include formal analysis of musical structures that are deemed salient. These are combined with listening and interpretation based on clinical considerations, impressions, feelings, notions and clinical processes and contexts and lead ultimately to constructing multiple levels of meaning from the music. In this study, an attempt to discover layers of meaning and interpretation garnered from musical exemplars was the method of integrating music and verbal narrative.

The therapy context was another related area of inquiry. The following questions focussed on this area: What are the salient therapeutic issues present in the therapy process? How would you characterize your stance and clinical
approach as a therapist? Please tell me about your client, and you may include any pertinent historical information. How would you describe the current therapeutic relationship and its development?

As data analysis in qualitative inquiry is an ongoing and recursive process (Ely et al., 1991), throughout the collecting and analyzing of data, I maintained an observer’s log of my meetings with the participants, including the verbatim transcripts of the interviews, I wrote analytic memos on developing ideas, impressions, interpretations and hunches, noting emerging questions and areas that need further attention. As Wolcott (1990) stresses, the writing process begins before the first data are collected and continues throughout the research process to bring new analytic insights. My observer’s log and analytic memos became data for further analysis (Bogdan & Bilken, 1998; Ely et al., 1991).

Before subsequent interview/listening sessions took place, I began to analyze the data obtained from previous interview/listening sessions. After transcribing these data, I analyzed my log, coding and developing categories, looking for patterns, relationships and beginnings of themes. In the initial phases of the data analysis, I used a computer-assisted qualitative data analysis software (CAQDAS), called N5. The program was not a method of analysis performed by the computer, rather it functioned as my data organizer.

When using this program, the researcher is at all times in command of the thinking process. The program enabled me to be more conscious of and clarify my developing questions, hunches, wonderments, and overall thinking process as I had to, in essence, inform the computer what I was thinking. While managing a
large amount of textual data, I coded the segments of data, and placed the
segments under multiple codes. The program gave me speedy access to these
coded segments that had been extracted across multiple interview transcripts, and
tracking from where they had originated. At all times, I had ready access both to
the raw data of the interviews and to the most recent levels of my analysis.

The program helped me to continually keep track of the organization of
the data that I was developing, and allowed me to keep thinking creatively and
analytically. It allowed me to build a virtual and graphic web of concepts that
remained connected to the raw data. In this way, the program allowed me to stay
immersed in the “integration of analytical and creative thinking while maintaining
organization, without one precluding the other” (Musumeci, Fidelibus, &
Nowikas-Sorel, in press). Through the organizational support of the program, I
could continually interact with the data, codes, and categories in a recursive
manner and on multiple levels, allowing flexibility in moving around the various
levels of analysis. Throughout the process, I could “move readily between a more
microscopic analytical view of words and notes, and a more macroscopic stage of
analysis --- a characteristic tenet of the qualitative research process” (Musumeci,
Fidelibus, & Nowikas-Sorel, in press).

Analytical memos were attached to the coded segments which linked my
thinking written in my own words, to the original words of the therapist-
participants. As the interviews continued, and more actively after the collection of
data, I looked for areas of congruence and difference in descriptions and
understandings of the clinical improvisation process. I compared and contrasted
these findings to the initial related literature and introduced additional theoretical frameworks that became relevant to the findings of the study.

**Trustworthiness and Confidentiality**

The confidentiality of all participants has been maintained through this study. Pseudonyms or codes were given to the participants as well as their clients as they appear in the study. Identifying information for clients and therapists has been omitted in the final document. All identifying information was left out of the data that were shown to others.

During the data analysis, I returned to the participants to conduct participant checks. Thus, these participants took an active role in maintaining the trustworthiness of the data (Ely et al., 1997). I presented to the participants for their review my developing ideas on their perspectives, both through in-person and phone conversations. Other participants were given verbatim transcripts of their interviews which they read and added comments in the margins.

A characteristic of naturalistic inquiry involves “negotiated outcomes … because inquiry outcomes depend upon the nature and quality of the interaction between the knower and the known, epitomized in negotiations about the meaning of data” (Lincoln and Guba, 1985, p.41). The participants’ insights and comments on my developing work were incorporated into the analysis process. Another activity which lent credibility to the findings of this study was spending sufficient time with the participants. Lincoln and Guba (1985) describe this as “prolonged engagement” in order to “achieve certain purposes: learning the “culture,” testing
for misinformation introduced by distortions either of the self or of the
respondents, and building trust” (p.301).

Throughout the data collecting and analyzing process, I met regularly with
a research support group, to garner multiple perspectives on the data, to question
my assumptions and unfolding ideas about the data, and to press me on the
strength of my analysis (Ely, Vinz, Downing & Anzul, 1997). In addition, this
type of “peer debriefing” worked toward “exploring aspects of the inquiry that
might otherwise remain only implicit within the inquirer’s mind” (Lincoln &
Guba, 1985, p.308).

Presentation of Findings

As I worked toward presenting the final report of this study, I remained
open to creating forms that have as their purpose “describing, shaping, and
emphasizing” meaning (Ely et al., 1997, p.59). Because this study focused on and
included the multiple dimensions of experience in clinical improvisation, I
composed and integrated musical vignettes and poetry into the text to illustrate
and bring to life aspects of the musical interaction. As I worked through the
analysis process, I discovered, invented and employed graphic representations and
forms to convey to the reader the essence and the complexity of the therapists’
clinical improvisation experiences.
Researchers's Stance – Then and Now

The initial and explicit scope and focus of this study centered on music therapists’ experiences of when the music flowed in clinical improvisations. Although the explicit focus of this study is neither exclusively on the therapists’ personal lives nor pointedly on their personal history, this study does implicitly ask participants to delve deeply into a clinical process that involves them as people. I recognize that the art of making music with another person involves its participants intimately in the creative process. My purpose here is to tell my story as the researcher as a way of being responsible and straightforward to you as the reader and to myself as the research instrument, and of lending integrity to the study’s final report. I appreciate the importance of exploring and remaining as cognizant as possible of my personal and professional tendencies and history that have influenced my thinking and perceptions along the research path. In reading this final report, the reader will indeed become well acquainted with my thinking and perceptions through my writing. As the research instrument, I must reflect on the many lenses and experiences that come together to influence and shape the research process. Ely et al. (1997) explain that

as qualitative researchers we feel obligated to inform our readers of the positions we have taken as we collect, interpret, and write up reports. If such stories of stance can be told, the reader has multiple ways of seeing and thinking about what is being researched and the researcher’s journey toward understanding. All this gives particular credence to the notion of being explicit with ourselves and with others about the stances we take as
researchers and of promising ourselves to monitor and report our stances as we best understand them throughout the gathering, the figuring, and refiguring, and on to final publication. (p. 40)

No doubt, the clinical experiences that I describe as part of the origins of the study have stimulated my thinking and my research interest. As I began this study, I was interested in Csikszentmihalyi’s thinking on experiences that he called flow. His views influenced my initial undertaking of the current study and helped me to formulate an initial focus. However, as typically happens in qualitative research, I found that other thinking systems came into play as I sat with interviewees and listened to their words and music, as I worked through the analysis process, and as I continued to work as a clinician. Some of the therapists’ words spoke directly to tenets of Eastern philosophy and aspects of meditation practice, while others resonated with these ideas.

Concomitant to and influenced by the research process, on a personal level, my interest and practice of meditation and readings in Buddhism continued to develop. The interaction between and confluence of my initial interest in Csikszentmihalyi’s ideas on flow, my stimulating and inspiring experiences with the participant-therapists, the time that I spent analyzing the data, and my personal practice of meditation came together as the ongoing process called the researcher stance. I have come to appreciate that my researcher stance is not some static and stable entity that has remained the same throughout the study. It has indeed been a process. While Csikszentmihalyi’s ideas initially spoke to some of the qualities of my own experiences in clinical improvisation, the practice of meditation, readings
in Eastern thinking and psychotherapy, and the research process expanded my perception of the participant-therapists' words and musical data.

Along the way, I was extremely wary of falling into a way of perceiving the data that might close off other perspectives. In truth, this is unavoidable, though I wholeheartedly questioned whether I would be imposing an agenda upon the research process. I was, and this is why I am writing about my stance. As I continued to work through the analysis, I was more sure that I was developing and embracing a way to utilize and integrate my developing personal and professional insights and lenses in service of the study. I felt that these developing perspectives could capture a glimpse of the vastness, complexity and richness of the therapists' experiences.

I have come to appreciate the exciting and meaningful process of integrating personal and research endeavors, which is especially inherent in a qualitative study that involves me as the research instrument. I explicitly state that my personal development and professional perspective have interacted on an ongoing basis. I grappled with this process through each and every step along the way. In speaking with my support group and others, I realized that I could only start where I was, see where it would lead, and remain cognizant of the path. Inherent in the process of creating this dissertation was the challenge of staying with what was happening in my writing and thinking process.

As I composed this final report, I found myself involved in a process of building boxes called categories, motifs, themes, and metathemes, feeling satisfied with new insights and understandings, and then working to open the
newly created boxes, unpacking them, and creating new boxes, repeating the
cycle over and over again. Whenever I read through the data or began to develop
a theme I questioned whether I was creating yet another box, and indeed I was.
But this became part of the process which then dictated that I open the boxes and
let the contents interact with all aspects of the process, including myself. In time,
my focus shifted to expand and explore aspects of the therapists’ experiences that
might have been stifled or overlooked by one way of thinking about them.

In later stages of the analysis, not surprisingly, the ideas in the literature
that I was reading concomitant to the writing of the study that were not included
in my original literature review, interacted to formulate my perceptions of the
data. This mutually interactive aspect of the process continued: the data
influenced what I was reading and thinking, and what I was reading and thinking
influenced my analysis of the data. The confluence of the therapists’ words and
music with my interpretation and findings, the writings of the initial literature
review, my personal interests and development, and recent writings on the
integration of therapeutic and Eastern practices, interacted as the process of my
researcher stance. The evolution and changes that have happened seemed
inevitable and my only obligation was to be as aware as possible along the way,
as evidenced by the reader as my writing reveals what and how I was thinking
along the way. That is how I see the story from where I am right now.
The Map of the Study

The participants spoke about and played recordings of exemplars from their clinical improvisations with individual clients that they felt illustrated when the music flowed. While in the interview setting and as I transcribed and reviewed the interview data, I began to hear in their narratives and in the music discernible features and phases of the unfolding musical and clinical process. Their highly personal and professional narratives created a rich tapestry that became a composite portrait of the therapist’s process.

From my observations and time spent with the data, I came to appreciate the multi-faceted dimensions of the therapists’ experiences during clinical improvisations. Their stories illuminated the complexity of their experiences that embodied past experiences, present phenomena, and future-oriented thinking. As we discussed and listened to the musical exemplars, they took me through their experience moment by moment in great detail and with candor and insight. I became increasingly mindful of their subtle and profound movements through the clinical improvisation experience. What became vivid to me were three discernible phases that portrayed this sense of movement. The following three chapters deliberately illustrate these three phases of the therapists’ clinical improvisation experience: Chapter III, Starting Where You Are, Chapter IV, Getting to the Point, and Chapter V, The Point.

In the first part of Starting Where You Are, I present data that explore the historical influences that the participants related in reference to the musical exemplars. In the second part of the chapter, I present data that illuminate the
tendencies of the therapists’ thinking that became apparent in their descriptions of their experience in the exemplar. The next phase of the process, Getting To The Point, emerged as a transitional one that shows the movement toward a qualitative shift in the clinical improvisation. In The Point, I present data that are meant to capture this shift to when the music flows, from the perspective of the therapists’ conscious process. I constructed these three phases as a means to capture the unfolding process of the therapists’ experiences as the clinical improvisation moves toward and into when the music flows. The temporal construct is but an analytical device used to slow down the process in order to see what is happening for the therapists in each of these constructed phases, as if in slow motion, moving moment to moment in the musical experience. I am aware that by constructing three discrete and concrete temporal boxes, I am distorting the complex, holistic and multi-layered phenomenon whose discernible parts are not so readily discernible, and ultimately interwoven. Yet the choice became a necessary, and hopefully, a helpful one in viewing the phenomenon.

In Chapter VI, Playing On Being, I develop themes from the motifs, or theme components, from the previous three chapters. In Chapter VII, Mindfulness in Clinical Improvisation, the metathemes developed in this study are discussed and presented as a model that is displayed in a diagram figure. The metathematic ideas raise the thematic material to a conceptual level that illustrates the process of therapists’ conscious minds in clinical improvisation. In Chapter VIII, Elaborating and Linking, I explore the implications of the model in clinical and theoretical contexts, and relate the model to writings in music therapy and
creative arts fields. Implications for educating music therapists are considered in light of the ideas presented in the model. Looking Toward Future Research concludes the study with my reflections on the research process and suggestions for future research.

The brief road map I have described was created to give the reader a notion of how the study proceeds. However, the reader’s and the therapists’ movement toward The Point begins with Starting Where You Are.
CHAPTER III
STARTING WHERE YOU ARE

Starting where I am
Such a simple phrase it is.
Yet I find myself right and left
And forward and back.
And being right here and right now
Eludes me.

When I find I am where I am,
Then here and there and forward and back
Elude me.
Now I am here with me
Now I am here with you
Starting where I am.

When asked to talk about the musical exemplar, the participants offered narratives of past experiences that they apparently understood as relevant to this experience in clinical improvisation. As experienced music therapists in the clinical improvisation with the client, personal and professional musical histories
were somehow related to their conscious experience. In an obvious way, the therapists’ personal musical experiences were part of their identity as musicians and music therapists, and essentially: what they brought into the room. Aspects of these background experiences had the potential to qualitatively affect and inform the therapists’ present experience in clinical improvisations. The therapists’ narratives portrayed the personal and professional influences present as well as the context in which clinical improvisations occurred.

The Therapist’s Life with Music

The narratives that follow, created from the therapists’ words, illustrate their thinking and feelings about early musical education, their relationship with their primary instruments, musical knowledge and histories, their sense of their own proficiency and musicianship, and past musical experiences. The therapists brought to the clinical improvisations a rich history that influenced their relationship and playing with the client. The events, thoughts and feelings came forth readily from the therapists as they spoke of their personal histories in music and how these related to their experiences in clinical improvisation. The motifs or theme components are presented in italics before the narratives, to capture and highlight the essence of the therapists’ words as I heard them.
Living with an Instrument

From early on in my life, I have worked hard to acquire technical proficiency on my primary instrument and to learn about music, giving me a sense of freedom and mastery.

Ogden describes his early training experiences that influence his musicianship and present day passion in music:

I started playing piano at five years old and I am very trained and it’s been part of me since I was a little child. My fingers are flexible. Just clearly on that piano track, through to the degree in performance. I spent many years and hours practicing and learning theory and ear training and sight reading and sight singing and analyzing big orchestral scores and knowing repertoire, knowing the world of music pretty well, being at a level of proficiency that I can play pretty much anything that I want to. So that if I can play at that level, then I can be playful on the piano. I can just play and let my fingers go where they want. Technically I can move my fingers the way they want to be moved. I can go and do whatever I want with them and I can play what I hear as I think of it.

When involved in clinical improvisation, Ogden clearly valued and relied upon his early training from a young age. His intensive training in many aspects of music gave him confidence in the technical aspects of understanding and playing music. Countless hours of practice and rigorous training in listening skills, writing skills, learning piano repertoire, and technical playing skills were
well honed to where he could trust the knowledge and skills in his clinical work. He emphasized the importance of training outside of the therapy situation and how this allowed him to play, meaning he had the freedom to be playful and let his musical imagination and emotional life take flight in the clinical improvisation. In this way, mastery and freedom became a vital and interrelated pair in his view of clinical improvisation.

*I have an intimate relationship with my primary instrument that has deep roots connecting to early and passionate musical experiences.*

Related to early training is Florence’s initial choice of instruments. In the following narrative, she relates the beginning of a lifelong passion for her primary instrument:

I will gladly tell anybody that my interest in drumming really comes from my interest in congas. Had I heard Djembe drumming as a child, I would not be a drummer, I might have been a dancer. It was the conga sound that I remember over and over again. I just remember the melodies, the patterns of the rhythms of the drums echoing out, sounding like music. That sounded like music to me as much as any singing or guitar playing or piano playing. I was always attracted to it and didn’t think that I’d ever get to play it until I was grown. I was in my mid-twenties before I even touched one, because I didn’t really have any nerve. It was a man’s instrument. No woman that I ever knew was even remotely interested in drumming. I was never attracted to a trap set. I was an anomaly because
most female percussionists play traps. My whole world is congas. I couldn’t care less about the trap set. I enjoy it now and then. It was so much banging for me. You know there are those people who need all four limbs engaged in order to survive. That was never me, never that rhythm crazy. I liked the melodic aspect of it. I guess I was somewhere between being someone who plays a melodic instrument and a percussionist. For me, there’s nothing more. Rhythm is primary, it’s a very primal thing.

In the preceding narrative, Florence passionately told the story of how she came to play her primary instrument. Her initial attraction to the conga drums and especially its melodic capabilities, which started at a young age, was still vital and evident to me as she told her story. She attributed her interest in the conga to her interest in music. Her initial listening experiences on hearing this instrument were her entrée into music. While she always had had a deep interest in percussion and rhythm, this particular instrument still held special meaning to her in how she heard and appreciated its vocal-like qualities. Although it had been an instrument not conventionally played by women, her passion for its sound remained the motivation for learning how to play the instrument and for breaking a gender barrier in her early adult years. Her deep connection traced back to her childhood when the instrument’s sounds had had a visceral and emotional impact on her. These profound experiences still seemed very much alive for her in clinical improvisations.
Past Experiences, Continuing Influences

I have had significant experiences in music with which I strongly identify and that have deeply affected me and subsequent musical preferences.

In the following narratives, Grace and Oliver relate two events that continue to influence them in clinical improvisations. In the first vignette, Grace finds herself unaware of her physical body. Her total immersion in the music is so complete that she is left with just the sensorial memory:

There was an experience that happened to me in college when I was playing a very complicated piece, I think it was a Chopin ballade. I remember the feeling. It was exceptional. I couldn’t tell anybody. As I was playing, there was no time, no space. I only heard the music. I was in like a fog. And that’s it. That’s where I was while I was continuing to play the piece. It stays with me. When I came to the seventh chord before the coda, I remember I was aware of having this experience. It was very profound.

Oliver recounts a related experience as a client in a music therapy group. While he has no memory of the specific music played, he recalls being keenly aware of his connection to the person with whom he played a piano four-hands improvisation. He characterizes the experience as “beyond being musical.” His intense musical experience remains a powerful memory, and one that he wishes he could re-visit through hearing the music again. He seems still intrigued and captivated by the event:
I had another experience that happened in a music therapy group. I don’t remember quite well what was going on musically. I would love to hear it again. I wasn’t in a trance, I was aware of the person sitting next to me, and of us playing and being deeply connected. It was a very special experience, one that goes beyond being musical.

In the following narrative, Nicholas associates a musical experience with his coming out process as a gay man. He is so emotionally affected by the aesthetic quality of a piece of music that he attributes this listening experience to his entrance into the world of music. Through this musical experience he discovers not only his identity as a musician but as a gay man as well. He finds that to this day he remains involved in this type of music as a performer. For him, this type of music continues to be strongly associated with a positive, transitional and pivotal musical event that involved the discovery and integration of two significant self-identities in his life:

I am remembering a very important music listening experience in my life. It was the summertime, and I heard this wonderful anthem that made me bawl because it was so beautiful. I’ll probably never go back to that place and hear that anthem in the same way because it will never be the same summer that I discovered that I was gay and came out. That experience opened me up to a musical world that I am in and still very happy to be in. It’s the kind of music that I ended up performing a lot.
I remember vividly music playing experiences in which my thinking attached to a single aspect of the music and interfered with my ability to continue to play music fluidly.

In the following narrative, Sofia recalls a moment during a recital when her focus and immersion in the music was hampered by what she refers to as “evil thoughts.” These intrusive thoughts interfered with her fluid playing of the music. Her thinking halted on a single aspect of the music. She attributes her lapse of concentration to the thinking of these thoughts. This experience remains a vivid memory for her today:

When I was young and performed recitals in school, I would have what I called evil thoughts, meaning that while I was playing, I would think about what I was about to play. All of a sudden, in my head, I would think: “what is the next bass note?” That’s it, I was lost. I don’t ever think about the key I play in. Probably nobody should, because it is such an unwelcome kind of thinking. It took me out of the music completely and stopped the fluid movement. I remember that well.

Locating Oneself in Music

Whether I am able to move forward or get stuck in improvisations depends on my relationship to the music and to myself, and how well I know the musical structure.
How well therapists understand and internalize the structures of music becomes an essential ingredient in their clinical improvisations. Jennifer explains this point:

It all depends on my relationship with something, whether it’s a song or my instrument. If I am familiar with something and know it inside and out, and if it fits like a glove, then there are two possibilities of how it can go. One possibility is stagnation: if it’s a dull thing, if my experience of it is dull, or I’m dulled myself, then there’s a lot of friction and it’s not such a smooth process; another possibility is that I can use it, develop it, and have it to come back to. With some songs, I’ll play the verse then improvise in between. It can be easy because I know them so well. I know where to start and where to come back to when I know the implied or latent structure of something. Sometimes I become stagnant and stuck and at other times I can improvise easily.

Jennifer found that at any moment in an improvisation, she could meet a clear bifurcation or a crossroads in the musical process. Which way she would go was dictated by her experience of the music itself or how well she knew the structure of the music. When she was familiar with the music she found that she could readily improvise within it. She accounted for this ease by knowing where she was at all times in the music’s structure. Being sure of her orientation in the music provided her the confidence to improvise freely. When she sensed her relationship with the music was itself lifeless, for whatever reasons, she found that
she became stagnant in the clinical improvisation. Similarly, if she found that her relationship with herself was dulled for whatever reasons, she felt that she would get stuck in the clinical improvisation.

*In making music with the client, I perceive the wholeness of music rather than the musical components in isolation.*

The movement of music can be experienced as coherent and seamless when Frederic is making music with the client. He finds that when thinking about the music, he understands his orientation in the music on a greater structural level, but when involved in playing, he experiences the wholeness of the music rather than perceiving the components of the music as isolated from one another:

I can think of the music in sections but the music itself remains as one whole entity when I’m playing with a client. There is a natural movement to music so that I can’t break up the notes. I’m not focussing on each individual note or drum beat.

**Tools of the Trade**

From their interviews and my analysis session, I learned that the therapists enter into clinical improvisation with years of musical experience. Their experiences create a body of knowledge upon which they rely in the process of music-making with the client. They understand where their focus can and cannot be as they play.
My focus and skills are interdependent: when my focus is pure and balanced, my skills are available to me in the moment.

The quality of Simon’s focus and how this relates to his capacity to retrieve and utilize musical resources is explained in this way:

There are times when many options are absolutely available to me. Not just sitting on a shelf, but all livingly there. I think as I work, a part of me is balancing one option with another, and yet, trying to be prepared to listen and wait. My focus seems kind of pure when my skills are available to me in the moment, especially when I am able to find a balance and move between my voice and piano. When I am improvising, I never really think about what I do technically.

Simon brought together two aspects of his experiences in clinical improvisation: his focus and the availability of his piano and vocal skills. He had the sense that his focus was absolute and balanced as his musical skills were accessible to him and readily applied in the living moment of the improvisation. There was an interrelated aspect to what he was saying: when his focus was pure and balanced, he had access to his skills; as well, when he had access to his skills, his focus was pure and balanced. The two aspects of his experience were interdependent. He found that he tended not to think about the technical aspects of his playing and singing during the clinical improvisations. There was a second nature aspect to his skills that allowed him to balance them, have access to them, and to keep his focus on other aspects of the clinical improvisation.
The limitations that I perceive I have in music become irrelevant when I can engage my sense of aesthetics and musicianship.

At times, the therapists can perceive limitations in their skills. Nora relates her experience of her skills that influence her in clinical improvisation:

My limitation is that I am classical, I’m not a jazz person. Sometimes I wish I could be more of a jazz person but that’s not who I am. But yet, I can imitate it well and I can feel the rhythms. I am not a jazz person because of my chord structures and my touch. That can be a drawback or limitation aesthetically, but not really, because it doesn’t ultimately matter. As long as I can get into those rhythms and play and get into the feel of that, then I don’t need to be a great jazz pianist.

Nora came to the conclusion that her apparent limitation in not being a jazz pianist became irrelevant as she realized that her aesthetic musical sense and her identity as a musician could compensate and come into play in the moment. Her initially perceived limitation transformed as she appreciated what qualities in music she did possess that were beyond the actual style of music. Her classical training had developed her musical sensibilities and technical proficiency, allowing her to play as close to another style as possible in the clinical improvisation. As she realized this, her attitude toward herself softened and her perspective of herself as a musician broadened.
Music as Second Nature

If I can know and feel music instinctively then I don’t need to think about music, giving me the capacity to effect change in my client.

Related to the participants’ previous narratives, Grace adds another dimension to the musical thinking process that relies upon knowing and understanding musical structures and learned resources:

You need to be a musician, you need to feel music, you need to not think about music. It’s not about the music at all. Although it is about the music because you have to be so flexible musically to be able to not think about the music. You have to know your music really well, whatever your thing is. You have to know your references of things that you can call upon, so you don’t have to think or ask, “what’s that chord?”

There’s no room in this equation for thinking. You need to be able to instinctively feel music. You have to have a good ear. You have to be able to match chordal structures. You have to hear and know what to play with it. You have to have a good ear. That’s where you have to know your stuff. That’s why you have to know your music! You’ve got to know the map! You have to know the map! And to really do the work on the kind of level I am talking about, you have to be a real musician, otherwise you can’t get to the depth of the place that I am talking about for change in the other person.
In her narrative, Grace highlighted that in clinical improvisations she could instinctively feel music without getting involved in thinking about the music. At an advanced level, musicianship and musical knowledge were internalized and characterized by her not having to think about the music on a technical level, but rather she felt and played in the emotionality of the music. She attributed her capacity to effect change in her clients to her capacity to play instinctively without engaging in thinking about music. She got involved in the music rather than thinking about the music. She directly experienced the music without the intervention of her thinking mind. While playing music in clinical improvisations, she found that there was no psychic space available for thinking about the music, rather the mind was immediately involved in the experience of the music and not stepping outside of the music. The capacity to play music instinctively called upon skills that could be likened to knowing a language.

*Mastering the tools of music allows me to communicate fluently and to be through the primordial and underlying language of creation.*

The following narrative relates Florence’s perspective on the influential aspect of musical knowledge:

Your music has to be part of you, like talking. You have to be so comfortable with music as a language, like how you talk in your native language. As I’m speaking, do I think: “now I am going to say this word?” That’s how you have to feel about music. It’s a language that you have to know fluently. And if you don’t know it fluently, you can’t speak it. So
any music therapist who is going to really do a good job has to be a musician at their core. There’s no room for figuring out. You can’t. It is a language. There’s a story that I recently read and it’s all about God communicating with his creations, and he makes them sing. Each only knew the part of God’s mind from which he had come. They could sing that part but as they listened to each other, eventually grew this great cosmic music. It goes on and I think this is what I mean when I say, that in music we have part of the still living creative process that underlies everything, in our language, our life, our desire. It hits every part of us. It could be sublime. It can be obscene almost. It can be on all these levels because it echoes the inner language of creation through which the creative beings themselves learn to communicate. What we have is the expression that underlies our way of being. So when people say these wonderful things about music, they are touching on these ideas. And when you get a client who can’t enter this world and a therapist with his magnificent music, they can both meet in this language. And they both can manifest their being in music, and both can feel it.

Florence expressed her profound consideration of music as the language of creation. Similar to Grace’s perspective, she believed that being fluent in this language of music opened opportunity to communicate and be with the client. The creative potential that was available to her through her fluency in the music touched on every aspect of being human, of being in a human to human
encounter, even with those clients who are closed off due to their condition. She underscored the primordial nature of music that is inherent in all creative beings. Having such a profound perspective influenced her in musical improvisations. Her intense beliefs were inherently integrated into her playing, and fostered her capacity to be present in the music in the clinical improvisation.

**Tendencies in Thinking and Playing**

The tendencies of the therapists’ thinking became a salient aspect of their descriptions of clinical improvisation. The therapists’ thinking could move in myriad directions. An array of thoughts were possible at any given moment. The therapists thought and had feelings about the client, themselves as therapists, the dyad relationship, musical considerations, past experiences, and anticipations about the future. There was a complex constellation of thinking and feeling processes that occurred for the therapists and informed their playing. The therapists appreciated that thinking and feeling were natural and necessary functions of the mind and an integral part of their work in music therapy. As the participants described how and what they were thinking during clinical improvisation, what began to emerge were the evidence of impediments to their capacity to be fully present in the clinical improvisation. The interplay and relationship between thinking, feeling, playing and being present in a clinical improvisation emerged as an area that seemed to hold some gravity. The participants’ following reflections shed light on the nature of their thinking as well as the content of their thoughts.
Ogden states outright that his mind has natural tendencies. The mind has the capacity to take an experience, manipulate and work with it in order to make sense of it. He introduces the following succinct point in order to illustrate this tendency of mind and its role in clinical improvisation:

The mind naturally
breaks things up
organizes
evaluates
judges.

The following excerpts of therapists’ words illustrate a myriad of thinking processes that can occur during musical improvisations. They recounted that they think of implicit and explicit agendas, the music, the client, the therapy relationship, and their identities as musicians, therapists, and people. Their musical inclinations, history and skills, are part of a matrix of thoughts.

*I find that I control and judge.*

Sofia finds that she can become involved in thinking that pulls her out of the moment and sets up a struggle in her mind --- a tension between what is happening, how and what the client is playing, and her thinking about what is happening in the form of judgements and wishes:

The minute you start to say:

that shouldn’t be happening

this is okay
that’s not okay,
you’re not in the moment
You’re trying to control when you say:
I want it to be this way
and not that way.
You can’t do that.
In the water
you can’t say:
I can get to the shore
if only the tide would go the way I want it to go.
You can’t do it.

\[I\text{ fantasize about how the musical interaction will unfold which separates me from the present moment with the client.}\]

By fantasizing about what she expects might or would like to have happen, Grace realizes that thinking in this way creates a disconnect that separates her from the present moment with the client:

If you only try to go for the result
you very often can’t achieve it
because you’re not really in touch with the moment.
You’re more in touch with your fantasy
of what you wish would happen.
Which goes back to ego
you’re fantasizing about the result

and that’s your goal.

*I analyze, formulate strategies, and ask questions about the therapy process.*

Nora tends to think of solutions to questions, to find the kind of music to play, and to imagine or wonder about the client’s response. She may think about re-capturing a previous experience or how to move into new musical territory:

*In the beginning of the session*

*I felt I was tentatively trying to figure out how I can help him.*

*There’s something about the music I feel like I am searching.*

*I just realized that.*

*I think for a while I was searching:*  
*what’s the best music for him?*  
*where can I go?*  
*what can I see about him?*  
*what can I figure out about him?*  
*will he respond if I make it softer?*  
*can we go somewhere else?*

*There was something previously in the music*
I don’t hear now.

Something

we were living in.

*I create possible scenarios and make assumptions and formulate* 

*expectations about the client’s response.*

Oliver imagines how the client will fit into the music that he is playing. He finds that the music he is playing is what he is accustomed to playing:

I was used to playing pleasant music

thinking that I would create this sort of bed of music

that now he could add these nice metallophone tones on top

that we would make this incredible music.

That had no effect.

In the beginning you hear me play beautiful music.

He was dropping the bars and not playing

with no relationship to what I was doing.

I was setting up this pretty music

for him to add the lovely ethereal tones.

I wanted him to play “ding”

Isn’t that lovely?

But

he didn’t want to be a part of it.
I set goals and agendas.

Through her experience with the client, Jennifer realizes that she has developed a plan that she wishes to fulfill in the clinical improvisation. She expects and hopes what and when will happen in the clinical improvisation:

And I realized at that point

before I picked up the flute

that I had an agenda:

I wanted to break through her block!

That was my agenda.

I find myself lulled into playing in an habitual and unrelated way with the client.

The therapists' thinking can follow trails to any number of places that are not related to what is happening in the moment with the client. As an example, Frederic's musical tendencies come into play as he is drawn into insular and isolated playing:

When I'm improvising with a client in a session

I can find myself on automatic pilot

And not related to him in the moment in the music.

I think specifically about how I expect the client to respond and then make musical choices based on these assumptions.
Florence keeps in mind an immediate objective for the client in the musical interaction. She finds that she makes assumptions about the client and how he is thinking. She reacts musically based on these thoughts:

For a full five minutes
I am trying to do something
he is sitting without any movement or response or anything.
This guy isn’t responding
except when he shakes my hand
responding to physical touch.
It’s not necessarily what I’m aiming for.
I play an accelerando
and repeat the same pauses between phrases.
It’s not very resolved,
it’s supposed to be tonic.
but I cannot play tonic,
I want him to do more.
He started to open and I play the vi chord,
then he was puzzled.
What I didn’t know about him
was his inclination to make a beautiful cadence,
to have the last word.
My idea of continuation and openness
is not necessarily his way of musical thinking.
I hold on with certainty to specific ideas about a clinical direction for the client.

Simon speaks with conviction as he states the needs of the client. He formulates a clear goal that sets out a direction and rationale for his actions in the clinical improvisation:

What I felt he needed was to be in participation with me through a physical process of doing something a musical expression. I didn’t care which instrument it was.

He needed to use his hand that was a clinical goal. He needed to have some sort of external expression that was meaningful and communicative. Those were his clinical goals.

I have learned to utilize theoretical thinking systems to understand and enter into the client’s reality.

Nicholas looks to better understand the client’s personality, pathology and neurology, informing how he approaches the client in the clinical improvisation. He has acquired this knowledge through the study of psychological theory and music therapy. His thinking reflects his view of the client as unique in the context
of an environment that affects the client. He uses these conceptualizations in order to better enter into the client’s relational world:

There exists a personality, defensive system, no matter how young a child, an already structured defensive system, a neurology that has been developed since birth in response to the outside environment, the limbic system, the neurological stuff that goes into reaction to trauma, and how kids’ brains work in reaction to the outside world, re-integrating sensory stuff, re-patterning neurology. It’s not just about connecting with the music and playing. It’s about entering into a defensive system that has been formed from an early time. Everybody forms defenses according to your disposition, your parents, to what you learn from your environment. You form your way of defending yourself in the world, and an autistic or developmentally delayed child has a much more extreme defensive system.

I’ve studied a lot of psychology, heard great lectures and read great books, so I had the opportunity to really study and interact with a lot of people in the field. This all added to my knowledge of psychology because you really have to know defensive structures of people. You don’t have to know the exact theorist, you just have to know that the basics of knowing people have defensive structures and how personalities are formed.

Everyone has a different fingerprint and what you have to do when you are working with somebody is to see their print, their person-hood
print, and get into it, and be willing to enter into their energy spheres and
know how they work. That’s really what it’s about.

*To inform my interactions with the client, I use a theoretical construct and create a narrative to make meaning of the dynamics of the therapy relationship.*

Grace works to better understand and create meaningful and useful ideas about the clinical encounter and her approach to working with the client. She creates a rationale for the client’s feelings and behaviors as well as her own potent feelings and reactions to the client in the clinical improvisation:

She had a kind of narcissistic defense. She wanted help but at the same
time it was as if she were saying or thinking, “I’m together, I’m perfect,
everything is great.” Often she played the role of the caretaker and would ask me, “How are you doing, how are you feeling?” Her verbal personality is cliché as is her piano playing which to me is kind of a hiding, a defense.

What I’m trying to do in the improv is get past the mask. Somehow our relationship must mirror power struggles, perhaps with her own mother. Occasionally she would get mad at me and say, you don’t advise me enough, and don’t give me enough. I think one time she stomped her foot and said, you’re not there for me! It was confusing for me, because when I was there, she runs away, and when I’m not there, she wants me. I think when she pushed her mother away, her mother got depressed, and then she felt guilty and wanted to take care of her. So I let her push me
away, but I didn’t get depressed or go away. She needed the ‘mother’s presence’ in a way that was non-intrusive.

I just wanted to say, stop being so compliant! I’m trying to mess it up a bit. I was getting very frustrated. It’s frustrating because I want to know who this person is. This was a patient that was so much like myself. I think that I had such definite countertransference stuff with her. I think when she pushed her mother away, her mother got depressed, and then she felt guilty and wanted to take care of her. So I let her push me away, but I didn’t leave and I didn’t get depressed. This is a developmental stage that she was waiting to finish, I guess.

*I assess the client and formulate ideas about the client’s presenting issues.*

Essential to the therapy process, Nicholas gathers information based on his interactions with the client, his observations, and reports from parents and professionals related to the client. He begins to formulate hypotheses and questions around the status of the client and how to proceed with the treatment process:

The most striking thing was that when he started he was kind of dazed and confused and flat and didn’t have a whole lot of connection with himself or with anybody else. He wasn’t in touch with his feelings. He was not fully in himself. His mom talked about him learning to walk, but he was walking into walls. There was nothing wrong with his sight, but he was not apparently grounded in his body. I don’t know what his perception
would have to be to walk into walls. He used to focus on something that
was above us. We wondered if he were seeing something. It’s almost as if
he were in touch with the non-physical reality, he still wasn’t in the
physical. This is quite speculative. But what he was actually manifesting
in the physical was very impaired, not being able to connect with anybody
or with himself.

*I hold in mind the history of the clinical process.*

Jennifer organizes her thinking in such a way as to create a narrative of the
process that is supported by specific details of the musical interactions. Her
current conception of the process can be organized into sequential stages, steps or
phases. Within the context of the narrative, she understands and evaluates
particular aspects and events of the past experiences as to their significance:

He initially would not play at all, he was either resistant to or had no
concept of actually doing something physical to produce sound or to
connect with people. Later on, when he began to do it, he began to do
short intervals that were discontinuous usually without seeming like he
had achieved any completion. It was just discontinued. He never really got
the idea of the basic beat, which is the basis for momentum that is inherent
in this underlying rhythm.

There’s a developmental process as well, how one step seemed to
build on the next. He came into therapy not being able to sleep well at all.
The first significant thing that he did in music was to fall asleep. That was
an amazing thing because he was doing something that he couldn’t
typically do which was to relax. He did sleep, but very fitfully, and
couldn’t settle down to take naps, atypical for a 2 ½ year old boy. The first
thing he did was sleep. There was something about the musical
environment that he responded to that enabled him to let go of some of
that internal tension. Sleeping is a letting go experience.

The next thing he was able to do was to run his hands along some
chimes which was the first thing he really played just using his hands.
Then, I did this jumping thing with him to get his body activated, because
he was not really focusing with his body. He was walking around and
doing certain things. We could give him small instruments but he would
not hold them, he would just let them go, or he would hold them briefly
and toss them away, he would not use them. What was interesting about
him was, you say you can let yourself let go, but we couldn’t do that for
him. He couldn’t really accept hand over hand. So, I tried to put a stick in
his hand try to help him move, first of all he wouldn’t take the stick and
second he would pull away his hand. He wouldn’t allow any real help. We
had to find ways to help him want to do that on his own.

_I attempt to understand the client, the client’s condition and status within
a social context._

Grace views the client as part of a social structure and formulates opinions
about the treatment of clients within the structures of culture and the institution.
She has strong feelings and is passionate in her perception of the client’s situation in society, questioning how a particular client group is treated in institutions. She looks to enact change in the institution based on her beliefs:

I have my own way of thinking about this society, culture, and how people who are older are disrespected and how terrible it is. There should be a whole change in the culture in terms of age. You know that whole thing. But then to see this is just really sad. And how nobody has done a program nationwide in terms of spiritual aging and transitioning. It’s so stupid and it just doesn’t make sense to me. Why are these people exposed to meaningless activities? Because it makes the staff feel better that they are doing something. Why do they have to be doing something? They should be having massages, they should be relaxing, they should be taught how to let go, or have faith, or have some kind of music day. Make them comfortable and happy. So, I talked to them about that.

My emotions in the clinical improvisation influence me to react musically as a coping strategy.

Sofia’s reactions influence her clinical and musical choices in her playing. In this instance she is feeling anxious, vulnerable, and unsure of herself. In reaction to her feelings, she finds that she moves the music into familiar and known territory as a place of refuge and safety. Though she ultimately finds herself immobilized and evaluates her music as uninteresting. She thinks of how
she would like to change her usual way of playing. Her emotional reactions have a powerful influence on her musical interaction with the client:

Sometimes I am feeling vulnerable during these moments, and subconsciously sometimes I want to protect myself and come to some stop in the music, to take a deep breath, and make the music finish or stop. I knew when I was stuck, the music I improvised was not interesting, the music reflected the state of my being: I was unsure of what I was doing. What I would like to do is create more musical space and then present some melody. I usually come up with the melody very fast. I’m very melody oriented: melody creates phrases, and leads to tension and resolution. Probably it’s the way that I could survive in these anxious moments in the beginning.

_I value my personal development as essential to the efficacy of my clinical work._

Florence considers her capacity to work on personal issues as well as how she feels about her own growth essential aspects of her clinical work. Her self-image, identity, and how she thinks and feels about personal experiences that have contributed to her development are engaged and integral to her clinical work. In clinical improvisations, she thinks of her unique musical ideas and creative process as part of the greater context of her life:

_I think the work I am doing now, the changes I make with people are stronger because I’m stronger. The stronger I get as a person, the better I_
am at the work. That I’ve learned on a personal level. Because if my self is more solid then I’m able to give that much more strength out. You’ve got to be grounded. You get stronger in your own work the more you do it. You don’t have to follow my music or my chords or follow a certain chord progression, because it’s not about that, it’s about developing yourself, and your own potential. And everything is your own to create in your own way.

Reflections on Starting Where You Are

Starting Where You Are begins to tap the rich font of influences of past experiences as well as the tendencies of the therapists’ minds that were essentially the starting point for them in clinical improvisations. The participants reported that past passionate and musical experiences were continuing influences in clinical improvisations. Their education, musicianship, instinctive knowledge and fluency in music became the foundation upon which they drew. The participants’ narratives tell the diverse yet related stories of their early experiences and education in music. These stories led me to think about how therapists’ experiences and perspectives were relevant in clinical improvisations.

It seemed that their relationship to a primary instrument played a key role in musical development, current musical experiences, and the level of competence attained. They suggested that musical knowledge, the internalization of musical resources, and self-knowledge are interrelated and key influences in clinical improvisation. The emotional state of the therapists seemed to influence fluency,
creativity, and orientation within the ongoing musical form and structure of improvisations. Developing and having access to higher levels of ability on an instrument seemed to have contributed to a sense of freedom and flexibility in musical improvisation.

The acquired musical mastery and subsequent freedom appeared to help create a musical environment in which change was possible for the client. The therapists’ rigorous education in hearing, understanding and manipulating musical structures seemed to have brought them to a point where thinking and doing became instinctive. Their words suggested that acquiring a level of fluency and comfort in playing and hearing music was comparable to speaking and hearing one’s own native language.

Music was considered the underlying language of creation that is inherent in all human beings. This language created a world into which both client and therapist entered and communicated with one another. The therapists could not be preoccupied with thinking about the technical aspects of playing or music, otherwise fluency and immersion in the music were impeded. Perceived incompetence in musical styles that were not part of the therapists’ early musical training were possibly surmounted by engaging an aesthetic sense of the style. Salient musical experiences remained integral to their personal, musical and professional development. That they recalled these personally relevant music experiences readily and with emotional intensity impressed on me the potentially prominent influence that these experiences could have on them in clinical improvisation.
Past experiences and ways of thinking in the clinical improvisation
impinged upon the present experiences to varying degrees, at times inhibiting the
therapists and at times enhancing the musical process. They had the capacity to
think and feel in ways that brought structure, coherence, and meaning, as well as
distraction, distortion and encumbrances to the clinical improvisation process:

dividing
synthesizing
evaluating
organizing
judging
controlling
fantasizing
analyzing
strategizing
questioning
assuming
expecting
planning
habituating
reacting
predicting
theorizing
intuiting
The participants related their diverse ways of thinking about the client, the therapy relationship and process. The array of tendencies and influences, by no means exhaustive, created an ample portrayal of a potentially double-edged nature of the therapists’ thinking. When in clinical improvisation, many of the therapists’ tendencies impinged upon their ability to be fully present in the moment with the client. As they reflected upon this phase of their experience, they realized the potential impediments inherent in their thinking process. Out of the data of Starting Where You Are emerged the intricate and complex array of directions and possibilities of the therapists’ thinking at any given moment in the clinical improvisation. Table 1 encapsulates key aspects of the therapists’ experiences as stated in the theme components in Starting Where You Are.
Table 1

*Starting where you are*

- Being influenced by past musical experiences
- Relating to music and primary instrument
- Knowing and feeling music instinctively
- Applying musical resources
- Thinking in a multitude of directions and dimensions
- Being in patterns of musical reacting and relating
- Exploring, searching and questioning musically
- Being distracted from musical involvement by thinking and emotional tendencies
CHAPTER IV
GETTING TO THE POINT

The closer I get to where I am
The closer I am to the point
Of it all.

Getting To The Point presents the participants’ reflections on a critical facet in clinical improvisation as it relates to when the music flows --- a phase in the process that comes just before their qualitative shift in the musical interaction:

There’s a critical point and knowing that point is the work, the rest of it is not the work to me. That’s like over, it’s over, you don’t have to do anything anymore, you just have to be and be in the music. The initial work is getting to this point.

Understanding Silence

Before music there is silence. After music there is silence. Within music, there are silences. In these silences the therapists seemed to know in some way that something was happening, and that what was happening was important to look at, stay with, attend to, and to regard. In clinical improvisations, the
therapists were aware that neither the relationship with the client nor the therapeutic process began or ended in the music. They had a sense that what had happened before the clinical improvisation began, and that what was happening in the silences, affected and played into the musical interaction between them and their clients.

*There is a spiritual dimension and non-rational aspect to the silence which entails an alignment with the client on multiple levels and is full of musical possibility that will get expressed in the music.*

As Frederic explains, he essentially listens and attends to what is happening in the silence, and from that way of being in the client’s presence, finds musical choices and inspiration that he feels align him with the client:

I’ve been thinking about what happens in the silences, meaning when there is no music, in the moments before I know what music I am going to give to the silence. I have to feel aligned with the client on so many different levels and if I’m aligned on many different levels at the same time, then that’s when it gets clearer on what I will play as the auditory expression of the silence that is between me and the client. It’s like when you have a jar filled with nickels, dimes, pennies, quarters, and you put a coin in the top and it slides into the slot: the nickel goes in the nickel slot, and the dime goes in the dime slot, and you have to put the coin in that is going to go in every slot. So, I choose the sounds or the combination of
sounds, or the chord or the melody or the voice or whatever that aligns with what is happening in the silence.

So the initial work is getting to the point of really knowing and respecting the silence. The silence is very pregnant with ‘what is’ and full of potential for ‘what will be.’ Music is the expression of this potent silence. The silence can last a split-second or minutes. The point is that there is something happening in the silence that will get expressed in the music. The silence means something on a deeply spiritual level. The studying, the learning and the work before the music is to get in touch with what is in the silence. When I am in this place and begin to play music with the client, I am in a confident mood of expectation and anticipation that is not rigid.

Frederic understood the silence as holding the potential of what the music was about to express. All of the learning and thinking that he had done prior to the music-making was contained in that silence. He highlighted the importance of being “respectful” and of “knowing” the silence. When he allowed himself to do this, he found himself confident in the expectation and anticipation of what was about to happen in the music. He found that he was not holding on rigidly as he began to get a sense of the imminent clinical improvisation. The moments of silence were “pregnant” with the possibilities that grew out of these moments. This kind of mindset seemed to open up Frederic’s thinking, allowing him to intuit what was about to happen in the clinical improvisation.
Frederic placed this silence in a spiritual dimension. He saw that this kind of phenomenon could not be understood solely through physical or psychological rationales. As he alluded to its meaning and importance in this way, he expanded his thinking to include those aspects of the therapy process that cannot be practically explained.

Frederic captured his ideas about what was happening in the silence through the use of metaphor. The metaphor portrayed his thinking about what it felt like to be aligned with the client, comparing how he aligned himself with a client to how several types of coins need to fit into the exact size of a slot in order to make their way into a jar or bank. He brought his attention to the silence, who was in the silence, and how he and the client were in the silence together. In this way he suggested an awareness of many different ways of thinking about being with the client. What happened in the silence spoke to the intangible aspects of his relationship to the client and his capacity to take in the client even when the client was not yet playing music. His idea of alignment seemed to suggest that before playing music with the client, he needed to be aware of a way of being with the client that was felt and sensed rather than played, heard, or spoken. He explained that his musical choices could then grow out of this felt phenomenon on his part. How and what he played was inspired by how he knew and what he knew about the client before the music.
The Balancing Act

The therapists encountered twists, turns, and stumbles along the way as they performed an intricate balancing act. They considered how to respond musically to their clients, how to negotiate feelings, where to direct their focus, which musical and clinical choices to make and how these could potentially influence the clinical improvisation process.

Feeling and Thinking and Musical Choices

*As part and parcel of the therapy process in trying out musical ideas to engage the client, there is the necessary work of getting in touch with feelings and balancing living fully in the uncertainty, vulnerability, anxiety, wonder and doubt, and remaining attentive to the moment to moment musical interaction.*

Nicholas experiences wonder, doubt, anxiety and vulnerability, and he makes musical choices influenced by his feelings and perceptions, sometimes leading down pathways with surprise endings:

There were all these beautiful, vulnerable and uncertain moments. In this work, I was totally improvising music for 30 to 45 minutes. It was a lot. And with this client, I was not quite sure what was going to happen, so I was as uncertain as he was. I was with him and I was making it up. I don’t know what state he was in, and I don’t know how he was in the five minutes before. Did he hear me, the music? What was going on? Actually when we deal with clients, we can only speculate, it’s only how I feel, what I think. Especially something like this. This moment of vulnerability,
uncertainty, trying different things, and trying to be intuitive. I needed to step out of this checking place of saying, this doesn’t work, this doesn’t work. So it doesn’t help really. In the beginning there’s nothing going on and I’m trying different things.

For five full minutes I have been trying to do something and he is sitting without movement or response or anything. I decide to shake his hand, and he does. I continue to sing “hello” with slight pauses between short phrases in slow tempo. Then I sing slightly faster phrases intermittently. I improvise and change my articulation between phrases. Then he looks directly at me and I look directly at him. Then I make an accelerando and I repeat the same pauses between phrases, and he looks as though he will sing but he doesn’t at this time.

I am really conscious of my anxiety. Because this guy wasn’t responding, except when he shook my hand, and was responding to physical touch. At this moment in the beginning of this session, I was pretty aware of something not about to happen and I am feeling frustrated, anxious and uncertain. I can hear my intent of picking up the tones and thinking, will that do it? I’m trying to find the right variable. If it can draw him more into playing, what is it? Is it just “forget about the tones and let’s just go”?

I pick up the two tone motif he plays on the xylophone.

“Is it here?” and he seemed to be pondering it as it happened too. Can this be something that can take off? What are we going for in the
moment that is presenting itself and could be? I listen to how he is playing his motif and try to feel what he is playing.

He plays the motif again and he sings out hello as he plays. He is singing in a full operatic-like voice extending the final tone and gently finishing the phrase.

I nodded my head as if I knew it was going to happen. I didn’t know! It may seem like I expected it to happen. Actually it was a huge surprise!

Nicholas became aware of his emotional state as he played and awaited a response from his client. He understood that how he felt and thought was all he had to work with, all else was pure speculation. He neither seemed to recoil from these feelings nor did he allow these feelings to override his attention to the client. There was a sense of finding and negotiating a balance between letting himself acknowledge his unpleasant feelings as he was experiencing them, and letting himself stay with the client, listening to the client play the two-note motif. He continued to respond to the motif and was surprised when the client sang in a way that he hadn’t before. While the client’s response was not what he expected, what Nicholas did manage to do was to stay with what was happening musically with the client.

When the therapists’ thinking was directed toward assessment strategies and questions, they found that this kind of thinking began to interfere with the creative musical process. The musical interaction seemed to be stifled by the therapists’ over-thinking and intentions in the situation. There were apparent
limits to the checking and the searching even when the intention was to assess the client.

Musically exploring, searching, questioning and trying things out are part of the process, yet I reach the limits of checking and searching musically, and find it is necessary to begin to relinquish this kind of thinking.

Nora realizes that she has been searching musically. This makes sense as this is an initial assessment session. In her exploration she discovers that her assessment strategy seems to be getting in the way of what had been happening moments before, when she felt that the music was flowing between them and they were ‘living in’ the music:

There’s something about the music that doesn’t feel as flowing. Because I feel like I am searching, ‘will he respond if I make it softer and can we go somewhere else?’ So there was something that was there previously that I don’t hear now, something that we were living in, that feels like it was flowing. At some point, I just realized that. I think for a while I was searching: what’s the best music for him, where can I go, what can I see about him, what can I figure out about him? Then there was a point where I just somehow knew this was the thing to do, just get into the music without probing to find out what his strengths were, what his skills or weaknesses, can he play through this? Those kinds of things we try to find out in an assessment. Especially in the beginning when it’s not locked or in sync in any way, it means we’re searching, but when we get locked and
then we sort of ride together. In any musical situation, you search and if it’s not right in sync, you’re working toward getting it there.

Attending and Responding

*In a seemingly unfettered state of mind and with precision, I sense and attend to the client’s moment to moment musical movements, responding and moving between supporting, guiding, and joining the client.*

Jennifer offers a moment by moment description of where and how her attention is directed, and her balance and movement between supporting, joining and guiding the client. She mentions musical details that she deems significant and intentional in the unfolding interaction:

I am quickening the tempo as he plays faster tambourine beats. I leave him space … we are quietly attending to each other… I pause with him… I’m motionless and I look at his hands… I am beginning to look to the end of the session, but then he keeps extending the music, he is not ready yet. There’s rather little harmonic change here, as I am kind of biding my time a little bit, to give him a chance to bring it to a conclusion. He vocalizes intensely and in short figures. I sense he has to do this, and so I sing in the same way, in rising intervals… I move into more gentle playing, in a slightly slower tempo, and I begin to sing “goodbye” to him… I sense that it is not yet goodbye for him… He sits even closer to me and rests his head on my shoulder… I am prepared to listen and wait, wait, wait… He sings out goodbye in a gentle voice… we end the phrase together with our
voices... I stand and take his hand and we walk out of the room without another sound other than our footsteps on the tile floor.

In this vignette there was an unfettered quality to Jennifer’s presence and state of mind. She attended precisely to the client’s every move and sound, moment to moment to moment. She remained steadfastly sensitive and present to both his music and his pauses. As she attended in this way, her responses seemed to show that she had access to her musical resources and could make subtle changes that stayed with the client while expressing her intention of singing goodbye. She maintained a subtle balance between attending to and joining the client, guiding the musical direction, and supporting the client. She seemed to not be flooded with emotion or ideas as she tended to the client’s music and movements, and took in and let herself be with the gesture of resting his head on her shoulder.

*I shift my focus acutely between being aware of the moment to moment movement to being aware of the overall movement of the musical interaction: moving between a microscopic and a macroscopic perspective.*

In the previous narrative, Jennifer’s focus seemed to be moving freely among several different places at once, without appearing scattered or distracted. Florence’s narrative continues with this idea as she describes how she shifts her focus. While she finds this challenging, she seems to derive satisfaction from it:
My focus is on where we are together. I really focus and I try to be as supportive as I can be, yet I’m conscious of whether I am stimulating or matching, whether I’m staying with him or letting him lead, or I’m leading. I am so conscious of it at the time and trying to keep the beat without losing it. My job in terms of rhythm is not to plod the way for him. I let him start the rhythm. He has me where he wants to sit and I fill around him, and give him a context. Sometimes I give him a little bit of context and sometimes a lot. My primary instrument is where I can do all that and not think about it as much. There are strong periods of playing together and improvising where I have to be really conscious. I try to get the whole picture in. It challenges me and it makes me feel like this is why I do this.

Florence remained highly aware of her intentions and the shifting relational dynamics in the musical interaction. She attended to the moment to moment rhythmic aspect of the music. She made conscious choices to move between the larger perspective of the relationship dynamics and keeping her focus on the basic element of the ongoing beat.

*I view the client as the leader, following, responding and joining the client through the circles and turns of a developing process of deepening engagement, taking in the client’s sounds and playing into the texture of the music.*
In the previous narrative, Florence was aware of the shifting dynamics of the relationship in the music. One aspect of the relationship in music was whether she perceived that she or the client was leading or following. In these next narratives and musical vignette, the therapists take a clear stance on their role with the client. They contend that there is judgement involved when they initiate a musical idea and then presuppose and wait for a response from the client. Oliver’s sense is that he responds to the client and in so doing this determines the nature of the clinical improvisation and the therapy process:

The thing is that I’m not the leader. That’s the core line. For me personally, I feel I respond. Now other people may feel that they initiate something and think, “this is what I am presenting and I feel the person is going to give back to this.” I think they do a judgement. I work in a way where I assess very quickly on lots of levels, and then I choose this is what I am giving to the silence. I’m not the leader. The child or person is.

Sofia relates a clinical vignette that concurs with Oliver’s approach:
I look at my client as he comes into the room and I am reminded how this little developmentally delayed two-year-old used to be afraid of sounds. I think of him as the leader here. It’s the only place in life that he has any control. He is coming in and I think of him as light. He is coming straight to the piano and climbs up on the bench next to me and he starts to play and he’s not even two yet. I remember when he was even afraid of a bell. This feels wonderful.
His mother just recently started to leave him alone in the room. It was hard for her because she loved watching him. I said, you know, this is his space and he’s the leader and he’s in control, and it would be great for you not to be in the room. He’s my leader, so I follow him, I don’t make the agenda.

He starts to play tentatively small light clusters with his right hand. I play a simple triad and hold it underneath his playing, singing “any notes are okay.” He starts to play more rhythmically and I come in with some melody that supports his playing. The phrases start to form as I add more harmony. He is starting to hear where he is and where we are together in the phrases. I just follow. I get my ideas from him, in the moment, from the client. Instead of viewing what’s happening as an interruption, I take it in, include it, and answer it. He starts to slow down and play even more gently. I follow his lead and play more softly without losing the fullness of the chords and melody. He abruptly shifts to loud accented single tones with one finger of each hand. I move into accented chords but I am repeating the theme that I have developed.

Following a similar approach to Sofia’s and Oliver’s, Nicholas explains his way of attending, responding and connecting to his client:

With whomever comes into that room, I like to get into this kind of depth because that’s where the change happens. This little child comes in and I follow him and so I am always connected from the second he walks into
the room. It's so easy, but when she first started he was just shaking I
wouldn't even go near him for a few months. He was so afraid physically.
I'm following my clients in order to hold their hand. So, the route is not
this straight line, it's more like making circles and turns.

Taking the stance to perceive the client as the leader and the therapist as
the follower kept these therapists focused on the clients' musical expressions as
the guide. As in this particular case of a child formerly phobic of sounds, Nicholas
explained his thinking that served as an overarching approach to all clients: at any
moment, the client's musical expression serves as the basis for the improvisation.
In this specific case he worked developmentally to bring the client from tolerating
musical sounds to being more fully engaged in a musical interaction. Using this as
an example, he illustrated that while he was following and taking the client's lead,
he was bringing in his own musical expression in response to the client. This may
be viewed as leading or initiating but it seemed it was a matter of degree and not
kind.

His stance of following and including a client's sounds into the overall
texture of the music, was placed in the forefront of his mind, and he knew that he
would be responding musically with his own musical expression. His attention
and listening were directed toward the client's sounds and ultimately he shaped
the music with his own ideas toward developing a theme that added an overall
coherence to the improvisation. He was allowing the client to determine the
musical direction in whatever ways he could, and allowed himself as the therapist
and musician to bring in those musical ideas that he could contribute to create the whole. His words of reassurance in singing “any notes are okay” added a verbalization of his overall stance as well as what was manifested through his playing and his approach to being with the client.

A Change of Direction

I am able let go of thoughts and feelings that are creating a struggle, and find myself able to be with the client in a different way in the music, freeing the musical relationship, interaction, and therapy process from its former state.

In the following two narratives, Florence and Frederic come to a point where they let go of fixed ideas about their clients, the therapy relationship. There is a shift in what happens musically:

So, in the music, I would give her some of who I was in the beginning and then I basically left a lot of space. I am remembering that there was something in me that said I was tired of the struggle. I’m going to let go and just give from the heart. I felt like I was in a struggle musically. And it’s like, I’m going to let go. I think somehow this must mirror power struggles, perhaps with her own mother. I’m just going to be, I’m just going to love you, and not want you to do what I want you to do. Or be more free, like, “you need to be more free!” No, I’m just going to love you now, and whatever happens, happens. And I really remember thinking that in my mind: this has been going on for a half hour and it feels like a struggle. She was perhaps frustrated too, to the point where she wanted to
play by herself. I just stopped playing. I think I just stopped and then listened to her and looked around the room, looking for a way to be with her in a way that would not be part of the struggle.

I was playing a habanera rhythm and I ask him if he wants to sing in the music. I was probably somewhere in this state where I wanted to go somewhere and I subconsciously did it. Everything I was doing was like trial and error, trial and error. Then it was probably a resolution for myself when I got to a certain point where I remember having the thought, an idea: I gave myself permission, and said something like, if it just feels right, it’s going to be good for him. I can give myself to get into the music, and create a sense of groove and playing together and that’s going to be just right for him. So, I made a conscious choice to extend the song, and change it and then come back to it. That’s what I remember consciously. I don’t recall any other conscious decisions. I am doing something consciously, but once having made up my mind to do it, to sort of get out of my own way.

In the first narrative, Florence interpreted the dynamics of the therapy dyad as being an enactment of the relationship between the client and the client’s mother, with her as the therapist in the role of the mother. She felt the inertness of the clinical improvisation as a mirror of this relationship. She sensed the depth of this struggle and felt embroiled. Her conscious awareness of this dynamic seemed
to allow her to make a conscious choice to relinquish this role and detach herself from this way of thinking about the relationship and feeling about the client.

In the second narrative, Frederic made a conscious choice to change his approach to being with the client musically. He gave himself permission to become involved in the music and to trust that this might benefit the client. He had been in a trial and error phase and this shift in his mind seemed to emphasize a commitment to his own musical idea of establishing a musical groove. He suspended judgement and further explained this as allowing himself to get out of his own way.

*I understand my shift out of habitual playing into a new direction and style of music as being a series of simpler and smaller moments of focused listening to the client's musical sounds.*

The following vignette illustrates Ogden’s change of mind, from playing in a habituated manner to simply listening to the client’s sounds:

I am playing on guitar legato and gently strumming parallel 7th chords in a diatonic scale while the client is picking up and dropping the tone bars of the xylophone. I continue with these chords thinking that he can come into playing gentle tones that would fit into my rhythm. He changes to bouncing the mallet on the floor. Intermittently he is playing some accented tones, and sometimes two tones at once creating some dissonance. I stay with my rhythmic strumming. I decide to play something that matches more what he was doing. I begin to play
augmented chords and resolving them. Then I move into extensions on the V7 chord without resolving. The other therapist sings out vocally almost in a shout and I move into a funk rhythm with dissonant intervals. The client starts to play in tempo single tones with intention and looks directly to me. He has a more focused and related expression in his face.

Something changed right there. What was really important for me is that I was used to the usual momentum of this kind of music which is extremely rhythmic and compelling, a dance kind of music that keeps going on. I'm a very rhythmic player and what I had to learn is I just can't go on automatic pilot. There's different ways of being in the music: there's the automatic pilot of being in the rhythm, but there is also being in the music in the moment and being connected with somebody. Instead of my viewing what the client was doing as interruption, I decided to take it in, and really listen to what he is playing, and then I shifted to the funk style music. And it didn't appear that he was coming to me, so my first decision was to make a more dissonant sound, responding to his accents, rhythms and dissonances. So, I didn't really make a big or abrupt decision to play funk music. I was more in touch with the little moments along the way which lead to the change.

Ogden found himself playing in a habituated manner and presuming that the client would come into his prescribed musical context. As he began to focus on the simpler elements of the client’s music, such as the accented and more
rhythmic intermittent tones, he made a change. He was drawn out of his reflexive state of mind and moved into the present moment in a way that attuned him more closely to the client’s music. He viewed the overall shift in his music as the experience of staying with and taking in the smaller moments in the music that eventually led to a new direction in the music. This new direction engaged his client more deeply in the musical relationship.

As another example of a therapist’s change of mind, Nicholas describes his change of direction in the music that brings the client into greater awareness of himself and allows him to be more present in the music:

He is sort of perseverative in his rhythmic expression, but as soon as I make a change, he is there. If I change tempo, or if we’re in the middle of something and I go in another direction. I do that from time to time. I don’t want to always do it because I know he’s comfortable with it. But he’ll look up and he’ll try to reach and find. He does it. He’ll follow me, and I try to follow him, and let him hear himself. I’ll mimic him in terms of rhythm and tonality. I’ll play the notes he just played. So he’ll hear it amplified.

**Connecting and Relating in the Now**

The therapists highlighted the importance of connecting and relating to clients. At this point in the clinical improvisation, the dimensions of the connection and relatedness through the musical relationship seemed to be perceived in an expanded way.
Bridging the Physical and the Nonphysical

I perceive music as a bridge between the physical and nonphysical worlds: between what I do and what I experience in my mind.

The therapists understand music as being at once a physical activity of the body and a non-physical experience in the mind. Simon, Grace, Florence, Sofia and Jennifer express their expanded perception of the dimensions of the experience and of the musical relationship:

He seemed he had really been coming in touch with a joyfulness in himself that he wasn’t in touch with before. I think part of that came from this sort of connection between the spiritual and the physical through music, the actual physical process of making music --- to hit things which at first he wouldn’t do at all, and then the tones that emerged, and then the quality of music that is bridging us to something which is non-physical.

Every being that has come before us was creative and whatever they created is also creative, down the scale until we appear as a physical expression of this whole pre-physical evolution that took place. And that is what we are as instrument, as being, as individual, as a physical organ.

Something about gaining more confidence in his body feels so important. It feels like dance movement, the way he’s moving his body and can turn and swivel, and connecting his movements to music. There was something
psychologically primary about him getting into a state of basic relating through the basic pulse of his beating.

I think it's also important that I'm playing up in the treble there not only to be heard clearly, but also to be seen. My hand is moving beside his, reinforcing the co-activity. My focus is on where we are together. I'm not down there playing in the bass.

It's moving between what we are doing together and who we are together, being on the level of volition together, feeling together, cognizing together. The cognition of how we are and how the music is and how we are contained by the music.

The therapists appreciated a link between the physical action that was required to play music and the nonphysical aspects of human existence. They reported that, through the act of music-making, the therapy dyad related with one another in the physical, psychological and spiritual realms of human existence. Through musical experience, the therapy dyads could be understood as meeting in three psychological domains: cognition, volition, and emotion. The primary pulse of the music was felt as a foundational way of relating in music that connected the players on this fundamental plane. The physical proximity between the therapists and clients, and the therapists' attention to this physical aspect while playing with the client, reinforced the connection between what they were doing and where
they were together, which were experienced beyond their physical actions. They formulated a perspective that sees human existence as the culmination of a pre-physical evolution of creativity, linking human physical existence to a chain of nonphysical existence. In essence, in all of the previous narratives, they understood musical experience as the integration of the mind and body, that through the physical act of making music, the nonphysical (psychological and spiritual) aspects of human existence were engaged.

**Qualities of Connection and Relatedness**

*Psychological, physical, and spiritual relatedness and connection occur between myself and the client as an interaction between the dyad relationship and the music.*

The therapists articulated the quality and complexity of the connection and the relatedness between themselves and their clients in the clinical improvisation. In the following narratives, Nora, Nicholas, Sofia, and Oliver find words to describe their understanding of the profundity and multiple dimensions of connection and relatedness:

There is an intuitive and a really special state, when thinking is not much involved and something is happening. It’s not even just a deep connection, and it is beyond understanding connection in music. It is difficult to explain.
I work with a woman with dementia who was not responsive, but when I matched her wheelchair movements as she was being pushed through a narrow passage, she said all of a sudden "me too." At this moment, there was such a powerful connection through everything.

It has to do with my relatedness to the client definitely. And on what level did we relate? On what level did we hear each other and co-exist in the same musical space. At first, I felt that I was suggesting the situation, that I was leading, and he was just going along with what I suggested musically.

It's very layered and it's not just about obviously the music, because the music is what happens when the connection happens. It's like the chicken and the egg: does the music connect, does the energy connect, do the people connect, or does it happen all at one time? For me, it happens all together, it happens all at one time. As the music therapist, the music that you decide to do at that second has to coincide with where the client is mentally, physically, emotionally, spiritually, on every level of their being.

Some of the therapists' difficulties in trying to capture the essence of connection and relatedness suggested the profundity of the experience for them. They described experiences of deep connection in the clinical improvisation that surpassed a mundane sense of connection between two persons. They
characterized the phenomenon as having multiple layers, spanning a continuum of connection and relatedness across psychological, physical, emotional and spiritual realms. They proposed a holistic perspective of the experience that could not be simplistically understood in terms of cause and effect: connection and relatedness happened as an interaction between the relationship and the music.

*My musical choices are at once manifestations of and means of moving toward relating and connecting on multiple layers, emotionally, neurologically, cognitively, physically, and spiritually.*

Simon makes musical choices that are at once a reflection of the connection between him and the client, and a means of fostering that connection as well. His musical choices address and entail the multiple layers of emotion, cognition, physicality, and spirituality. That this connection is happening in a musical interaction highlights the spontaneous nature of these decisions. At the deeper levels of connection, he cannot discern any separation between cause and effect in the musical interaction:

So, you’re going to choose the sounds or the combination of sounds, or the chord or the melody or the voice or whatever you are going to choose that’s going to reach the client neurologically in the way they respond: it’s going to reach them on an emotional level to get through their defenses, it’s going to reach them on a curiosity/interest level that’s just going to make them react because it catches their attention, and it’s going to be a motivating factor in wanting them to get a response. So that when you do
that, and it’s a split second decision. So that’s what I mean as the chicken
and the egg: have you responded to something or have you initiated
something that you pre-suppose that person is going to respond to, or have
you responded to something that already exists?

Through her musical choices, Grace creates conditions that foster and
draw the client into deeper connection:

Embodied in the musical moment, you create the need through your music
for the client to reach out toward you in the music. You need to ask
yourself, is everything being taken care of by me (the therapist) in the
music? Am I ‘filling in the gaps’ and inhibiting the client’s capacity to
initiate? The therapist needs to hold back and create the context for the
client to reach out, to come forward and initiate in the music.

As Sofia describes, the connection can be manifest, fostered, and
expressed vocally and nonverbally:

I felt like it was easier for me to connect with her through the breath. I
could have sung words but I think of the connection as pre-verbal. I
wanted it to be like, humming. It’s what I wanted, I wanted that breath
energy to penetrate.
Through a rhythmic interaction, Frederic and his client work to develop a connection. The rhythmic synchronization between him and his client forms a basis for the connection:

Sort of like when you are entrained rhythmically and it’s there. You’re just in there. You’re more in sync and that was one of the things that I noticed in his playing: he’s always looking for that connection, looking to stay synchronized, even when we aren’t playing the same exact thing.

Through challenging moments of disconnect and unrelatedness with the client, I bring myself back to the point of accepting what is happening musically, in working toward connection and relatedness.

Ogden finds it challenging to get to the point of staying with what is happening in the moment to moment interaction, and realizes that this is also part and parcel of the therapy process. The process entails his capacity to be able to bring himself back to the unfolding musical moments whenever he senses disconnect and unrelatedness in the musical interaction:

It’s a challenge on some level. But, it’s part of the work, the concentrated moment of accepting the moment and striving for connection and not being completely thrown off by moments of lack of connection or someone doing something other than how you wished they would act.
Negotiating Boundaries

Deeply knowing a client and developing intimacy in the therapy dyad in a creative process depends upon and entails my capacity to enter into the client’s world through maintaining my inner boundaries and loosening my outer boundaries as I sense and move closer to the client’s boundaries.

The therapists’ awareness of their own boundaries and those of their clients were brought into play in the clinical improvisation. Nicholas describes how he negotiates boundary issues in the clinical improvisation:

I think you need the capacity to remove boundaries while keeping your own. There’s the ability to feel another person’s system and how it works. And to look into somebody’s eyes and really know where they’re at on a very deep level, and to be willing to go there. And not being afraid, or getting pulled in. That’s the point. And what you have to do when you are working with somebody is to see their print, their person-hood print, and get into it, and be willing to enter into their energy spheres and know how they work. Only then can you and the client move into that other deeper dimension in the music. That’s really what it’s about.

The therapists developed the capacity to appreciate the utility of boundary awareness in the therapy dyad as well as the possibility of when their inner boundaries could loosen and be flexible in service of the creative process of
clinical improvisation. The quality and depth of the creative process interrelated to the level of intimacy between therapist and client.

**Being with What Is**

The therapists conveyed their presence to their clients by simply being there with the client. Inherent in this presence was the acceptance of the moment as they understood it. Conveyed through their presence, and through their acceptance of their own perception, they opened the possibility for the clients to do so as well.

*By simply being there with the client, and through my own acceptance of what is, I help the client to accept what is, fostering a deeper connection in the therapy dyad, and creating music that embodies our perceptions and allows for a change of perception.*

Grace and Nora explain their respective approaches which speak to the simple power of just being there with the client in the clinical improvisation:

Being there with them in the experience. And just, somewhere, saying, oh that’s the way it is, there is nothing that you can do, nothing’s ever going to change, but you can change. You can change your attitude about yourself to feel better about yourself. Even with the nonverbal people, giving them that message through the music in the confidence they get from being able to create something.
And for me, I’ve gotten to know them as individuals. And what happens is when you get to know someone with a handicap, in the music, you don’t see what other people get put off by. You just know them as people. I get to know them in their Alzheimer’s personality.

The clinical improvisation held the possibility for the clients and the therapists to stay present and to accept whatever they experienced in that moment. The music that they improvised could be seen as both the manifestation of their perceptions and as a means of changing perceptions as well.

**Awakening Musically**

*The client awakens musically as I make musical choices that stimulate, attract, and ultimately engage the client aesthetically.*

Musical and clinical decisions by the therapists, apparent in their musical choices, seemed to have the intention of waking up the client. Both implicitly and explicitly stated, this notion of awakening the client comes forth through the voices of Sofia, Frederic, and Jennifer:

The music has to have some kind of relevance or else they’re not even going to engage. It needs to be relevant. If there is an improv in a blues style, then it is often a very good way to engage them given the age of the clients, late 20s to mid-50s, their socio-economic status, just blues is something that they can relate to.
It’s constantly playing on his memory of what’s gone before, the memory of these themes. I am constantly stimulating his attention, or attracting it. Other times, I’ll play way away from where he is or can go, just to stimulate him.

This woman sits in her wheel chair and when I come with the singing she just comes alive. So the music taps into a place that is still very much alive in her and in all these people.

Sofia chose a musical style that seemed relevant to the client’s social status, gender, age, and culture. This helped to deepen the client’s engagement in and the development of the music. Within the therapy process, Frederic re-visited and further developed musical themes from previous sessions or from the current clinical improvisation that drew the client’s attention to the present musical moment. Jennifer chose to play in contrasting ways to the client’s playing or in ways that were not in her repertoire of playing in order to stimulate the client and bring him into the moment. The sheer aesthetic perception of music was part of the therapists’ musical choices. They ‘wake up’ the client to the present through their musical choices.

In the following vignette, Oliver explains his rationale for using a specific style of music and how he perceives the characteristics of this style as a means to awaken the client to the present moment in the clinical improvisation. His clinical and musical decisions are fused and manifested in the present musical moment:
I moved into a funk music style. It uses dissonant intervals and can be heard as a little grating. That’s what I came to feel after thinking about this. It’s one of the elements of funk music, it uses dissonant intervals, and has that insistent rhythm, and it doesn’t let you feel comfortable, the rhythm pushes you and the intervals jar you. I think of a flat nine and a minor second as having the same intervallic quality and relationship. That’s used a lot in funk type music. There’s something stimulating, agitating, grating that doesn’t let you relax, there’s something unresolved about it. If you think about the minor second as a beginning of inner movement, it’s sort of getting inside of you, but at that same time, that rhythm is bringing you out. It’s taking something that is deep and sort of private and doesn’t feel comfortable being expressed, into being expressed through the rhythm. A contrast in a way. That’s one of the powers of that type of music. It’s not just the rhythm. In funk music you’re using dissonant intervals but with extreme syncopations, the rhythm is moving you in all different ways. It’s not just two and four. It uses one and three as the main beats with all these internal syncopations. The music was steady, but at the same time, it was very activating. That’s why all music doesn’t have the same soul. The contemporary music is not using all the elements, just the pounding two and four. The two and four is not creating internal motivation that your body can respond to.
Oliver engaged and brought the client into the present moment, using music that had particular musical elements that, as the therapist, he perceived as holding inherent qualities. The characteristic qualities of the intervals and rhythm of funk music that he perceived were critical in his musical choice. His perception of the intervals of the minor second and the flat ninth and the syncopated rhythms influenced his rationale for choosing this style. His investment in his musical and clinical perceptions allowed him to make a committed choice. In his musical choice, his clinical and musical intentions were embodied: to bring him and the client into the present moment, and to engage and relate more deeply through the musical structures of the clinical improvisation.

**Reflections on Getting To The Point**

Getting To The Point begins to home in on a multitude of aspects of the therapists’ processes in clinical improvisation. The silence between the therapists and clients held meaning for them in how it contained the possibility for the musical expression of the dyad relationship. The work of aligning with the client began and continued in the silences and in the music. The therapists made musical choices and tried out musical ideas with the client, and based their choices on their perceptions of and emotional reactions to the clinical situation. The therapists began to realize the challenge of being in touch with a range of emotions as fully as possible, while working to be as present as possible in the clinical improvisation.
This musical exploration began to move to a phase where the therapists started to relinquish thinking about what to play, and attended to the subtleties of their clients’ moment to moment movements with greater precision, with an evenly balanced attention. Fixed thoughts and feelings as those illustrated in Starting Where You Are began to loosen and be relinquished. The therapists’ listening focus became more precise as they found the direction of the improvisation out of the present musical moment. The therapists brought themselves back to being with what was happening musically.

The balance between maintaining a perspective of the bigger picture of the improvisation and the moment to moment unfolding became a consideration for the therapists. They made musical sense of their clients’ sounds by hearing them as part of the texture, and related to them in that way. They balanced initiating, responding, and joining their clients’ music in service of engaging the clients by consistently incorporating and responding moment to moment to the clients’ music. The physicality of playing music and the psychological experience of the therapy dyad began to meld during this phase of the improvisation. The therapists’ musical choices were the means of making themselves available in the relationship and of relating more intimately toward their clients.

The therapists suggested that through the interpersonal and musical interaction, the connection and relatedness spanned the psychological, physical, and spiritual realms. The sense of a developing intimacy relied upon the therapists’ capacity to moderate the loosening of outer boundaries in service of sensing and getting closer to the clients’ boundaries. They worked to awaken and
engage the client in the present musical moment by utilizing relevant musical references as well as their aesthetic sense and creativity. Table 2 encapsulates salient features of the therapists’ experiences by distilling the theme components in Getting To The Point.
Table 2

*Getting to the point*

- Perceiving silence as full of musical possibility
- Relating and playing at the music-silence boundary
- Maintaining an awareness of presence in silence
- Moving from *thinking about* to *being with*
- Becoming absorbed in the present musical moment
- Alternating attention between microscopic and macroscopic perspective
- Focusing listening to client moment by moment
- Aligning with client and developing an empathic stance
- Relating beyond pathology
- Moving toward experiencing fully and being with feelings
- Observing thoughts, feeling and musical tendencies
- Moving out of dualistic and polarized thinking
- Loosening and maintaining boundaries
- Engaging more deeply in creative process
- Being aware of fantasy and control
- Letting go
- Making musical decisions reflecting deepening engagement and relatedness
- Sensing music as a bridge between physical and non-physical realms
CHAPTER V
THE POINT

That’s how it works.
So you don’t have to make it happen anymore,
it will just happen.
It flows like a river
it just moves.
If you go on the right path
you’ll just go.
Starting like the marble down the track,
it will just go.
You don’t have to move yourself,
you just have to start from the right point
and you will go.

The preceding poem, composed of the therapists’ metaphorical words,
illuminates the essence of their perception and experience of a point in the clinical
improvisation which seems precisely right, and from which the path of the music
unfolds in a way that is distinct from earlier on in the improvisation.
What's the Point?

There is a point in the clinical improvisation that is an entrance into a space in which the creative process happens differently and goes by itself.

At a point in the clinical improvisation, my perception broadens and I experience reality, the whole of existence, as a microcosm in the present moment.

There is a point at which I perceive the presence or essence of the client beyond pathology.

I experience being at this point as being right there, absolutely present.

The therapists spoke of a point in the clinical improvisation at which there was a qualitative shift in their experience in the musical interaction with the client. They expressed their perception and understanding of this point quite resoundingly. The point became a representation of a lived occurrence that stood out in the clinical improvisation. While seemingly elusive and transient in nature, the therapists worked to grasp and convey the multi-faceted character of this point through their words. The following dialogue is an amalgam of several therapists’ voices brought together to convey the abstract, profound, and paradoxical understanding of this point: a metaphysical point that occurs in time and space in clinical improvisation:

Florence: All that happens before is shaped like a funnel. It starts out big, big, big and then comes down to one tiny point.

Grace: It’s probably not even a point, we only think of it as a point.

Ogden: The point is really the point of the boundary and the border of the
other dimension.

Grace: It’s the place where you reach the client, saying to that person, “no matter what’s wrong with you, no matter where your head is at, no matter how far out you are, I really see you.”

Florence: I don’t know the word for that point. It probably doesn’t have one because most people don’t talk about it. There has to be one in Buddhism or something.

Ogden: It’s the entrance. You want to get into the other dimension, the other place where you are in the perfect flow of the creative process, where the creative process goes by itself.

Florence: But if you want to get into the other place, you can only get there through that point. That point will never get bigger. It will not stretch for you. You have to be right there, on the dot. Because if you aren’t, it won’t let you in.

Ogden: What it really is, is a microcosm of everything. It’s like looking through the microscope at something, say a crystal, water or dust. And all of a sudden you see this huge city. But it’s not really a huge city, it’s just a tiny little dot. But in the microscope it’s really huge.

Grace: It’s really the whole. It just really reflects everything in terms of life. It’s really a mirror image of this. Not to see it as only half. You were only seeing half. But now, going beyond and seeing the whole.
Florence: When you think of that image of creation. Everything unfolds like that. Everything is symmetrical. You look at a flower, or anything in nature, everything is that split in half.

Grace: It’s like those pictures of reflections of something that create an image of the whole. All of a sudden you see new images in the trees, in the water. And all of a sudden all of these magical things happen. That’s what we’re talking about. That’s the point.

Ogden: On the other side of the point, it mirrors this side, but it’s not going to happen on this side. It can’t. Because through the point on the other side is where things happen differently. The creative process happens in this space. The music flows here. It doesn’t happen here. Here it’s the equations, it’s what you need, it’s the recipe, that you put together to work. The recipe is formed here, and if it’s the right recipe and the right combination of the lock, then you get to the point.

As the therapists referred to this point in the clinical improvisation, they created an image of a point that had time and space dimensions in a metaphysical sense. There seemed to be a preciseness in being at this point, reflected in how they described what was experienced and what was needed: to be precisely present and on the dot. As their perceptions broadened to a point where they felt absolutely present in the moment, they had the capacity to sense their clients in a way that transcended pathology. At this point in the clinical improvisation, the
creative process took on a different character, whereby it seemed to move on its own. They described what happened at this point in the creative process as happening differently, and they take a step further to say that it seemed magical.

The participants described this point in the music as a shift, a turning point, or a passageway through which the therapy relationship travels and finds itself in new territory where the creative process takes on a qualitatively different character than previously experienced in the improvisation.

I experience an unfolding and uninterrupted musical path happening without conscious thought or control.

Paradoxically, I expend great effort effortlessly.

I realize the transient and elusive nature of the experience.

I lose my sense of time.

The therapists' words that follow paint a phenomenal portrait of their experience at that metaphysical point in time and space in the clinical improvisation. In a resounding chorus of voices, these ten therapists describe being at this point in the clinical improvisation:

It's easier at that point,

there's a reduction of friction,

whatever that friction might be,

and there's no more halting motion.

I never have the feeling that I'm lost or stuck.

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There's a seamless quality and we are both in this.

There's a lack of interruption in some sort of process.

It's like you are being played by the instrument
by some higher force.
And the patient feels it,
you both feel it.

All of a sudden the instrument is playing itself.
I wasn't really thinking about it.
I was just watching myself play.

You go somewhere else
beyond the consciousness of even knowing where you're going
you just go there.

Thinking is not much involved,
something is happening.
Somehow you know,
but you don't think about it.
I believe the moment you start thinking,
it vanishes.

I don’t think about notes or anything.

There’s no room in this equation for thinking.

It’s like an athlete
when their bodies start to move
without conscious thought.

There’s an ease to her singing,
that it is just coming out
without thinking about
how to sing and what sing.

It felt totally effortless,
though I was expending great effort.

The interaction is happening
beyond conscious control,
but yet it seems exactly right.
It's as if we are going down the rapids together before it broadens out again and we're on a journey together hand in hand through musicscape both being in a river together and we are making the river as we go along.

I am just following the path that seems to be opening up to me.

Time doesn't matter,
I could just keep going.

All of a sudden
you're caught up in some reverie
and you're not thinking about time.

The chorus of voices expressed many aspects of this point in the improvisation. The therapists experienced the clinical improvisation as being released from a friction and halting quality in which feeling lost or stuck no longer impeded or interrupted what was now sensed as a seamless process. Their experience of playing their instrument shifted to a sense of being played by the instrument or that the instrument was playing itself. They perceived themselves in a detached manner, able to observe themselves and seemingly watch themselves
play. They related the sense that thinking was not much involved in the
experience as it was happening, and specifically, not thinking about the notes or
the movement of their bodies.

The therapists’ involvement was such that there seemed to be no room in
the equation for this kind of thinking. This seemingly non-thinking state or place
felt elusive to them and that what was happening in the moment would vanish if
they were to engage in thinking. They expressed the ease they experienced at this
point, as well as the paradoxical sense of expending great effort in an effortless
manner. Their words suggested that their interactions with their clients remained
beyond their conscious control and as they had a sense that what was happening
was exactly right.

The analogy was drawn between the clinical improvisation moving across
a musicscape and the propulsion of a river that was being created mutually
between therapist and client. The therapists appreciated the unfolding nature of
the path of the clinical improvisation, which opened up in a timeless manner in
the musical interaction and was something to be followed at this point. The
therapists found themselves caught up in some kind of reverie in which time lost
its relevance.

In the Moment

As the participants described their experiences of being in the moment
during the clinical improvisation with the client, they expressed their appreciation
of the challenges inherent in staying present and creative, while making moment
to moment shifts in the music, as well as connecting these moments musically to one another.

*The present musical moment is the preparation for the next musical moment.*

Nora begins by acknowledging the value of staying present in the clinical moment as the preparation for the next moment:

If you want to be in the clinical moment, then you are ready for what’s next. That’s one of the big challenges of this work: to stay in the moment, to be extremely flexible, to be in touch with your muse, and at the same time, to be in touch with the moment, and make minute shifts, make right turns and left turns at any given moment without losing the connection to the moment before it. That’s very hard to do.

*The present musical moment embodies the past and the future musical moments.*

How the present musical and clinical moment embodied the past and the future is truly captured by Sofia’s words. In essence, she experiences a paradoxical sense of the present moment. She experiences the music as compelling, as it encapsulates the past and future into the present. Her sense of the present musical moment is one of forward movement, and the subsequent moments are natural outgrowths of the present:
The music becomes so compelling from one moment to the next when there is an anticipation of where it is going, and yet it is so solid in the present moment, now. It’s so about now, and yet at the same time it’s about moving forward. It’s like transforming the past and the future into the present, infusing the past and the future into the present. It never feels like going backwards. And the future seems to grow organically out of the present moment.

*When fantasy and control fall away, I am able to relate musically to what the client is playing in the moment.*

Simon aptly describes the inherently formidable practice of relating musically to what the client is playing in the present clinical moment. He appreciates what else is possible when fantasy and control fall away, no longer pulling him out of the present musical moment. He alludes to an adjustment he makes in bringing himself back to the present moment:

How do you maintain and make musical sense in some way or another and at the same time be fully in touch with the moment? So that you’re relating to what’s actually happening rather than to what you wished were happening and it were all laid out and you could control it. You have to adjust to the situation.

*Fantasy and expectation about a desired result impedes my capacity to relate musically to the client in the present.*
Florence’s perception as she reflects on being present in the clinical moment in the music illustrates that what appears to be a sought after result is in fact a moment to moment contact with what is happening, only appearing as a result upon reflection. Further, the apparent result is not necessarily what she expects, predicts, or strives toward. In retrospect, there is a point when fantasy and expectation are not part of her experience when being fully present in the clinical moment. She attributes fantasy and expectation as part of thinking associated with ego, and relates to meditation the experience of moment to moment presence:

If you only try to go for the result, you very often can’t achieve it because you’re not really in touch with the moment. You’re more in touch with your fantasy of what you wish would happen. Which goes back to ego, you’re fantasizing. It’s not really what was happening. In truth, you were in some moment to moment contact with what was happening which then emerges into something that appears to be a result. The result couldn’t have necessarily be predicted. That’s the thing about meditation, to be in every moment, and not anticipate the results. You suspended expectations of what should be happening, how the other person should be, or how the scenario should go, and were completely not involved in that kind of consciousness. You were connected with what is rather than what could or should be in your ego view of things.
I make musical decisions based on what is happening moment by moment, creating an unfolding path.

Similarly, what appeared as a full decision actually had been experienced by the therapists as smaller level decisions in the clinical moment. Nicholas sees the full decision as an illusion of sorts, in that it actually consists of micro-decisions that are being made extremely rapidly and involve many aspects of the mind, all of which he cannot consciously think about in the moment. At the point when his focus remains on the present happenings in the music with the client, he experiences these unfolding musical moments as a path that is opening up and that he was simply following:

That may have something to do with the acceptance of the moment, being in touch with what’s happening around you which leads you somewhere and it appears as a decision, but in a way, you didn’t really make the full decision. A decision is being made on much smaller levels in the moment. It all takes place actively microsecond by microsecond as a very complicated, subtle decision-making process that happens in a split-second, combining your intuitive and intellectual and emotional levels all together. You were just following the path that seemed to be opening up to you.

I am able to relinquish patterns at any point in the music to be with the client in the moment.
There is a point when the therapists relinquished their habitual tendencies, and they arrived at a point of not being attached to the safety net which then became obsolete in the moment. Jennifer appreciates the relinquishment of these musical habits and her own capacity to be present in the clinical moment:

I had to get more into the connection with him through, “where are you now?,” and where I could re-establish the contact in the moment with him, and not just keep my own safety net or distance through some stylistic habit of keeping the rhythm going. It’s not just getting someone into motion, it’s about really staying in touch with each moment as it occurs rather than saying, “okay, we have this going and we can just keep going, and I don’t have to pay attention to you anymore.” But then he wasn’t able to sustain it, so I had to keep that rhythm going and he could keep playing. He was initially motivated but then would pause. So, it was more important for me to be in the moment with him that it was for me to continue that rhythm.

*As I stay musically with the client, I find the direction of the music in the present moment.*

Staying in the moment with the client took on superficially deceptive appearances in its musical shapes and forms. In this specific example, Grace marks time in the music as she waits for the client to indicate which direction to take. In marking time she experiences this abeyance as being absolutely present to the client’s needs in the present moment until another musical direction is needed.
In fact, her apparent abeyance is paradoxical: as she waits she is fully present in her waiting. Nothing else is happening besides the waiting, and the next musical moment grows out of this waiting:

When I am marking time in the music, it’s not for me but it’s for the client. I’m finding out which direction to take, but only out of the moment.

_A sense of urgency is inherent in my experience of being musically present._

Nora feels a sense of urgency as she describes her approach to the musical moment. In the musical interaction she feels the gravity of the present moment, that there is nothing but the present moment to which she attends: “Urgency needs to be embodied in the musical moment.”

_In the Space_

_The client and I co-exist in parity and synchronistically in a creative space in which thinking, judgments, and self-consciousness are superceded by listening as the primary mode of perception between us._

Sofia describes the point when she experienced herself and the client co-existing in the same musical space. In this space, she highlights the absence of thinking, judgement, fear, worry, and what she describes as checking. While admitting difficulty in explaining this place, she colorfully describes being in this place. Her difficulty in finding the words speaks to the profundity of being in this space with the client. In this space, they co-exist, working in a creative medium.
Listening acutely to one another seems to be the primary mode of perception between her and the client:

On what level did we hear each other and co-exist in the same musical space? I don’t know how it happened, but I started to not watch him. I didn’t look at him, but somehow we were in sync, and there is no doubt, there is no thinking, there is no judgement, no checking. It’s like this state of I don’t know what, of co-existence in some creative substance where we are equal, absolute equals. He doesn’t check with what I’m doing except listening to the piano. There is no fear there. There are no worries here, we are there.

_I perceive a mutual trust and heightened awareness in a creative space as the dyad moves into new musical territory._

Being together in this space, Nora experiences trust and a movement in the musical process whereby she and the client move into new territory. She is aware of going beyond her previous experiences with this client and senses that he is aware of this as well:

We were together. It’s probably very simplistic to say it that way. But we were in this creative state together, completely in the same space, and there was a lot of trust, and somehow a knowing, somehow we knew. I don’t know how he knew and I don’t know how I knew. But we knew each other. At that moment, we were doing something that he hadn’t done before, and neither did I!
I attribute my ability to facilitate the client’s movement into a creative space to the trust and connection that has developed in the therapy relationship as well as to my own past musical experiences of creativity.

Oliver characterizes and appreciates this space as one in which the creative process takes place and with which he is familiar from his childhood. In his own life, he has derived security and comfort from being in a creative space. He explains that his past and positive experiences in this creative space as well as the trust and connection that has been established in the therapy relationship contribute to his capacity to readily facilitate his client’s movement into this creative space:

The creative process happens in this space. I’ve always had access to it. And it’s been my place of therapy, it’s been my security place, it’s been my place of comfort. It’s where I like to be to create and write and do my thing. It’s just a very nice place to be. I am so familiar with it, that it’s very easy to go over here and take somebody by the hand and say, come on, come on, let’s go. But they may not be able to. That’s part of the whole thing, the trusting thing, and making that connection.

My capacity to play as would a child and to be present are vital aspects of being in the creative space with my clients.

Grace explains that she has not lost the ability to play that she had as a child. This capacity remains a central part of her adult personality. She
understands that being present is vital to and characteristic of how it is for her to be with clients in the creative space:

You have to be present in that space with them. I have an ability to play, to be a child in the real sense, in my real core. I haven’t lost that at all. I’m still the same child I was when I was little. In some way, I am still that person.

*My ability to provide a nurturing environment by being present as the good enough and non-intrusive mother allows the client to play freely.*

In the following vignette, Jennifer describes being in this space where she is the non-intrusive and good enough mother creating a nurturing environment for her client and herself as well. Her capacity to be present in this way allowed the client to play freely. Her ability to simply listen allows her to shift her way of being and playing with the client:

It felt nurturing, very nurturing. I felt like I was creating a nurturing space and she was letting herself rest in it. And she was also supporting the flute with her piano playing as well, so she joined me in that space. So I felt nurtured by her too. Like the good enough mother that allows the child to play freely without intruding upon the play. When I got up from the piano and played, and I was just listening to her at that point. I was there and I found a way to be present in the music with her. That was so powerful that shift, that change from playing, to not playing, to just listening, then coming back into the music in a different way.
I enter into the client’s reality as fully as possible, wondering how the client would play or perceive music.

The notion of entering into a space takes on another facet as Frederic describes his experience of entering into his client’s reality, and living as deeply as possible in this new musical territory. He compares this process to an actor’s in which the actor immerses himself in the character’s reality, wondering how the character would feel, think and act:

I’m able to be with him in his zone, and that’s what it is, to be willing to leave your place, to be willing to enter into another person’s reality, and not be afraid, and keep your boundaries, and really being willing to fly and just give over to another way of being, and really understanding it from a very deep level, so that you can feel that reality and create music from that new place, like an actor. Like an actor feels a part, what would that character do if they were mad, what would that character do if they were sad, how would that character express themselves? It’s a very similar process, getting into a character, getting into a mental state of another person: how would they hear this? How would they incorporate this sound? Feeling it like an actor.
Just Listening

I have learned that the simple power of letting myself instinctively listen allows the musical process to flow.

The notion of just listening is taken to its fullest degree as the therapists described their ability to just let the listening happen. While perfect pitch could be understood as a necessary cognitive skill to listen deeply, Simon stresses that his listening happens on an instinctive level that does not involve thinking:

I have a solid good ear, not a super good ear. Having perfect pitch could be a detriment then it’s in the brain, and you end up not being instinctive enough. Mine is a combination that I can really give over to just letting it go and not thinking.

Nora attributes moving into music that flows in a clinical improvisation to her capacity to listen and states this quite simply:

To fall into a musical flow is quite simply attributed to listening, just listening.

Just Letting Go

I allow the musical interaction to happen by a letting go process that is similar to letting myself fall asleep.

In trying to find the words to explain the simple and yet profound experience of letting go in the clinical improvisation, Frederic makes the comparison to a naturally occurring experience. As he sees it, the musical process is not something that can be controlled or coerced into happening. So, the analogy
of falling asleep provides a useful analogy to convey the absence of conscious control that he perceives as necessary in clinical improvisation:

Sleeping is a letting go experience. You can’t make sleep or the musical interaction happen. You have to let it happen, you can’t consciously control it or make it happen.

_I reach a point in the clinical improvisation when I am able to let go of thoughts and feelings, allowing the music to just happen._

In this letting go process, what is being let go? The mind can hold on to perceptions, sensations, fantasy, thoughts, and feelings. Florence describes her experience:

Then all of a sudden, a huge surprise when you leave all your hopes and wishes behind, something is starting to happen. But at this moment, there is no thinking. It’s not something that I can force myself to do.

_There is a profound shift in the quality of the music as I am able to detach myself from a proscribed role and agenda in the therapy relationship._

In the following vignette, Sofia lets go of her expectations, her agenda, and allows herself to relate to the client in another way. She has been acutely involved in, and aware of, a role she has assumed in the therapy relationship and gets to the point where she can observe and then detach herself from this proscribed role and begin to release herself from it in the moment. She detaches herself from her thinking and her control in the relationship. In doing so, she
discovers that the former struggle which manifested in the music and in which she felt embroiled dissipates. At this point, she finds herself in a place in the present moment where she lets whatever happens happen, not knowing where the music is about to go. She notices that the quality of the music changes as well:

There was something in me that said I was tired of the struggle. I’m going to just let go and just give from the heart. I felt like I was in a struggle musically. At this point I had no agenda at all. And I realized at that point, before I picked up the flute, that I had an agenda: I wanted to break through her block! That was my agenda. But obviously it wasn’t working. It was just alienating her more and more. And it’s such a repetition of what goes on in her life. Like it was being induced. She invites you into this struggle. And she keeps isolating and vacillating. And it’s like, I’m going to let go. I think somehow this must mirror power struggles, perhaps with her own mother. I’m just going to be, I’m just going to love you, and not want you to do what I want you to do. Or try to make you be more free, like, “you need to be more free!” No, I’m just going to love you now, and whatever happens, happens. I had no idea of where the music was about to go. I had completely let go. This is really what she needed. She needed the mother’s presence in a way that was non-intrusive. Like she said the music felt warm and soft. The piano music we were playing was so percussive in the first part.
New musical directions become possible as my understanding and feelings reach a point in the therapy relationship when I become open to the possibility of the music falling apart at any moment in the clinical improvisation.

In a supervision session, Jennifer discovers her attachment to a fantasy in which the music falls apart between her and the client if she alone does not keep it from doing so. She discovers that patterns of thinking, feeling and playing support this fantasy, impeding the music from taking a new direction between her and the client. In the subsequent session, she recalls being more present in the musical interaction, more able to hear opportunity in the music, more apt to respond and move in new directions with the client:

My supervisor asked me what was my fantasy of what would happen if I relinquished my old patterns of thinking about and playing with this client and let go of them. I said that I thought the music would fall apart. She asked what the consequence of letting the music fall apart would be. I had to look at my countertransference toward this client and re-visited an old relationship pattern that I was now stuck in with this client. The music had been feeling stuck between me and the client and there were opportunities that I was not hearing and missing, where the music could take on a new direction because I was holding on to this idea that I had to keep the music together on my own. In the next session, I found that I was able to stay with these feelings when playing with the client and to let go of my fear of the unknown and be open and responsive in the moment to moment
musical interaction. The relationship seemed to have new musical opportunities now available.

Deeply Involved

As I allow myself to get more involved in the music, I perceive the client as more involved and in the flow of the music.

The therapists described discernible moments of deep involvement in the clinical improvisation process. They seemed to allow themselves to get more involved in the music and characterized the music as starting to flow. Concurrently, the clients’ involvement moved from playing minimally to more continuously and without any perceivable intention to stop the music. Oliver describes such an interaction:

It was musically just happening. He was just involved in the music and I was involved in playing the music. At a certain point, and I don’t think this was conscious, I almost feel that the more I got into the music, the more the music flowed. He started off barely playing, barely willing to play, playing very softly, and by the end he would not stop. He just kept playing. I sort of went into the music, closed my eyes and swayed in tempo to the music as I played, encouraging him to go into the music.
Shifting Perceptions

I experience a deeper pulse in the music that can be relied upon as a trusting foundation from which rhythmic freedom ensues.

Musical perceptions appeared to shift at this point in the process and were clearly articulated by the therapists. They perceived what they called a deeper pulse in the music, a pulse that seemed to be mutually felt and understood by the therapists and their clients. While the music may have had a clear pulse prior to this point, there was a qualitative difference that the therapists perceived. They described deeper as the therapy dyad’s mutual understanding and feeling of the pulse. This suggested that they might have felt this pulse in a visceral and emotional sense. Experiencing this deeper pulse seemed to allow for greater rhythmic freedom in the music, including syncopations and rhythmic variation around the basic pulse. Both players seemed to rely upon and trust the mutually created pulse as a foundation. The experience of the pulse reached a point where the therapists sensed a release from individually maintaining it. They simply knew and trusted its existence as a fundamental part of the music and apart from their individual role’s in playing it. Ogden relates his experience of a deeper pulse in this way:

Something is being shared on a deep level. That I can stop and he can play through the rests is like we both know where we are in time, feeling the pulse together. We don’t need to be playing together on every beat to know we are playing together. He is holding a basic beat and I play syncopations ahead of it. That kind of sense of accented syncopation,
feeling the pulse. The syncopations and me coming in ahead of his beat with my melodic rhythm, that holding together with him. That feeling of upbeats even in the downbeats. Both of us getting deeper into the pulse.

*A deeper pulse suggests a spiritual connection between myself and my client that transcends the ego and personal realms.*

Nicholas explains further that the deeper pulse suggests a connection that expands the ego and personal realms. The deeper pulse points to a spiritual realm:

There’s also a pulse in the music that I think is some kind of deeper pulse that goes beyond the ego, beyond the personal connection, to a spiritual connection.

*I perceive an expansion in the harmonic palette of the improvisation by experiencing the client’s tones as part of a mutually created musical structure.*

Similarly, Oliver, while playing piano hears his client’s tones on the metallophone as extensions of his piano harmony. His perception of his client’s music creates for him a sense of expansion in the palette of the therapy dyad’s music. In this instance, the expansion is manifested in the harmonic realm of the music:

It’s something about the music becoming more expansive, not just the dynamic becoming louder. Something about the tones being extensions of the chord, like major, he’s playing like a ninth and a sixth.
I experience my musical choices as both risks and opportunities.

Nora finds that her perception of taking risks is transformed to where she experiences them as opportunity to discover more facets and unforeseen potential in the musical interaction. Though she maintains that the opportunity still feels risky:

I was making changes and shifts as we continued. It’s risks. It’s constantly taking risks. There is always a risk component in it. The wonderful part is that I don’t think of those risks as risks. It’s an opportunity. It’s like another facet of the same stone. It’s just like another petal, there’s more and more and more. It’s like finding treasures, although it’s risky.

Music is the dye of the moment to moment connection and communication of the therapy dyad that goes beyond cognitive understanding.

Through the musical interaction, Grace explains that there is evidence of communication in the music between herself and the client, and of connection even when she is not certain about the client’s cognitive understanding:

The only thing we do is communicate in the music. A smile comes over his face that lets me know that the connection is happening in the music. I’m not always sure in what way he is cognitively there. But in the music, it just works. The communication and connection is there in the music and it doesn’t matter. Music is the dye of the connection, of both of us being there and connected moment to moment.
My musical responses emanate from being elevated out of dualistic thinking.

Frederic describes the point in the clinical improvisation when he experiences a momentary lift out of separation and duality. He is released from dualistic thinking and, sensing the client's presence, makes a musical choice from this place. He rules out the notion that any part of the experience could be separated out or thought of in a compartmentalized manner. He feels that this would be an inadequate representation of his experience. He appreciates the nearly unattainable aspect of his experience in the physical realm, although he acknowledges that one can continue to approach and work toward these moments:

There's something about the moment in the improvisation, when I made a choice, the client was there, everything was this momentary elevation out of separation and duality. You cannot go back and say "what if." That is a model for our whole lives. We don't have the ability to achieve that fully, but in a sense, there is no such thing as "what if." I don't think you could ever fully achieve it in physical reality, but you can have these approaches to it.

As I disengage from dualistic thinking, my sense of a self dissipates, allowing a non-polarized perception of the musical experience.

Simon explains his experiences of non-dualism in clinical improvisation as those that do not entail thinking in terms of right or wrong, thinking that the
improvisation is working or not working, or being engaged in any sort of polarized thinking. He asserts that his experience of non-dualism epitomizes the essence of reality. Furthermore, he experiences the relinquishment of dualistic thinking in the moment as the collapsing (or expanding) of the observer and the observed into one. In short, Simon understands this as his sense of a self dissipating:

When it was it was. It has to do with duality in a sense, because duality has to do with right or wrong, it works or it doesn’t work. But the essence of reality, if you go deeper into spiritual perfection: there is no wrong, no polarities, works, doesn’t work. It’s hard for us to analyze that on this physical level. Somehow we are able to momentarily pull out of that duality. The observer and the observed are one.

_The inherent qualities of music allow me to experience and value non-attachment in experiences that are not self-based. I respond musically to ‘what is’ rather than react based on fantasy and judgment._

Ogden grapples to find the words to explain experiences in clinical improvisation that he considers as momentary releases from the enslavement of the self. He understands the vital importance of having a sense of self, although he values the opportunity and value in clinical improvisation of being released from the inherent suffering that comes from an attachment to a self-concerned experience. His musical experience entails being connected to ‘what is’ rather than becoming drawn into habitual tendencies of his mind:
The idea of the self is the root of all misery. Because you are worried about yourself, what could or might happen. All these experiences that are focused on the self are the root of all suffering. There’s no doubt about that in my mind. So, to give us opportunities to be removed from that experience briefly, through whatever qualities music has which releases us from that, is the whole essence of music. That’s essentially how music therapy functions: to completely not be involved in that level of consciousness, to be connected with what is rather than could or should be in your own view of things, suspending our judgements. All our words make it difficult to illustrate that experience, because they tend toward the physical, and self type of experience.

As I let go of thinking that derives from a sense of individuality, I experience the joy and oneness of life in merging with the music and the client.

Frederic describes the point in the clinical improvisation when he believes individuality and self-centeredness dissipate. This is when he experiences what he calls the oneness of life. He appreciates the power of this human experience in music when there is a sense of merging with the music and others in the moment:

I think there is this unbelievable joy in losing your self-consciousness and merging with something that is just coming through you and merging with other people. We’re all doing something together and we’re not all really thinking about it, we’re not being too nervous about what the other person is thinking, all these things that block it. That is a very powerful thing in
human experience where we stop being closed in our individuality. All
spiritual doctrines talk about that, letting go of your individuality and
getting into the oneness of life. And I think that’s what music does, it gets
people out of their individuality and into the oneness of life.

*I perceive the dyad as entering into new territory which paradoxically I
experience as unique to myself and shared with the client as a universal human
experience.*

Speaking to the idea of oneness or universality of experience, Nicholas
recognizes the new territory as a familiar one into which the therapy dyad enters.
He experiences the new territory that the dyad enters as individualized and unique
to him. Although he feels exclusively familiar in this new and personal territory,
paradoxically he senses that the experience is universally appreciated and shared
by both him and the client:

This new territory is the client’s on the one hand, and it looks like I’m
going into just their territory, but on the other hand, it’s familiar territory
to me too, so it’s some kind of universal territory, it’s not just that of that
one person. It feels like both things at the same time.

*Through playing music, I experience the oneness of reality being played
out in time.*

Similarly, Sofia understands her sense of oneness in the clinical
improvisation as reality that is experienced through time in the music. Her
understanding speaks to a timeless nature of reality that music makes available in a sequence of moments:

If we don’t look at it really in time, but as a reality being played out in time, then very obviously every therapist and their client are in a sense one.

I sense that through the music I can come into contact with the client in a deeper way.

As Grace searches for a way to make contact with the client on a deeper level in the clinical improvisation, her impasse speaks to her sense that there is potential in the music for a deeper connection between her and the client:

As we were playing, I found that she was just rambling on the surface. I didn’t know quite how to get to the deeper self.

I experience a shift in my relationship with the client from the intimate and personal level to the spiritual realm which has the sense of merging or oneness.

Sofia explains through analogy how she experiences a point in the clinical improvisation as changing the channel on television, from the intimate and personal ‘channel’ to a spiritual ‘channel.’ She attributes this shift to a high level of identification that verges on the notion of merging with the client. In the playing she has the sense of oneness with the client:

I think that it feels like you are watching TV on a certain channel and then things go into a spiritual realm, it’s like you’re changing the channel. It
has that quality of a deep sharing on a personal level, a deep understanding, almost like a merging, or identification on some level. That you know exactly how a patient feels, you know exactly where the patient is, and you both feel it. This was a patient that was so much like myself. I think that I had such definite counter-transference stuff with her. We were almost a unit when we were playing.

* A sense of parity ensues as boundaries loosen in the therapy dyad. *

Nicholas talks about experiencing a loosening of boundaries and a shifting of roles in the clinical improvisation. In the dyad’s musical interaction, boundaries become less rigid and the dyad adopts roles that have a quality of parity:

> We weren’t in the roles of younger and older in the music, therapist and client. There is a complete shift of roles, he took an initiative, he is making decisions. Maybe because it was like equal parts, so much together.

* Through the language of music, I meet the client on a human level which I perceive as happening beyond the interpersonal. *

Ogden describes an encounter with the client through what he calls the language of music in clinical improvisation. Yet again, this meeting is characterized as human and beyond the personal. In this encounter, Ogden senses directly the client’s presence and his ‘being’ in the music:
I worked with this client who couldn’t enter this world, but we could both meet in this language. He manifested his being in music, and I could feel it. We met in another realm, but it was a very human realm.

*Our usual playing abilities are exceeded in an effortless manner, and without the seeming intervention of a thinking process.*

Florence brings together several aforementioned aspects of the process. She finds that she and the client are able to play their instruments effortlessly beyond their usual capabilities. She has a sense that her capabilities are nearly limitless. She lets go of any thinking that is concerned with where the music will go:

When the flute and singing started, we went into a different space or something like that where it felt totally effortless, like I had no idea of where the music was going. I had completely let go. Particularly since I’m on an instrument that I don’t know, and it was a difficult key for her to play in. In that state, you can almost do anything. It’s beyond the thinking mind.

*A musical experience can move me beyond thinking and a self-centered experience.*

Through his involvement in the clinical improvisation, Simon experiences a release from the thinking that defines and fosters individuality and ultimately
causes misery. Being in the moment and exceedingly related to the client, he moves beyond what he characterizes as a limiting experience of self:

In music we can be taken out of our miserable selves, thinking and creating all our hang-ups, problems and hopes for the future, and everything else that defines our individuality. We really need release from that, so we can cease to be our individual selves and become part of a more related experience. That is the function of art, to transcend your limitations as an individual, and to take you out of that tunnel vision of yourself. It brings you to some sort of experience in the moment that is not just related to your own individuality.

The Process Across Client Groups: Clinical Vignettes

Across client groups, the clinical improvisation process is essentially the same, although the music may sound different.

Each of the three following clinical vignettes is composed from many therapists’ voices. The first vignette tells the story of clinical improvisation with a child living with autism, the second with an elderly client living with dementia, and the third with a young woman who comes to therapy to address relationship issues. The participants recounted experiences of reaching a point of compassion, love, beauty, and joy in the clinical improvisations. There was a clear underlying unity in the therapy processes that took place across these three contexts:

Whether it’s a baby or an older person, the process is the same work whether with a child, a teenager, or adult. It’s the same work using
different music, but it’s the same process. I work with babies to elderly people who are dying. It’s the same exact process. The only difference is the result of what comes out of it, it sounds different, but it’s really the same.

**The Joy of this Moment**

*I experience joy and love through connecting with, relating to, and being fully present with my client in clinical improvisations.*

When they arrived to the first session, his mother said, “this is our last prayer that something can be done.” Well, it turned out that this young boy was so smart. I’ve had so many wonderful musical experiences with him. He started out being so rigid and defensive and scared. He wouldn't do anything, but he was so musical.

The sessions started with him just sitting with me at the piano, not moving. All I did was make up songs about everything in the room. He loved it. I could see that he was just taking it all in. Then, he started bringing in cartoon characters. We put them on the piano and I would sing about this one and that one, then incorporate some familiar songs that he knew. He started saying or singing words. I had these bells and would sing, “The bird is yellow, the bell is yellow, ding, dong, ding, dong…” Then he started saying one word at a time. Then, he started to make up songs. So now we make up songs, I’m helping him with the words. He’ll make up everything from candy bars to macaroni and cheese.
He is now really exploring the synthesizer. He’s getting into the rhythms and he is so sweet. He’s writing songs. I mean I love this guy. I said to his parents, I love your son, he is so wonderful, he’s so sweet. They say, “you think our son is sweet?” I tell them, you’ll see, he’s a wonderful boy, he’s just so nervous. He recently got a keyboard for his birthday. He has a guitar that he uses now, and I’m encouraging him to sing and play and to do music and it’s great and he’s even found a friend. There’s no doubt, if he were to grow up and have no exit from his isolation, that it would be a source of misery for him. His family sees him growing now. So that’s exciting.

That’s what it’s about for me: making changes in people who are so vulnerable and who have the potential to get further and are not given the opportunities because they can’t do it in a traditional and typical way. His parents were so concerned with wanting him to act normal and be normal. They were desperate to get him whatever help they could just so he could exist out in the world. What I try to do with this kid is make him aware of his disability in some way and teach him new coping skills through the musical experiences. So now he knows.

I like to think that I am dealing with the inner issues and the inner psychological issues of this special needs boy. The joy in this work comes from getting to this point in the music with him and it is what keeps me being able to work everyday.
In this story, the therapist worked in the music to reach the special needs child and to help him develop ways of relating that might serve him in his life. She recognized his inner psychic world and worked in the music to connect and relate to him on this level. She fully understood the extent of his condition and believed that through the music they would be able to meet and play in parity. She met him where he was, through the cartoon characters, and used music to develop a relationship. She allowed herself to have and stay with her strong feelings toward the child and described the musical events with exuberance and passion. Her presence with the child as well as her attentiveness to him moment to moment came through in her description of the musical interaction.

**Just Us Beings**

*I perceive that my client is experiencing the joy of being as he transcends the limitations of his condition physically, emotionally, cognitively, and spiritually within the clinical improvisation.*

He found a way to trust his body in time and space. I had the sense that he felt more mastery to play strong accents. Once we got into a pulse and flowing through time, then he could make choices, “okay, now the cymbal, because I’ve got this going and I feel okay.” There was something about his halted tentativeness when it moved into “I’m ready to keep going,” just that shift felt unique for him. All of a sudden, he has strength. He is a strong man in this moment. He deals with two instruments. His fine motor skills are functioning at a high level. He is playing syncopations in a fast tempo and crisply. It is very
different, and for a longer period of time, and a lot of things are happening
musically. I’m changing a lot but still it is at such a profound level.

He is opening up so much, and there are possibilities for him. He doesn’t
have limits in this experience. There is always a risk component involved and
enormous creativity and freedom, and a knowing somehow. There are no
judgements. Really flowing beyond some usual level and really trusting,
connecting, understanding and power. Power! Enormous power in him. He feels
so powerful.

While it was happening in the music, it was happening. So I didn’t realize
how joyful this moment was at the time. I wouldn’t call it bliss, but I felt blessed
to know this guy and to be able to touch this part of him through music. It seemed
unlikely to have happened in his life at this time. All of his confusion and
agitation vanished. He had dementia and from session to session he didn’t even
recognize or know that it was me. Usually when a confused client comes into
singing and playing, and you really relate to this person, after that experience they
may say something unique. He said to me afterwards, “I have music in my throat
all day long.”

So, that is happiness for me. That’s what makes me happy. It always
involves more than one in order for it to happen. Other people who worked with
this man saw that he was more in himself, but more in himself in a joyful way.
That was what I noticed in the end, was that he was happy, joyful, and had
beautiful smiles a lot of the time. He seemed he had really been coming in touch
with a joyfulness in himself that he wasn’t in touch with before.
I think part of that came from this sort of connection between the spiritual and the physical through music, the actual physical process of making music. Joy is our fundamental and original substance. That joy is what goes with these kinds of experiences. It’s the joy that exists before there is physicality. It’s the joy of being, and the fact that being of itself is joy.

Being gets wrapped up in the human personality and comes with all kinds of vicissitudes and problems and tensions and strife and all the anxieties and pain, but that does not discount saying our original being is joy. Though, when you are in that realm it all remains nameless. It all takes place actively microsecond by microsecond. Then there’s the esteem, the esteem of being accepted, respected and loved, actively and practically. And then he is more present as a person transcending the limits of his condition he possesses, far more than he will ever articulate. To what degree is he conscious of this, it is impossible to know.

The therapist sensed and observed that his client in the clinical improvisation moved beyond his limiting condition. He viewed this as a transformation that spanned the spectrum of human experience: the physical, the emotional, the cognitive, and the spiritual. He highlighted the joy of being as a fundamental human experience that took place in the therapy relationship through the clinical improvisation. He expressed further that being in itself was joy and that these musical experiences engendered encounters between beings, between therapists and clients. The bare presence of therapists and clients, the original beings were brought into a relationship in music.
The Passage of Emotion

Through the process of deeply feeling intense emotions toward my client, and being absolutely present with these feelings and with my client's feelings, I come to a profound place in which I experience love and compassion toward my client.

After we had been playing for a while, I think she was perhaps frustrated too, to the point where she wanted to play by herself. I just stopped playing. I just stopped and listened to her and looked around the room, looking for a way to be with her in a way that would not be part of the struggle. This was a patient that was so much like myself. I think that I had such definite counter-transference stuff with her. In that moment, I think I broke through my counter-transference. I said, "I am going to love you, even though you are pushing me away." That's exactly what she needed. I think when she pushed her mother away, her mother got depressed, and then she felt guilty and wanted to take care of her. So I let her push me away, but I didn't leave and I didn't get depressed.

This is a developmental stage that she was waiting to finish, I guess. So, right after I started to play the flute, there was a change in her piano playing. As if she was sinking into her music. I think she was expressing vulnerability, and before it was more capability, as if she were saying in her music: "I am capable, I can do this, I can move on with my life, I'm fine." But when she started singing, when we got into that place, she was singing "a strange new music." She didn't sing: "my mother never sang to me, or I'm so sad because I feel so abandoned."
She didn’t say that, but it is what I heard in her singing, “this music is so strange to me.” I felt the pain and the hurt. Because that music to me feels normal, it doesn’t feel strange at all. That was the music of intimacy and love.

That was strange new music for her. I had never heard her play or sing music like that. The music was so beautiful and spiritual. I really wanted to hear it again because the music was so beautiful! I think we pulled out the best in each other in this experience. The music was so compelling that it just kept pulling me in deeper and deeper. Every part of every choice has a truth to it.

In playing the flute, my presence came out so strongly and then she came forward with her voice to be with my flute line. She came into the music as the highest melody line by using her voice, the most intimate instrument. It was a truth. It has to do with your own state of mind: if you’re clear, and at that point, you don’t have counter-transference issues with your client. If you are involved in those things and you’re thinking of other things in the session, then that can get in the way. I do think it was a turning point when she was trusting me and I was realizing how deeply wounded she had been.

She was narcissistically defended and often she seemed like she was so together. She didn’t show her vulnerability. She had been, over the years, saying, I need a break. What I think she was saying was, I need to separate from you as the mother figure. But she wasn’t ready yet, she hadn’t gotten what she needed which was this unconditional regard. It was a spectacular thing.

That’s what it is about music that is so satisfying, you don’t always consciously think about and know what is happening that way, but you can feel it,
you can feel it on a very clear, subtle and not so definable level. You and the client both feel it. And usually afterwards, it takes a while to come out of it, so you’re sitting in silence for a while. The verbal doesn’t really comes easily, because I think you switch hemispheres or something. So it’s not easy to communicate verbally once the experience is over, but usually there’s no need to because you both understand that something deeper has occurred and that hopefully it could last if you don’t talk about it.

We had other positive turning points over the years. The work we are doing is helping her, but I’m not sure if it’s the words, the music, the relationship or her time to get better. It’s really hard to know. I was very happy to have been part of her process of letting go. She has finally let go. She said, “you know, I can’t remember my mother ever singing to me.” I could just see the repression just lift.

The therapist experienced strong emotions in her relationship with the client. She greatly identified with her client and came to realize a role that she had adopted toward the client. The therapist allowed herself to feel these emotions deeply to where she was able to let go of them in the moment and relate to her client, ultimately experiencing love toward her client. The therapist’s compassion seemed to emerge as she was able to stay with her intense identification and strong feelings. As she said, she was able to not run away as she imagined her client’s mother had in the past. The therapist’s capacity to sit with her feelings in
the moment, as intense and deeply rooted as they were for her as well, allowed her to move through them and to arrive at a new place emotionally.

Reflections on The Point

So, what is the point? The participants painted a complex and vivid picture of an experience at a point in time, a point in space, and a metaphysical point of psychological, physical, and spiritual dimensions. It was when, where and how the music shifted profoundly. As I sifted through and re-read their words, the participants revealed the countless and fascinating qualities of their musical experiences in clinical improvisation. The simple phrase, “when the music flowed,” expanded, or rather exploded, into a vast spray and array of insights and interconnected concepts that when put on paper could be considered and appreciated for their complexity, simplicity and profundity. In describing this point they revealed intricate facets of a gemstone that reflected the clinical improvisation process, adding a fresh angle as well as polishing and clarifying similar facets of this magnificent stone. The reflections coming off of the multi-faceted stone blinded me at times as I faced the challenge of focussing on each nuance, trying to see beyond the glare of its total brilliance. Though, the image of a stone needs to be modified, since the experiences that were described appear malleable, fluid and ineffable. There was nothing solid and fixed about this process. Table 3 brings together salient aspects of the therapists’ experiences that are extrapolated from the theme components in The Point.
Table 3

*The point*

- Directly experiencing client and music
- Sustaining a mindful attentional stance
- Experiencing musical fluency as focus and skills work interdependently
- Listening clearly and responding to *what is* in the present musical moment
- Communicating creatively
- Entering into a client’s reality
- Perceiving the client’s music as the expression of presence
- Being a non-intrusive and nurturing presence
- Experiencing a deeper pulse
- Being involved in the affective flow of the music
- Experiencing joy, love, and compassion
- Perceiving music and client in a non-polarized and non-dualistic way
- Detaching from feelings and thoughts
- Letting roles, agendas, expectations, and fantasy fall away
- Changing perception of musical choices: from risk to opportunity
- Experiencing integration, oneness, and inter-being nature of music
- Not-knowing
- Perceiving music as the impermanent dye of moment to moment presence
- Trusting aesthetic sense and musicianship
- Being musically inventive and playful
The previous three chapters, Starting Where You Are, Getting To The Point, and The Point, form a temporal construct of the therapists’ process in clinical improvisation as they related it --- starting where they are, getting closer to the point, and then arriving at the point that becomes a passageway into the moment to moment flow of the clinical improvisation, into new uncharted musical territory, a third space, where the music and the relationship happen differently.
CHAPTER VI
PLAYING ON BEING

In Playing On Being, I present theme statements, shown in italics, that are meant to encapsulate salient aspects of the therapists' clinical improvisation experience. The themes are drawn across the temporal events of Starting Where You Are, Getting To The Point, and The Point, weaving together the motifs from these sections to create themes. While the previous three sections portray a process as happening in time, the themes presented in this section are manifest throughout that temporal perspective. The themes span the journey of the therapist to, from, into, out of, and through the point. I came to this way of exploring the phenomenon through the process of analyzing the data in the last three sections. Key ideas rose to the surface of my thinking as I was constructing the motifs in the previous sections. For each theme, I assembled a chart that portrays the central ideas for each theme across each phase of the clinical improvisation process.

The poems that are interspersed throughout the theme sections are drawn from analytic memos comprised of my impressions and my experiences of listening to the musical exemplars which the therapists played during the interview. I have included these impressionistic poems as well as excerpts from analytic memos to convey a sense of the musical interaction as I discuss the
themes. By adding another analytical piece, I hope to portray the rich and complex clinical improvisation process.

The Art of Showing Up

The therapists explicitly addressed the inherent artistry and challenges of coming to an attentional stance that allowed them to show up fully in the present clinical improvisation. I venture to say that these therapists learned the simple power of showing up which brought an immediacy of awareness to the musical moment with the client. The simple yet profound stance of being fully present is expressed in the following thematic statement and will be explored in an attempt to shed some light on the therapists’ capacity to do so in the clinical improvisation.

Each of the participants described an openness to experience music with the client in the present moment as fully as possible. Embodied in the present musical moment was the therapist’s self-awareness, awareness of the client, personal musical history and past experiences, emotional, intellectual and spiritual experience and understanding of the therapy process and relationship.
### Table 4

*The art of showing up*

<table>
<thead>
<tr>
<th>Starting where you are</th>
<th>Being influenced by past musical experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relating to music and primary instrument</td>
</tr>
<tr>
<td></td>
<td>Applying musical resources</td>
</tr>
<tr>
<td>Getting to the point</td>
<td>Perceiving silences as full of musical possibility</td>
</tr>
<tr>
<td></td>
<td>Relating and playing at the music-silence boundary</td>
</tr>
<tr>
<td></td>
<td>Maintaining an awareness of presence in silence</td>
</tr>
<tr>
<td>The point</td>
<td>Being right there in music in an absolute sense</td>
</tr>
</tbody>
</table>

In their own words, the participants articulated in many ways that throughout the clinical improvisation process they either found themselves at a point or they were working toward a point when they were fully present in the music, bringing past musical and clinical experiences into the room and into the present musical moment.

In Starting Where You Are, the therapists spoke of their past experiences in music, music therapy, and in their musical history and education. Forinash (1992), in her study of clinical improvisation in the Nordoff-Robbins approach, found that the therapists’ personal musical biographies were considered by therapists to be part of their preparation for clinical improvisation, and were not seen as limitations but rather a vital foundation upon which the therapists could rely and from which they could continue to grow. In the current study, these past experiences were described by the participants as becoming part of how they
understood the therapy process, how they understood themselves as musicians and music therapists, and how they came to understand their clients in the present moment. That they recalled these experiences with emotion speaks to the meaningful and influential nature of these experiences in the clinical improvisation process.

Proficiency and mastery of skill on a primary instrument through years of training in music gave the therapists a font of musical resources that could be accessed in clinical improvisation. The hours of practice and experience on their primary instrument were what the therapists brought into the present therapy encounter. When playing with a client, the therapists had access to honed skills that were used in service of musical expression, relatedness, and therapeutic intention. Technical proficiency coupled with years of music therapy experience, particularly in clinical improvisation, were manifest in the moment as the integration of musical and clinical expertise. As seen in the data, the therapists were continually working to develop as musicians, and may have perceived limitations while honing newer musical resources.

Forinash (1992) found that the therapists, while aware of moments of frustration with their music and with what they considered as their musical limitations, regarded these as a need for continued musical growth and development. In this current study, the data suggests that an aesthetic sense and an advanced level of musicianship developed through years of playing music upon which the therapists could rely. This had the potential to transform the perception of deficiency into a more assured reliance on musical sensibility and creativity.
As seen in The Point, the therapists’ capacity to perceive and trust themselves as musicians and artists prevailed, rendering impotent the limiting self-perception and thoughts of incompetence.

The personal work through therapy or other means became highly valued and essential to being effective in clinical improvisation. Self-awareness, the capacity to self-reflect, and to reflect upon the therapy process were clearly part of the therapists’ professional and personal development and were crucial in their preparation for clinical improvisation. Forinash’s (1992) study revealed that therapists valued post-session analysis as providing them with “insight into their own personal feelings and issues, and increased understanding of how these affect their improvisations” (p.134).

The application of musical resources in the clinical improvisation process became a fundamental clinical tool available to the therapists in the present musical moment. Intensive training afforded the therapists the freedom to play without focusing on the technical aspects of playing. In a sense, that had been taken care of prior to the meeting with the client. In the present musical moment with the client, the therapists’ musical and clinical skills were essentially given a true trial in the living encounter. Technical expertise and musical resources were called upon in the split second moment to moment unfolding of the clinical improvisation. When these resources were well honed, the therapists came to trust that they would be accessible when needed. While internalized resources may have become an integrated component of the therapists’ clinical experience, they remained ever mindful of what and how they were playing with the client. As
seen in The Point, the therapists’ skills and recall of resources, while second
nature in a sense, were not relegated to mindless musical activity. There seemed
to be a way in which the therapists balanced and integrated their knowledge of the
cognitive constructs and mechanics of music with musical expressiveness,
relatedness, and presence.

While a complex issue, one of the central ideas that emerged from these
participants’ words, and from my impression of the musical exemplars, was that
the therapists’ self-perception of their skill and competence came into play in the
present musical moment. The way in which the therapists felt and thought about
their level of skill could have either impeded or enhanced their playing throughout
the process. While skill level is relative, when listening to the music, I could hear
moments when the therapists’ sense of musicianship and aesthetics came through
no matter how complex, intricate, or simple the actual structure of the music. The
therapists’ capacity to use whatever skills were at hand with sensitivity and
musicality drew me, and in my impression, the clients as well deeper into the
music.

The therapists entered into the clinical improvisation process with a
musical heritage that was steeped in specific styles of music or traditions. While
the therapists may have broadened their stylistic repertoire, whatever foundation
that had been firmly established became a great resource and one that could be
called upon quite readily. The therapists’ perception of their clients’ sounds and
expressions were seemingly heard through the therapists’ historical lens of their
own musical styles and traditions. For example, a classical player may have heard
a succession of tones as a Romantic melody of Brahms or of Mozart, whereas a therapist trained in jazz heard in those same three tones an implied harmonic structure containing chordal extensions of a kind that were more typical in jazz harmony. While there were infinite possibilities, the therapists heard from their individual musical foundations. Forinash (1992) discovered that the experience of clinical improvisation “extends back in time to the therapists’ individual and complex musical histories, which are brought to life in the session” (p.137).

Past experiences of seemingly complete immersion in the present musical moment unquestionably influenced the therapists’ openness to such experiences. The therapists realized that these types of experiences were possible in personal and clinical situations. Having had such experiences of immersion in music seemed to become a permanent reference point from which they played in the present moment. In a similar way, negative experiences played a role in the present moment as well. How they had either learned from, remained injured by, or had coped with such events had the potential to influence their capacity to be in the present musical moment. The emotional impact and gravity of these experiences became apparent as the participants recalled significant musical life events.

As evidenced in the data, each therapist had developed a relationship with a primary instrument that remained active in the present musical moment with the client. The history of this relationship to an instrument, albeit inanimate, could be as complex as any other kind of relationship. When the roots of these relationships were deep and passionate, the therapists entered into the clinical
improvisation familiar with the potential for expressiveness and responsiveness acquired through highly personal learning and playing experiences on the instrument. The richness of these positive and negative experiences, and whether or how these experiences had been integrated by the therapists, influenced their capacity to be present in the moment with the client. Developing fluency on a primary instrument engendered a trust in skill and resources that supported and expanded their capacity to be expressive and responsive in the present musical moment with the client. Experiences of expressiveness on their primary instrument had become part of the therapists’ musical repertoire.

Music playing experiences prior to music therapy education and clinical experiences in musical improvisation formed a store of past experiences of expressive playing that were continually present on some level in the session room. The therapists’ mastery of skills and experiences of creative and expressive playing on a primary instrument had the potential to come together in service of the clinical demands in the present musical moment. Thus, the therapists’ musical attention became available to focus on and interact with multiple aspects of their clients’ musical expressions.

In Getting To The Point, the silence around and within music was described as being full of musical possibility. Silence was seriously considered as an essential counterpart to the music. The participants interpreted the silence between themselves and their clients as an embodiment of what was happening in the therapy dyad. Whatever existed interpersonally in the silence found expression in the music. Thus, paying closer and closer attention to what was
happening for the dyad in the silences became a salient feature of the therapists’ capacity to be present throughout the clinical improvisation process. The heightened awareness of the silences was an important aspect of the therapy dyad’s encounter. Langdon (1995) describes an “inner silence,” which she discovered through her practice of meditation, whereby the therapist can be “truly present.” She identifies a “depth of silence” that can become a “place of connection” (p.67) from which she receives the client and the client’s music. Langdon’s ideas extend the notion of interpersonal silence that happens ‘between’ therapist and client, to include the therapist’s intrapersonal experience of silence which can be undeniably effective in heightening the therapist’s awareness of the client and the development of the dyadic relationship.

In this current study, the participants explained that their responses to the client’s initial sounds were based upon and grew out of what they sensed in the relationship in the silences. By realizing the potency of silence, silence was considered as a medium in which there was an ongoing relationship happening. From this perspective, the therapy dyad in clinical improvisation chose sounds that moved them into and out of the medium of music. As the therapists brought their attention to what they were sensing between themselves and their clients in the silences, they continually heard the immediacy of the present moment and the potency of music against the backdrop of possible silence. Silence then became a living medium in its own right from which the therapists played music. In a sense, the therapists held in mind the notion that music and silence could happen at any given moment, and that each player played a role in transforming one into the
other. That silence always remained a potential occurrence in music enhanced the immediacy of the present musical moment. By regarding the silence with such reverence, the present musical moment attained gravity and urgency, and required the continual conscious infusion of sound onto the canvas of silence, creating a tonal and rhythmic landscape. Awareness of the present musical moment was heightened as therapist and client were continually situated between music and silence, essentially playing, relating, moving, and shaping the silence-music boundary. As I listened to the clinical improvisations, the silence-music boundary shifted: as the music approached The Point, both the occurrence of music against the background of silence, and silence against the background of music, became more and more vivid. The music seemed to pop out of the recording, as did the silences in the form of musical rests, slight pauses, and breaths. The interplay of silence and music became heightened as the clinical improvisation moved closer to and through The Point.

The participants intimates that a full presence in the silence and the ability to sense the client’s presence could be understood and explained in physical and psychological terms, yet could not solely be understood or explained in these realms. Their thinking expanded into a spiritual conceptualization of what was happening in the silence. In thinking about the silence in this way, they opened up their perception to include an intangible and, in a sense, an abstruse, non-temporal, non-spatial, and non-rational experience of the present moment. As I listened to the recordings, the therapists’ musical presence was increasingly palpable in both the silence and the music as the dyad moved through the clinical
improvisation process. Over time, I perceived more musical colors harmonically, melodically, and rhythmically. A rich and intensely clear musical palette saturated my listening.

In The Point, the participants described their experience of being present as unencumbered and being right there musically in an absolute sense. Related to this idea of presence, Turry (2001) describes the Nordoff-Robbins concept of “poised in the creative now” which identifies the therapist’s openness and willingness to receive and respond to the client. The therapist is poised in a “state of balanced, receptive alertness” and “readiness” (p.352).

In this current study, the participants’ descriptions of their experiences in their musical examples concurred with my impressions from listening to their music. There was a precise way in which the therapists were present in their music playing. A disciplined awareness and precise attention came together in the present musical moment. This did not seem to exclusively imply a narrow focus and attention. In fact, the therapists explained that their perception seemed to broaden to where reality and the whole of existence were experienced within the microcosm of the present musical moment. So rather than being perceived as a proscribed moment that excluded aspects of their reality, the present musical moment engendered an expansive and inclusive quality. The Zen-like quality of their attention appeared relaxed, open, and they seemed ready to play and respond on the dot, in the moment.

Amir (1995) posits that the “meaning of listening” for music therapists is a listening stance that attends to and takes precise notice of what is happening in the
therapy dyad: “listening with our whole selves to the client’s thoughts, feelings, images, sensations, and wants as being expressed musically” (p.55). Furthermore, and in a paradoxical sense, the participants in this current study recounted a broadened existential understanding of life that was embodied and realized within the present moment. They perceived reality as both focused and expanded in the present musical moment.

The following poem captures my impression of listening to the musical exemplars. The notion of presence coupled with the fullness of the therapists’ vast musical and clinical experiences saturated my own experience of the music:

Here, here
Who’s here?
I am here
Hear me
You are here
Hear you
We are here
Quiet
Here we are
Quiet
Hear we are
We are here
What’s that?
Your look, your way, my look, my way

The way you are

Just now

And now

The way I am now

And now

Just now

The quiet is full

What might happen?

Do I know what could?

Who’s here?

Here hear

What’s that?

Hear here

Here we are

Playing now

And now

And now

And now

Playing now

Hear we are

We are, here
At the Limits of Thinking

While the therapists' in-depth thinking about their clients, the therapy relationship and processes played an essential role in the clinical process, there was a point in clinical improvisation at which they reached the limits of thinking about the process, and moved into a precise attention to the unfolding musical moments.

Table 5
At the limits of thinking

<table>
<thead>
<tr>
<th>Starting where you are</th>
<th>Thinking in multitude of directions and dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to the point</td>
<td>Moving from thinking about to being with</td>
</tr>
<tr>
<td></td>
<td>Becoming absorbed in the present musical moment</td>
</tr>
<tr>
<td>The point</td>
<td>Directly experiencing client and music</td>
</tr>
</tbody>
</table>

In Starting Where You Are the participants described the many directions and tendencies of their thinking. The therapists intentionally thought about critical and fundamental aspects of the therapy process, the therapy relationship, and the client. Therapists from diverse orientations in music therapy learned and used thinking systems to further their understanding of the fundamental aspects of the therapy process.

The data suggested that while some therapists thought about their clients purely from a musical stance, describing and understanding the client in musical
terms alone, others thought in terms of psychological or psychotherapeutic theory, while others engaged in an eclectic way of thinking that included and combined several theoretical constructs. The specific construct itself as well as the extent to which it was used varied amongst therapists. Further, the balance between diverse constructs fluctuated amongst the therapists and could vary within a single therapist’s approach.

I could hear in their words that their use of thinking systems was determined by a multitude of factors, including which aspect of the process they were looking to explain. Regardless of the greater context of the clinical improvisation, in some form or another, a thinking system was employed to shape and further the therapist’s understanding and clinical intentions. In addition to theoretical constructs, the therapists formulated narratives about the client, which informed and contextualized their perceptions within the overall process. This was decidedly apparent in the interview setting as the participants spoke of their clients and the clinical improvisation process.

The therapists informed me of the moment to moment process of the music through a running narrative, or spoke to me as they paused the tape, to convey their perspective and understanding of the musical story that was unfolding. More specifically, psychodynamic thinking about the client was integral for some of the therapists in making meaning of the dynamics of the therapy relationship. As revealed in Starting Where You Are, the therapists’ musical choices in the clinical improvisation were determined by thinking
systems: when, how, why and what to play with the client at the onset and throughout the clinical improvisation process.

As an ongoing facet of the therapy process, the therapists assessed, analyzed, strategized and questioned what was occurring in the clinical situation. Ideas about the client, presenting issues, and the overall therapy process were continually turned over and over in the therapists’ thinking. Some therapists perceived the client and his condition within a social status and structure, thus integrating this perspective into their clinical thinking about the client. As the therapy process continued through time, the therapists continued to work toward integrating present experiences into an ongoing understanding of the clinical process. They created a context for the present experiences within a constructed and evolving narrative of the process.

As illustrated in Getting To The Point, while the therapists thought in these multi-dimensional ways about the client, the therapy relationship and the clinical process, they described reaching a point in the clinical improvisation when this kind of thinking was relinquished and transformed, shifting from thinking about to being with. They became more absorbed in the unfolding of the present musical moments, moving into a way of perceiving or thinking that, in some way, integrated the broader perspective with the more localized view of the improvisation. Their thinking began to shift. The participants were able to describe this shift and transformation in their thinking.

The data suggested that thinking about the client, the music and the therapy process impeded the therapists’ capacity to be fully present with the client
in the musical moment. Prior to this shift, and out of myriad possibilities, the
therapists found themselves involved in expectations, assumptions, judgments and
fantasies of the client and the musical process, some of which were quite specific,
even to the point of creating scenarios of how the client would specifically
respond musically and which direction the clinical improvisation would take. The
therapists who had set agendas and goals found that these became barriers to
being fully present and creative in the unfolding musical interaction. Amir (1995)
posit that the therapist “needs to be open to receive the [client’s] music without
judgement or preconceived ideas” (p.53).

In The Point, the therapists’ fantasies and tendencies to control fell away.
Fantasy and control seemed to go hand in hand, in that, the way for the therapists
to fulfill their fantasy of the client and of themselves was to take a more
controlling stance in the music. This stance relates to Getting To The Point when
assumptions, expectations, agendas and goals may have been construed by the
therapists as a means to find direction and clinical intention in the music.

Albeit complex and complicated, what can be gleaned from the data is that
the therapists’ awareness of their thinking process led them to be able to
relinquish this kind of thinking and to attend moment to moment to the music
itself. Hence, the therapists may or may not have been making a conscious
decision to let go of fantasies and tendencies to control the client and his musical
responses and expressions. Though, nonetheless, at some point, they either
consciously or not, relinquished fantasies and control in the music. The mere
awareness of these fantasies and controlling tendencies may have contributed to their ultimate letting go of them in the musical interaction.

This falling away or letting go phenomenon seemed to allow the therapists to relate directly through the music to what and how the client was playing in the present moment. Stated in other words, the therapists directly experienced the music and the client. Their thinking seemed cleared of extra-musical thoughts about the client and the music. The therapists appeared to reach the limits of ‘thinking about’ the music, and moved into allowing their attention to be precisely on the present musical moment. Langdon (1995) describes the phenomenon of “silencing the rational mind” (p.68) that enables her to be fully present with the client, without engaging her thinking in developing a rational understanding of the present moment. Hesser (1982) explains that therapists “need to let go of fixed ways of thinking that cause us to act in habitual ways, so we can perceive what is happening freshly” (p.7).

As I listened to the musical examples with the participants, I noticed how their way of talking changed. As they started the tape, they mentioned lots of details about their client’s presenting issues, what they thought about the client, their ongoing and changing impressions of the client, and their assessment of the overall therapy process and relationship. They obviously held in mind a font of ideas and feelings about these clients.

However, as we continued to listen to the music, while it became more evident that the therapy dyad was getting more involved in the music, the therapists spoke differently and even less frequently. I could see that they were
again getting involved in the musical process. My impression was that they were letting the music speak for itself. When they did pause the tape to speak, there were often long pauses as they seemed to change from being musically present to using words to talk about the music. As I saw it, this spoke to the conscious process of their minds when involved in the music, how they were experiencing the music without thinking about it. Their comments seemed to focus on the moment to moment happenings from inside of the music. I found myself in a similar mode: experiencing without thinking. In fact, to the point that I had difficulty formulating questions and moving back into the interviewer mode.

**Listening and Playing in the Present Musical Moment**

_The therapists played from being present in the moment to moment flow of musical experience in clinical improvisation. Their preparation allowed them to instinctively know their musical resources as they remained poised to listen deeply and to respond musically to their clients._

As shown in Starting Where You Are, from early in life the therapists had worked hard to acquire technical proficiency on their primary instruments. This afforded them a sense of mastery and freedom that in turn allowed a full and expressive musical presence. Freedom and mastery were an interrelated pair in clinical improvisation. Through disciplined learning and education, the therapists had come to know and feel music instinctively and did not need to think about the music. In fact, the participants recalled how thinking about what they were about to play pulled them out of being absorbed in the music.
Table 6

*Listening and playing in the present musical moment*

<table>
<thead>
<tr>
<th>Starting where you are</th>
<th>Knowing and feeling music instinctively</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring, searching, and questioning musically</td>
</tr>
<tr>
<td>Getting to the point</td>
<td>Alternating attention between microscopic and macroscopic perspective of music</td>
</tr>
<tr>
<td></td>
<td>Focusing listening to client moment to moment</td>
</tr>
<tr>
<td>The point</td>
<td>Listening clearly and responding to <em>what is</em> in the present musical moment</td>
</tr>
<tr>
<td></td>
<td>Experiencing musical fluency as focus and skills work interdependently</td>
</tr>
<tr>
<td></td>
<td>Communicating musically</td>
</tr>
<tr>
<td></td>
<td>Trusting aesthetic sense and musicianship</td>
</tr>
<tr>
<td></td>
<td>Changing perception of musical choices: from risk to opportunity</td>
</tr>
</tbody>
</table>

Similarly, Forinash (1992) reported that therapists involved in clinical improvisation viewed their musical skills and relationship to music as an "inner quality that enabled the therapists to spontaneously and fully feel and exist in the music-making process" (p.124). In Starting Where You Are, the therapists exhibited a greater capacity for being involved in the music, for being present in
playing with client, and for listening deeply to their clients and the unfolding music.

In Getting To The Point, the therapists shifted focus between being in the moment to moment movement of the music, attending to their clients’ moment to moment musical movements, and perceiving the overall musical interaction. In essence, their attention hovered between a microscopic perspective to a macroscopic perspective. As they attended to their clients’ moment to moment musical movements, they were in a seemingly unfettered state of mind, playing with a Zen-like, precise awareness. They responded and moved between various musical stances, including supporting, guiding and joining the client. With the seeming intention of awakening the clients musically, and ultimately deepening the clients’ engagement, they made musical choices that were potentially stimulating and aesthetically attractive to the client, that captured an overall emotional sense of the client and the dyad relationship, and that created an evolving, fluid, and emotional musical space that included the clients’ music.

In listening to one particular musical example, I was amazed and struck silent by the therapist’s use of the whole tone scale to create and hold such tension between her and the client. The music seemed to be moving but at the same time there was a static quality that she generated from the whole tone scale with its evenly spaced tones and no half steps. Yet, with every beat of the client’s drum, she was there, just there, sometimes pausing, yet ready to move in a millisecond in whatever direction the client moved rhythmically and dynamically. By holding and sustaining this musical tension, I sensed in the client’s beating that the
therapist was drawing the client, and me as I listened, into the very, very, absolute present musical moment. What was happening between them was heightened and enhanced by a laser-like precision in her playing. This seemed to transform the client’s tension into a beneficial and healthy tension between them, similar to the tension that holds water molecules together to make it water. Here it was, the tension that held them and the music together. She impressed me as a Zen master swordsman who is ready to move any part of his body in any direction that his opponent could move, without favoring one over the other. Similarly, this therapist’s focus was specific, open, and clear. An even, hovering, yet precise attention. It was amazing and captivating to listen to!

In Getting To The Point, the participants considered musical exploration, searching, questioning, and trying things out as part of the process, yet they seemed to reach the limits of checking and searching musically, and began to relinquish this stance, approach and thinking. The therapists accessed their capacity for focused listening to the consecutive and smallest moments of their clients’ playing and the overall music. This seemed to create the potential for a shift out of habitual playing and into a new musical direction. In the musical examples, this new direction included a contrasting change of musical style or idiom.

As the participants spoke of the unfolding musical moments, slowing down the process for me to grasp the subtleties of their experience, they were able to pinpoint the critical points at which they moved from habitual playing to more
spontaneous playing. How they were listening to the music in the interview seemed to parallel what they were describing in the clinical improvisation.

As the data in The Point revealed, from this focused listening stance in the present musical moment, the therapists were able to relinquish patterns that had developed in the music in order to be increasingly with the client musically. As the therapists were absolutely focused in the present moment, paradoxically the present moment seemed to embody the past and future musical moments.

Furthermore, the present moment simply became the preparation for the next musical moment. The therapists demonstrated the capacity to stay with the client musically and to find the direction of the music out of the present moment. Their experience of making musical choices shifted from perceiving them as risks to perceiving them as opportunities. Their focus and skills worked interdependently: a precise and absolute focus as their skills were available in the present moment.

In The Point, the therapists had the capacity to simply listen instinctively. Furthermore, through their mastery of the tools of music and their innate understanding of musical structure, they could trust and settle into a fluent communication with the client. The participants explained that this fluent communication was possible through music. One participant described music as the primordial and underlying language of creation. Some participants suggested that music was the medium that allowed the therapy dyad to communicate on a fundamental and creative level. As explained earlier, the therapists found that they were able to trust in and engage their aesthetic sense and musicianship. In The Point, they seemed to be doing so in an effortless manner and without 'thinking
about' what was happening musically. Paradoxically, they experienced a great expenditure of energy effortless.

The data suggested that the therapists were using music as an emotionally expressive medium, making musical choices that enhanced the emotional quality of the music and the clinical encounter. Similarly, Forinash (1992) points to the need for the therapist to have "an innate feeling for the music," "the ability to bring that feeling into the clinical session" and "to be able to be fully expressive in the music-making process while maintaining a sound clinical awareness of the clients" (p.126).

Relating and Being in the Third Space

There was a point in the clinical improvisation that was an entrance into a space where the therapy relationship and creative process happened differently and the music seemed to play itself.

In Getting To The Point, the therapists made great efforts toward aligning with their clients. The participants carefully and thoroughly considered the essential work toward alignment which called upon their capacity to understand and relate to their clients on an emotional, cognitive, and physical level. Through challenging moments of disconnect and unrelatedness in the therapy dyad, the therapists guided themselves back to the point of accepting what was happening musically. It was through this guiding back to the present musical moment that connection and relatedness were re-established.
Table 7

**Relating and being in the third space**

<table>
<thead>
<tr>
<th>Getting to the point</th>
<th>Aligning and empathizing with client</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Being with <em>what is</em></td>
</tr>
<tr>
<td></td>
<td>Relating beyond pathology</td>
</tr>
<tr>
<td>The point</td>
<td>Perceiving the client’s music as the expression of presence</td>
</tr>
<tr>
<td></td>
<td>Being a non-intrusive and nurturing presence</td>
</tr>
<tr>
<td></td>
<td>Entering into a client’s reality</td>
</tr>
<tr>
<td></td>
<td>Experiencing a deeper pulse</td>
</tr>
<tr>
<td></td>
<td>Being musically inventive and playful</td>
</tr>
</tbody>
</table>

By just being there with their clients and accepting *what is*, they explained that the client was, in turn, helped to accept *what is*. At this point in the therapy relationship, the therapists were moving closer to the client, and developing an empathic stance. They were beginning to deepen their perceptions of their clients, and relating to the client beyond pathology or condition. This movement toward greater alignment, connection, and empathy continued to shape the therapists’ musical decisions.

The work in Getting To The Point moved the clinical improvisation to this entrance into a *third space* --- meaning a new territory. As described in The Point, it was a space where the creative process and the therapeutic relationship
happened differently. The use of the word “third” describes this space as one that is metaphysically occupied by both therapist and client, and not exclusive to either the therapist or client. In this third space, therapist and client co-exist and interact in a mutual manner.

At the Point, the primary mode of perception between therapist and client was listening. There seemed to be a narrowing toward a listening mode by the therapists as a way of homing in on their clients’ musical sounds and to perceive them as expressions in the present musical moment. The therapists were able to hear their clients’ music and sounds as these were, with minimal distortions created by expectations, assumptions, agendas, and emotional reactions.

Amir (1995) addresses clarity in listening as she highlights the need for therapists “to be open to receive the music without judgement or preconceived ideas,” to put aside their own goals, interests, and desires, and to be “fully in the present moment, receiving the music on a moment-to-moment basis” (p.53). This requires “total concentration and attention to the music… and the ability to fully ‘be with’ the music” (p.53). Hesser (1982) emphasizes that listening is fundamental in music therapy process, and avers that therapists are often filled with their own responses and thoughts and consequently they do not actually hear what the client is playing or saying.

As the data suggested in this current study, the therapists’ focused and unfettered listening allowed them to respond, rather than react, to the client musically. The therapists began to fully trust in the clients’ sounds as a musical expression of presence. Thus, the therapists’ responded musically from their
deepening perception of their clients’ presence, rather than reacting musically which would be based on assumptions, agendas, and preconceptions. Hesser (1982) suggests that therapists move toward being present with the client through “true listening” which she explained as listening “with our heart as well as our brain” (p.7). She further states that “in order to listen this carefully to another, the therapist must be able to open himself to experience in a deep way” (p.7). Ansdell (1995) describes “a fine precision of listening-in-playing” (p.159) that encourages musical reciprocity in the therapy dyad. He purports that listening is the “vital condition for making contact in the music and going on to establish the close, creative musical relationship” (p. 159). His ideas speak to what is happening in the therapy dyad relationship through the therapists’ clarity in listening.

In the present musical moment, the therapists facilitate their clients’ entrance into this creative space:

let’s go to this place
just as you are
just as it is
a place to play
just as I hear you
just as we are
here in this space

Inherent in this third space was the capacity of the therapists to create a nurturing environment by being present as the musically and emotionally
accessible and non-intrusive parental figure. This non-intrusive presence of a parental figure allowed the client to play freely without undue interference, similar to Winnicott’s (1971) conception of the potential and intermediary space with mother and child. The therapists supported and scaffolded their clients’ musical play. The therapists’ own capacity to play was activated and fully functioning in this space. Their ability to be playful and inventive as would a child, along with a capacity to be present were vital aspects of the creative process in the third space.

In this space, they entered into their clients’ reality as fully as possible and this could be thought of as an outgrowth of the work of alignment described in Getting To The Point. In explaining his theory of shifting consciousness in Guided Imagery in Music, Bruscia (1995) suggests that he has the capacity to “experience what the client is experiencing” through his close observation and attending to the client’s attitude and responses, and putting himself “in that same position” as the client (p.169). The participants in this current study described an alignment with their clients that can be thought of more as a thorough wonderment and imagination of how the client would play or perceive the music. Rather than the enactment of their clients’ behaviors, the therapists’ psychically put themselves in their clients’ musical shoes without the musical enactment of their clients’ music.

In this space, the therapists perceived their clients’ music as an expression of presence and as an essential aspect of the musical content and texture. They perceived an expansion in the improvisation’s harmonic palette by interpreting the
clients’ tones as part of a mutually created musical structure, whether or not this was the conscious intention of the clients.

As a particular musical example, the therapists described what they called a deeper pulse that was characterized as a mutually understood foundation of the music. The pulse was implied or explicit, or shifted between being implied or explicit, without the therapy dyad losing a sense of their rhythmic foundation. This foundation was constantly renewed moment to moment in the pulse, and may have contributed to the therapists’ sense of deep experiencing in the present musical moment. That the therapists understood this deeper pulse as mutually created and needing both players to sustain it, exemplified its potency, immediacy, and critical role in the third space. It could be relied upon only to the point of its present occurrence.

There seemed to be a mutual understanding that at any moment the pulse could indeed dissipate or change, yet there was a deepening trust and reliance in the present musical moment that it was being renewed by either or both persons in the therapy dyad. Viewed from a broader musical perspective, new musical directions became possible as the therapists reached a place where they held in some part of their consciousness the possibility that at any moment the music could fall apart, and that all musical elements (harmony, rhythm, tempo, etc.) were continually renewed moment to moment. Paradoxically, the sense of a deeper pulse (or deeper harmony, tempo, etc.) could be relied upon as a trusting foundation from which creative freedom ensued between therapist and client.
Musical trust was at once renewed and relied upon in the present musical moment.

In thinking about his idea of a creative space where the music and the therapy relationship happened differently, especially as the dyad moved through this metaphysical point, I am reminded of the scene in Lewis Carroll’s Through the Looking Glass as Alice imagines if it is possible to go through the looking glass. The following excerpt captures what I am imagining as an important aspect of this third space:

“...if you leave the door of our drawing room open: and it’s very like our passage as far as you can see, only you know it may be quite different on beyond... Let’s pretend there’s a way of getting through into it... Let’s pretend the glass has got all soft like gauze, so that we can get through. Why, it’s turning into a sort of mist now, I declare! It’ll be easy enough to get through ---" And certainly the glass was beginning to melt away, just like a bright silvery mist. In another moment Alice was through the glass... The very first thing she did was to look whether there was a fire in the fireplace, and she was quite pleased to find that there was a real one, blazing away as brightly as the one she had left behind. “So I shall be as warm here as I was in the old room,” thought Alice: “warmer, in fact, because there’ll be no one here to scold me away from the fire.” ...Then she began looking about, and noticed that what could be seen from the old room was quite common and uninteresting, but that all the rest was as
different as possible... "They don’t keep this room so tidy as the other,"

Alice thought to herself (Carroll, 1998, p.127).

The Middle Way with Feelings and Thoughts

*The therapists moved musically in evolving affective states with greater tolerance through their nonattachment to feelings and thoughts.*

Table 8

*The middle way with feelings and thoughts*

<table>
<thead>
<tr>
<th>Starting where you are</th>
<th>Being in patterns of musical reacting and playing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to the point</td>
<td>Observing thoughts, feelings, and musical tendencies</td>
</tr>
<tr>
<td></td>
<td>Moving toward experiencing fully and being with feelings</td>
</tr>
<tr>
<td>The point</td>
<td>Being involved in the affective flow of music</td>
</tr>
<tr>
<td></td>
<td>Experiencing joy, love, and compassion</td>
</tr>
</tbody>
</table>

In Starting Where You Are, the therapists’ attachment to thoughts and emotions led to reacting, rather than responding musically to their clients. As a coping strategy in the clinical improvisation, the participants reported that they reacted in an habitual manner as they faced the unknown prospect of the clinical situation. Their reactive stance appeared to grow out of the anxiety around not
knowing what and how to play. This, in turn, influenced and manifested in what and how they play. Whatever the source and nature of their feelings, when feelings were not fully within the therapists’ awareness, they had the potential to hold the therapists in a musically reactive stance, rather than a musically responsive stance.

Further, in Getting To The Point, the therapists’ awareness appeared to bring them to a point where they could observe feelings and be present with them. They experienced a shift from grasping and rejecting feelings toward not being attached to the feelings. The participants described thinking patterns, that included theoretical constructs as a means to create therapeutic meaning in the musical encounter. They found that their thinking often led to their clinging to feelings, and subsequently to having a sense of disconnect from the client in the music. When they were able to observe their thinking and relinquish it, and to allow their feelings to happen with awareness, the therapists moved into being present in a different and fuller sense in the musical moment.

As described in Getting To The Point, there was the necessary and ongoing process of moving toward being with feelings. Forinash (1992) found that “acknowledging and allowing one’s own feelings and trusting in oneself is vital for those who practice clinical improvisation” (p.134). In this current study, the greater the extent of the participants’ awareness of and living fully in the uncertainty, vulnerability, anxiety, wonder and doubt of the clinical encounter, the more they seemed capable of responding musically from their present state of being, rather than from a habitual and reactive stance.
In clinical improvisation, the therapists continually moved between the tension created by rejecting or clinging to intense emotions, to the resolution of being aware of and capable of observing feelings. This nonattachment created a *middle way* of being with feelings and thoughts whereby the therapists were able to initiate being with their clients differently in the music. Through this middle way, the therapy dyad was released from the bondage of habitual and reactive thinking, and reacting musically based on old emotional patterns, thereby opening up the possibility to move out of locked styles and relating patterns in the music.

As seen in *The Point*, the participants described experiences of deeply feeling their emotions toward clients, and being able to be fully present with these feelings and with their clients. By going through this process, the therapists came to a profound and paradoxical place in which they could ultimately detach from these feelings yet remain fully involved in the emotional substance of the music.

Their capacity to sit with and experience this nonattachment to feelings and thoughts seemed to contribute to their sense that the music was just happening. They found that they responded to ‘what is’ in the present musical moment rather than out of their fantasy, judgment, fear, anxiety, and expectation of what was or could be happening. While playing, the therapists sat with and moved through potent affective states, sustaining their capacity to bring themselves back to the present musical and emotional moment.

Amir (1995) describes an attentional stance that engenders a “state of being which is still but moving at the same time, relaxed yet stimulated, passive but active” (p.55). These paradoxical ideas of relaxation and stimulation, passivity
and activity speak to the participants’ experiences in which they were able to stay active and involved, and yet appeared to have an inner quietness. This balanced stance, or middle way, allowed responsiveness, fluidity, and movement through the affective qualities of the musical interaction. Langdon (1995) further suggests that through “silencing the rational mind,” the therapist’s response “rather than coming from the personal or theoretical, comes from the universal” (p.69). Her suggestion speaks to the relinquishment of thinking that the participants in this current study have described, and further relates this notion to their characterization of being connected and present with clients on a spiritual level.

The participants described the inherent quality of movement in music as having the potential to engender and support an affective fluidity. The data suggested that there were implied tendencies of the music that could be mutually understood between therapist and client. This engendered direction and momentum, while sustaining the awareness and gravity of the present moment. Interestingly, concomitant to moving through this fluid range of emotions moment to moment, in the present musical moment the participants reported experiencing feelings of joy, love, and compassion. Their experiences of emotional fluidity and breadth of emotional responsiveness appeared to contribute to their sense of universality of experience between themselves and their client.
Breaching Beyond

The participants described a shift out of dualistic thinking, polarized perceptions, and a release from the bounds of self toward an interdependence and universality in the therapy dyad’s music.

Table 9

<table>
<thead>
<tr>
<th>Getting to the point</th>
<th>Moving out of dualistic and polarized thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loosening and maintaining boundaries</td>
</tr>
<tr>
<td></td>
<td>Engaging more deeply in creative process</td>
</tr>
<tr>
<td>The point</td>
<td>Perceiving music and client in a non-polarized and non-dualistic way</td>
</tr>
<tr>
<td></td>
<td>Detaching from roles, agendas, fantasy</td>
</tr>
<tr>
<td></td>
<td>Being in a place of not-knowing</td>
</tr>
<tr>
<td></td>
<td>Experiencing integration, oneness, and inter-being nature of music</td>
</tr>
</tbody>
</table>

As expressed in Getting To The Point, deeply knowing their clients, aligning with their clients, and developing intimacy in the therapy dyad entailed the therapists’ capacity to enter into their clients’ world. The extent to which the therapists experienced a loosening of boundaries suggested a significant aspect of being in a creative process with their clients. In this way, the therapists moved
away from the kind of thinking that involved conceptual dichotomies as well as thinking and perceptions that continually vacillated from extreme polarities such as right and wrong notes, beautiful and ugly music, my music and your music, and so on.

Much of the theoretical thinking that therapists adopted to help in understanding the client and the process involved ideas that either placed the therapist and client at various points along a continuum between poles of well-being, or within prescribed roles in psychodynamic constellations in the relationship. Goals and clinical objectives fell within this polarized and dualistic thinking. As mentioned earlier, these thinking systems gave structure, rational support, and meaning to the therapy process, yet these very thinking systems seemed to be rendered impotent as the therapists found themselves more engaged in the creative process of clinical improvisation.

The therapists described a shift in their relationship with the clients. They moved into a deeply intimate level within the realm of human experience, yet without the boundaries that divided and separated them from clients, and the therapists from their own experiences as well. In this regard, Bruscia (1995) states that therapists need to pay close attention to boundaries as they shift their conscious focus to move into the “client’s world” and become deeply involved in the client’s experiencing in the moment. He asserts that therapists need to have “personal boundaries that are clear and defined, yet open to fusion and permeation” (p.193). Bruscia (1995) warns that there is a potential for considerable risk if the therapist lacks sufficient ego-strength, training and
maturity. Langdon (1995) posits that therapists need to develop the capacity to
discern between their own issues and the client's so they can work with greater
therapeutic clarity. Once this capacity is developed, she contends that in order to
work musically on a deep level with clients the therapists may be required to “let
go of their usual defenses and boundaries” (p.66). The participants in the current
study highlighted the need for maintaining clear inner boundaries while having
the capacity to have permeable outer boundaries in order to connect with clients
in the emotional and spiritual realms.

In Getting To The Point, they described a shift in their outer boundaries as
they became more present in the musical moment. The therapists were living fully
in the present with themselves and with their client in the music. To capture their
sense of the interactional field, the participants used the term spiritual to give
meaning to an experience that appeared to bring the therapy dyad into a way of
being with one another that could not be adequately described through language,
which is dualistic by nature. With that in mind, ironically here is my attempt to
use language to convey the therapy relationship as it moves closer to the point:

Images mirrored are we:  We are mirrored images:

    Me in you, see I.     I see you in me,

    You in me, see you.   You see me in you.

We are mirrored images. Images mirrored are we.

Music reflected.  Reflected music.
Listening and playing,  Playing and listening,  
Play and listening,  Listening and playing,  
I and You,  You and I,  
You and I.  I and You. 
Reflected musics.  Musics reflected.  

You knowing me,  Me knowing you,  
Me knowing you.  You knowing me. 
Musics are shared.  Shared are musics. 
Musics are human.  Human are musics. 

Me in you, see I.  I see you in me. 
You in me, see you.  You see me in you. 
Me reflecting you,  You reflecting me, 
You reflecting me.  Me reflecting you. 

As seen in The Point, when the therapists disengaged from dualistic thinking, their sense of a self dissipated, allowing a non-polarized perception of the musical experience. Their musical responses emanated from being elevated out of a dualistic thinking stance. Their perception of the musical path that involved two music-making partners whose contributions were each vital to shaping and moving the music moved into an intersubjective perception of the musical interaction. This new perception appreciated the paradox of sensing the
music as belonging to both and neither of the music-making partners. This sense of heightened parity in the creative process of the therapy dyad can be thought of as a shift from thinking about what is happening in polarized terms to grasping the notion of experiencing the fundamental openness of being creative with another human being.

The participants described their experience of a shift from a stance of knowing to a place of not-knowing as they directly involved themselves in the present musical moment. Forinash (1992) found that therapists spoke of clinical improvisation as “facing the unknown, which they recognized as a powerful force” (p.127). McMaster (1995) describes a therapist’s stance as “a sense of not ever knowing completely what is here, now, either within or around us... a willingness to be profoundly surprised” (p.73). Hesser (1982) concurs in stating that therapists need to “let go and rest in a state of ‘not knowing’... [and] put aside all the theories and techniques that we have learned and come to the experience open to being surprised” (p.7).

In The Point, the participants described a profound shift in the music as they were able to detach from prescribed and essentially proscribed roles and agendas. Amir (1995) states that therapists’ musical listening must transcend the personal realm whereby they are able to set aside their own goals, interests, and desires, which allows for a deepening presence with the client.

Furthermore, the data suggested that the therapists moved into an awareness that did not involve the self and the thinking mind. In this way, the observed and the observer collapse into just being the experience. Through the
music-making process, therapist and client experienced a sense of universality, or oneness of reality, being played out in time. As they continually relinquished thinking about and moved into and through feelings from a place of nonattachment, the therapists described having a sense of joy and oneness in life. In The Point they experienced their relationship with the client as moving into new territory of universal human experience, and in a joyful and deeper contact with the client, as being to being. They perceived the client in a way that opened up creative musical possibilities, without the limiting thinking about condition, pathology, psychodynamic constructs, and in a holistic sense that melded physical, emotional, cognitive and spiritual experiencing. In this way, the participants reported experiences of moving through a deep and profound sense of empathy for and relatedness to the client, to a sense of universal experience.

The Unfolding Path from a Bird’s Eye View

Each of the participants described a musical path that unfolded out of their movement to and from the point of being in the present musical moment with clients physically, psychologically and spiritually.
Table 10

*The unfolding path from a bird’s eye view*

<table>
<thead>
<tr>
<th>Starting where you are</th>
<th>Being distracted from musical involvement by thinking and emotional tendencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to the point</td>
<td>Letting go</td>
</tr>
<tr>
<td></td>
<td>Making musical decisions reflecting a deepening engagement and relatedness</td>
</tr>
<tr>
<td></td>
<td>Sensing music as a bridge between physical and non-physical realms</td>
</tr>
<tr>
<td>The point</td>
<td>Sustaining a mindful attentional stance</td>
</tr>
<tr>
<td></td>
<td>Perceiving music as the impermanent dye of moment to moment presence</td>
</tr>
</tbody>
</table>

As illustrated in the following poem constructed from analytical memos, the clinical improvisation moved along the temporal events of Starting Where You Are, Getting To The Point, and The Point, yet not necessarily in a linear manner throughout the clinical improvisation. It seemed to be a cyclical process in which movement from one phase to another could occur at any time. It was as if, at any moment, there could be a spontaneous blossoming from starting where you are through to the point where the music flowed. The image of a flower opening up as seen in a time lapse photography sequence can be used to portray...
this movement in the clinical improvisation. As well, there was continual
movement toward and away from the point where the therapist is absolutely in the
present musical moment. To continue the blossoming flower metaphor, there are
moments when the flower returns to its starting place of a smaller bud (moving
away from the point), and then blossoms again as the conditions allow. Similarly,
this movement to and from this point of the blossoming music describes the
process of the clinical improvisation:

You play chromatics up and
down and up and
down in
melodic
circles
as I play in between and around your
notes as we twist and turn the
melodies
around and
around and
around
and around.

High, high up in the treble I am
and you are in the deep
deep
bass.

I move closer to where you are and you retreat
to the deep,
depth

bass.

I stay up in the high, high treble
and you stay low in the
deep,
depth

bass.

Twisting the melodies around and around,
half steps up
and down
and up

with rhythms steady and busy and steadily busy
plodding through the
rough, rough terrain

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We go and go and go and go
But,
Where are you?
Where am I?
Where are we right now??

But then I listen to how you play.
I simply listen to what you play.

As you twist the notes around more and more,
on your own, with me here, I hear, and you hear
right now it’s you
here and I hear what you play right now,
right here.
I listen as you listen, as we listen right here to you
as your right hand falls into a gentle bass motion,
moving up and moving down
the broken chords create a new ground, a fresh terrain
with fewer spikes and different points
as when we played together
when we started just a while ago.
I hear as you play a short lyrical melody on top
as we get closer to the point
when I hear my voice
on a flute come in
with long, long breaths of pentatonic tones, long,
long breaths of pentatonic tones.

I hear where we are
we are here in this new
new music for us to play.

Like a lullaby I think
and we go and go
as we rock and sway
in our rhythmic way
and now you sing out strange new music,

strange new music.

I am
with you
you with me
this is mine
this is yours
this is ours.

As I play my breathing pentatonic tones
  You sing out
  You sing out
  "strange new music"
  loud and clear and loud and clear
  it goes and flows,
  it goes and flows.

I start to think
What am I doing?
What are we doing?
Where are you going?
Where are we going?
Is this right for you?
And for me?
Should it be?
What to play?
What to do?
I must stop
so I pause, and I think, pulling back, pulling back, and then you pause and here I think we are right where we started from
but then I know this is right to let ourselves
go on
to the point where we were
just a while ago,
so I fall back in
to the strange new music,
we let it go,
we let it flow,
it's me,
it's you, it's we,
it's what we play
right here
right now.

In Starting Where You Are, the therapists brought to every moment in the
clinical improvisation their unique musical histories, experiences, and thinking
about their clients and the clinical process. In Getting To The Point, their *thinking
about moved into simply listening and making musical decisions based on what
was happening musically moment by moment, thereby the therapy dyad created a
musical path as the moment by moment musical flow. The therapists’ musical
choices were at once manifestations of and a means of moving toward relating to
their clients across the span of emotion, cognition, physicality and spirit. In this
way, the music can be perceived as a bridge between the physical and nonphysical worlds: between what therapist and client play and what they experience in the mind.

In The Point, the participants described an attentional stance that moved to one of a highly mindful nature. The clinical improvisation reached a critical point through which the therapy dyad passed and the musical interaction took on a qualitatively different character. At The Point, the therapists experienced an uninterrupted musical path. Through their process of becoming mindful in the present musical moment, a letting go of ‘thinking about’ allowed the musical interaction to happen, seemingly on its own. Forinash (1992) explains that therapists in clinical improvisation “saw the need for awareness and acceptance of the event and a necessary sense of trust and ability to ‘let go’ into the process” (p.139). Furthermore, she found that therapists “concorded on the importance of an essential willingness to be open and vulnerable to the experience” (p.139).

As they allowed themselves to become more present and immersed in the music, the participants in this study described their perception of a musical path as a continuous moment to moment flow. The therapists realized that the music was being sustained mutually between the therapy dyad and that at any moment there was the potential of the music to fall apart, that the music was transient and elusive in nature. This speaks to the sense of impermanence of the present musical moment which at once heightens the vitality of the therapist and client role in the music. Furthermore, a sense of immediacy and urgency were inherent in the therapists’ experiences of being musically present.
The music that is created in the moment to moment flow along the musical path takes on the character of the dyadic interaction, its connection and communication. At The Point, the music could be described as the dye of the absolute presence of the therapy dyad in the music: the music was the aural manifestation of the experience of the therapy dyad. Paradoxically, the music was both relative and absolute in nature: relative in the sense that it was the manifestation of the particular dyadic relationship, and absolute in the sense that it was the meeting of two beings, realizing the universality of being in the musical experience. Explained metaphorically, each of the two players in the therapy dyad could be thought of as one of the wings (relative) of a single bird (absolute) that has taken flight:

I am one wing

You are the other

Together we take flight

Not one without the other

As one.

There was a clear interdependence between the therapist and the client. Though, perhaps more precisely, the nature of the therapy dyad could be characterized as inter-being at the point and in the third space. The interplay between each player happened across multiple domains of experience. The being to being relating came to fruition through the physical, psychological, and cognitive act of playing music. As the therapist and client moved toward and
away from being absolutely present, the therapist experienced the music as having the characteristics that have been detailed in The Point.

The point appears to be a shift in the quality of presence, and of being. It seemed to happen spontaneously and at any moment, though, in listening to the participants' descriptions of the process, it was evident that their hard work and precise discipline of coming back to the present musical moment were key factors in this shift. The experience of musical flow is grounded in and sustained by the practice of being in the present musical moment. Its duration fluctuated. It did not appear to be a trance-like or transcendent state necessarily, as it was firmly grounded in the therapists’ awareness and mindfulness in the present musical moment, including the precise perception of the music.

The therapy dyad moved instantaneously through the point to where the music flowed in an instant, yet the work and precise discipline illustrated in Starting Where You Are and Getting To The Point continued through The Point. These three phases of the process are only imagined as three concrete boxes. I have necessarily created them in order to describe and discuss the holistic process of clinical improvisation.
CHAPTER VII
MINDFULNESS IN CLINICAL IMPROVISATION

Proposing a Model

I propose a model of clinical improvisation to illustrate, coordinate, and synthesize what I learned about the many interrelated aspects of the music therapist’s experience of clinical improvisation. In this chapter, I present and discuss a developing model that portrays metathemes that were lifted from the themes of the previous chapter. I found that by developing a graphic and visual model, I could better depict and ultimately understand the relationship between these concepts that interact in a process. The model synthesizes the themes of Playing on Being and the temporal scheme of Starting Where You Are, Getting To The Point, and The Point. The model, shown in figure 1, creates an abstraction in visual form of a whole, complex, and lived experience.

The overall structure of the model implies a cyclical process that can happen in the flash of a moment or over a sustained period of time. True to the nature of the described phenomena by the therapists, the integrated components of the model can dissolve and form in an instant at any moment in time. By its very nature of having a discrete and discernible form, the visible structure of the model tends to distort the interrelated nature of the experience. The model is a graphic
AFECTIVE FLOW
Impermanence
Nonattachment

MINDFULNESS
Direct experiencing of music

INTER-BEING
Being-for
Fluid transactional musical self
Oneness

MUSICAL CO-ARISING
Open listening
Skillful being

THIRD SPACE

The Point
PLAYING ON BEING

GETTING TO THE POINT

LETTING GO

BEING WITH
THINKING ABOUT

MUSICAL SELF-AWARENESS
Concentration
Deep listening
Responsiveness
Expanding musical perception

MUSICAL TENDENCIES
Habituial playing
Musical reacting

HISTORY
Past musical experiences
Skills
Musical resources

TENDENCIES OF MIND
Dualistic/polarized thinking
Static self-constructs and self-identifications
Clinging/rejecting feelings
Agendas, goals

Figure 1 Mindfulness in clinical improvisation
device that allows a closer look into each aspect while keeping in mind the holistic evolution of clinical improvisation.

The shape of the model tells a significant part of the whole story. Imagine that the two upper phases of the model, represented by spheres, have a bubble-like quality with a thin film holding each of them together. Their forms are flexible and malleable, can contort in myriad ways, exist and float for a while, but at any time, may dissipate. All aspects are at once interdependent and tenuous in nature. The lower portion of the model consists of foundational aspects illustrated as angular geometric shapes and spheres that support the more spacious sphere, or bubble, of the third space. The rectangles and triangular forms represent Starting Where You Are, the middle spheres represent Getting To The Point, and the uppermost sphere as the third space represents Playing On Being. The shapes of the lowest section have angular and contained spaces, representing the containing and foundational quality of those aspects in the process. The three phases together portray the therapist’s musical and psychological processes and are connected to one another as an illustration of the interrelation amongst them.

The third space has been intentionally depicted as precariously and dependently floating atop the lower sections. The existence of the third space depends upon the existence of the lower spheres. The passageway of the point connects the third space to the lower spheres. Imagined as a vast and limitless sphere, the third space has no visibly contained frame as a way of conveying its unbounded potential. The suggestion of a metaphysical structure, which takes license with the laws of time and space, portrays the non-linear time/space frame
of the clinical improvisation process. The interconnecting ovals of the third space characterize the interdependent nature of their existence.

The succession of phases outlines unfolding, interconnected and foundational pathways that lead to being in the third space. Imagine the process as a continual, cyclical creation and dissipation of the upper spheres, as indicated by the arrows.

As I began to develop the metathematic concepts, I began to see explicit and implicit connections to Zen and Buddhist meditative practice. These spiritual systems most readily spoke to the paradoxical nature and salient features of the clinical improvisation process as described by the participants. Much of the music therapy literature cited in the previous chapter intimates and relates implicitly, if not explicitly, to spiritual tenets that can be linked to and are effectively explicated in Buddhist philosophy. The model expands these music therapy authors’ ideas to explicitly encompass the physical, psychological and spiritual realms of the clinical improvisation experience as recounted by the participants in this study.

The spiritual tenets support and flesh out the multiple and profound dimensions of the therapists’ experiences. Buddhist meditation practice is a process-oriented practice that speaks to what I have learned and gleaned from the data, and further integrates the thematic material of the study. Mindfulness and related ideas form the theoretical and practical center of the developing model. Thus, I have appropriated aspects of the Buddhist metaphysical belief system,
placing the themes within a larger thinking system, one that elucidates human
universals or truths that have emerged from the data.

The Path of Unfolding Present Musical Moments

What would I mean by asserting that the work of the therapist in clinical
improvisation involves a practice of being mindful? What I mean to convey is the
therapist’s continual work to be ever attentive and present with himself, the client,
and the music throughout the clinical improvisation. He simply guides his
attention to the present moment. The present musical moment is essentially the
only moment that is truly happening. Past and future are aspects of his
imagination. The simple and yet profound capacity of bringing himself to the
present moment involves a disciplined and precise attention and awareness. To be
mindful means that the therapist is directly experiencing the present musical
moment. He is directly experiencing himself, the client, and the music of the
therapy dyad. His work is the work of the present musical moment.

The previous chapters have brought to light this basic element of the
therapist’s experience in clinical improvisation. Woven throughout the data, the
music, and the thematic materials, I have come to appreciate the therapist’s simple
and awesome practice of being mindful and active with the client in the present
musical moment. The inherent struggles and efforts became apparent as I listened
to the therapist’s words and music, often hearing the difficult path of aligning
awareness with experiences in the present-tense. My impressions and thoughts
about the clinical improvisations lead me to believe that it would be enlightening
and useful to formulate metathemes that incorporate tenets of a longstanding practice that clearly addresses the fundamental nature of being.

The idea of mindfulness can be attributed to the Buddhist tradition of meditation practice. While I would be reluctant to explicitly define the practice of clinical improvisation as a meditative practice, there are implicit and explicit aspects common to both. Interwoven throughout the discussion of the developing model of ‘mindfulness in action’ in clinical improvisation will be writings on Buddhist meditative practice (Chodron, 1994, 1997; Conze, 1975; Kapleau, 1965; Hanh, 1987, 1998; Rahula, 1974; Rinpoche, 2002; Suzuki, 2001; Trungpa, 1988), Eastern philosophy and existentialism (Batchelor, 1983), as well as the integration of Buddhism and psychotherapy (Magid, 2002; Thomson, 2000; Twemlow, 2001), and Buddhism and psychoanalysis (Christenson, 1999; Christenson & Rudnick, 1999; Cooper, 1999, 2001; Epstein, 1995, 1998, 2001; Langan, 1999; Morvay, 1999; Rubin, 1999). The recent and integrative writings that explore the common ground of therapeutic approaches and Zen Buddhist practice have paved a convenient path through their extensive theoretical and philosophical considerations. Their thoughts will be an integral part of my attempt to consider a model of clinical improvisation that integrates some of the fundamental aspects of mindfulness practice.

The work of this chapter is to interpolate, extrapolate, and coordinate concepts from the themes and findings of this study. As seen in the diagram of the model, many spokes of related ideas radiate to and from the central axis of mindfulness. In the previous chapters these related ideas are implied and
explicitly present in the data of therapists' words and in the findings derived through my interpretive modes of analysis. This current chapter will take these ideas further by tracing and relating them to relevant literature that supports the discussion. I will take on the task of separating and integrating ideas that come together in this constellation of related ideas.

With this in mind, it is time to begin this discussion. Yet my mind moves away from the writing to what-if scenarios, future projections, memories of writing experiences, my feelings about writing, and the anticipated and current emotions around what the reader might think of this discussion. Here is a fine illustration of the tendency of the mind to stray and embark on spontaneous and fantastic trips, similar to the improvising therapist in clinical improvisations. As I become aware of my thoughts and feelings, this is a way for me as the writer to sit with, move with and through these thoughts and feelings. As I become ever mindful of what is going on in my mind and body, I find myself fully in the present moment.

As shown in Starting Where You Are, a similar process is at work for the therapist in clinical improvisation. Mindfulness embraces collateral aspects of meditative practice: bare attention, concentration and inquiry. These aspects of meditative practice are not some otherworldly place to which the therapist retreats and inhabits, but they speak directly to the practical work of the improvising therapist. In fact, the tripartite aspects of Buddhist tradition includes right view, meditation, and action. Right view is "to see directly the absolute state, the ground of our being; the way of stabilizing that view and making it an unbroken
experience is meditation; and integrating the view into our entire reality and life, is what is meant by action” (Rinpoche, 2002, p. 156). The emphasis on the interconnectedness of these three prongs of practice supports the proposition of the model to correlate aspects of meditative practice in action, to the practice of clinical improvisation. The concepts presented in the model can appear reified when viewed as purely theoretical constructs, but just as in meditative practice, they are indeed grounded in practice and the practical work of the musical moment. With that said, I begin with an exploration of the pervasive and central concept of mindfulness.

According to Buddhist writings, mindfulness, or right mindfulness, as part of the eight right practices, is defined as the energy that brings us back to the present moment. The feature of attention is that it is universal, our attention is always being directed somewhere. A distinction is drawn between appropriate and inappropriate attention: inappropriate attention draws us away from the present moment, whereas appropriate attention happens as we dwell fully in the present moment. The Sanskrit and Chinese origins of the word can help to give mindfulness subtle facets. The word for mindfulness in Sanskrit means remembering. So, mindfulness is remembering to return to the present moment. In Chinese, the character for mindfulness is comprised of two parts, one meaning now and the other meaning heart or mind. Mindfulness can be understood as when our hearts and minds are present in the now (Hanh, 1998).

The improvising therapist works to bring his heart and mind to the present musical moment. The quality of the therapist’s attention becomes a central issue
when exploring experiences in clinical improvisation. It is clear to me that the therapist appreciates how difficult, yet possible, it is to surrender to the flow of experience. At the heart of meditation practice is the idea of mindfulness. Sometimes called bare, or naked, attention, it is defined as the “clear and single-minded awareness of what actually happens to us and in us, at the successive moments of perception” (Thera, 1962, p.30). There are a multitude of directions in which the therapist’s mind can move. The specific content was richly elucidated throughout the data in the previous chapters, and especially in Starting Where You Are. As the model illustrates, the therapist moves from being distracted from the present moment by thoughts and feelings to the bare attentional stance. In meditation, this attentional stance allows for an exact registering of what is happening in the body and mind.

Apparent in clinical improvisation, as in meditation, the improvising practitioner has the capacity to be keenly aware of what is happening for him in the present musical moment. He is able to separate thoughts and mental and emotional reactions to the musical event from the actual experiencing of the core musical moment. In a paradoxical sense, the therapist’s mind is both receptive, involved, and detached from the experience. As a distinctive contribution of Buddhism, mindfulness or bare attention “might be described as a kind of radical acceptance of, or tolerance for, all of our experience” (Epstein, 2002, p.3).

Epstein (2002) continues to say that this state of bare attention is familiar to artists who describe their “studio selves” as the “combination of focused concentration and open, non-discriminating awareness” (p.3). Essential to the
creative process, this is a state in which the artist discovers new ideas, loosens his grip on old ideas, and becomes aware of and relinquishes habituated aspects of his practice (Epstein, 2002). The therapist involved in the artistic endeavor of clinical improvisation attributes moment to moment awareness of himself, his music, the client, the client’s music, and the music of the dyad as key in loosening his grip on habitual tendencies in his playing. He finds the creative direction of the improvisation out of this more open and non-discriminating awareness.

In meditative practice, one cultivates right mindfulness as accepting everything without judging or reacting (Hanh, 1998). Similarly, historical references in psychoanalysis of Freud, Bion, and Horney address the listening stance of the analyst. Freud instructed physicians who were practicing psychoanalysis to “suspend judgement and give impartial attention to everything there is to observe” (Freud, 1909, p.23). The music therapist attends to the client’s sounds in a similar manner, suspending pre-conceived notions and listening to all there is to hear in the aural field. The music therapist, who is specifically involved in a creative process, refrains from the intellectual reasoning and understanding of the unfolding art form as he becomes ever more mindful.

Epstein (2002) further clarifies Freud’s stance with two basic tenets: “the absence of reason or deliberate attempts to select, concentrate, or understand; and even, equal and impartial attention to all that occurs in the field of awareness” (p.4). While the music therapist may focus on a particular aspect of the client’s music, there is a fluidity in the attentional stance that allows the music therapist to shift attention readily without becoming unduly fixed on a particular aspect of the
music. Freud adds yet another facet to these ideas: the analyst was to maintain an "evenly suspended attention" to all that he hears and he "should withhold all conscious influences from his capacity to attend in the face of all that one hears... he should simply listen, and not bother whether he is keeping anything in mind" (Freud, 1912, p.11). When mindful, 'keeping in mind' does not take up psychic energy and space. The improvising music therapist's attention remains on the musical material in the moment, working with it in the present. His attention in the present musical moment embodies the past musical moments as when he forms musical ideas that relate to past ideas.

Freud's idea of not keeping anything in mind emphasizes that the therapist's attention cannot be fully in the present if he is interpreting and thinking about what he is hearing, or attempting to remember what is happening as it is happening. There seems to be an inherent implication that the therapist can trust that he will remember what he will need to remember when he needs to recall it. The same holds true for the music therapist: while attending fully to what is being played in the moment, he will recall salient aspects of the music as needed without effort. He consistently attends to, or guides his attention back to the present musical moment. Furthermore, the music therapist need not keep in mind anything other than what is required to create music. The music therapist does not keep in mind rational thinking that involves extra-musical interpretations of what is happening in the present musical moment, represented in the model as tendencies of mind, interpretation and extra-musical thinking. These tendencies, while part of the therapy process, ultimately take the improvising therapist out of
the present musical moment in clinical improvisation, keeping the dyad from moving into the third space.

Two types of concentration fall under the term right concentration in meditation practice: active and selective. When we actively concentrate, our attention moves to whatever is happening in the moment; when we selectively concentrate, we dwell on a particular object and stay with that. When we actively concentrate, whatever may come into our attention, comes and goes. When the object of concentration has passed, our mind remains clear and poised for whatever comes next (Hanh, 1998). This is similar to Freud’s idea that the therapist need not keep anything in mind as he listens to the client. Similar to Freud’s notion of evenly hovering attention, the Chinese character for concentration literally translates as maintaining evenness. In clinical improvisation, the therapist attends to the client’s music, his own, and the moment to moment flow of music created by the therapy dyad, without holding in mind thoughts about the music and its participants. Selective concentration entails the therapist’s attention directed toward a particular object. The improvising therapist may at times concentrate on a particular aspect of the music or the client’s music. As an example, a therapist in this study cited the harmonic interval of the minor second being played by the client as an entrée for the therapist to align himself with the present-tense music of the client. The therapist focused on this aspect of the music quite specifically, which gave musical direction to his music out of the present musical moment, allowing him to be with the client more directly and fully.
Bion (1983) describes the ideal therapeutic listening posture as a disciplined attitude in which tolerance of the unknown is paired with confidence that something will evolve in the emotional contact with the patient. He further explains that any wish to cure or remember interferes with the process of listening and hearing. In fact, all desires, including the desire to help, the desire for the session to end, or the desire for improved skills, are considered future-directed tendencies of the mind that interfere with listening and hearing.

Bion strikes several key points regarding the music therapist in clinical improvisation. The improvising and mindful therapist’s disciplined listening posture involves his capacity to tolerate the unknown of the clinical improvisation. In a mindful stance, the therapist cannot be both fully present in the musical moment and be concerned with wanting to know what might be happening in the next moment. Any such concern distracts his attention from the present musical moment. The improvising music therapist’s tolerance for the unknown is paired with confidence that something will evolve out of the emotional contact with the client in the music. The therapist’s disciplined mindfulness contributes to his capacity to remain in emotional contact with the client. The therapist need only stay in the present musical moment with the client, and from that present moment evolves the music of the next moment.

Bion’s proclamation that desire interferes with the therapist’s ability to listen deeply is a concern of the music therapist as well. All desire is a future-directed tendency of mind that pulls the therapist from the present moment. Desires around acquiring improved technical skills, especially relevant to the
music therapist, distract the therapist’s attention from the present moment. Improvising music therapists, as musicians, continually hone, evaluate, and have feelings about their skills. Therefore this tendency of mind has great potential to interfere with his capacity to listen deeply in the present musical moment. The desire to help can be pervasive and borne out of conflicting motivations, lending itself all the more to becoming an undetected and natural tendency of the therapist’s mind that can ultimately draw the therapist’s attention from the present musical moment.

Epstein (1995) elaborates on meditation practice and the Buddhist view of desire, or appetite-based awareness:

Gradually expanding the foundations of mindfulness to include feelings, thoughts, emotions, and mind, the successful practitioner keeps coming up against her own desires to somehow halt the flow, to convert the breath-based experience of fluidity and change to an appetite-based one of gratification or satisfaction. (p.146)

The experience of clinical improvisation can provide the improvising therapist with opportunity to better understand blocks to staying with the flow of direct experiencing. While involved in clinical improvisation, the therapist continues to come up against impediments to direct experiencing. As reflected in the cyclical arrows of model, encumbrances may keep the therapist from moving into another phase, thus moving into a former phase. Through the practice of clinical improvisation, the therapist guides himself to the present moment, allowing him to move through the phases. Through the reflective practice of
mindfulness in clinical improvisation, or whether through meditation, supervision and/or therapy, the therapist faces and works through the dialectic of staying with the fluidity of the moment and striving for gratification in the musical encounter.

*Right speech* addresses the importance of listening deeply without judging or reacting. Without such deep listening, whatever we say will only be our own ideas and thinking and not in response to the other person (Hanh, 1998). The improvising music therapist is faced with this challenge, though in music. Deep listening allows the therapist to respond to the client’s sounds and to not just play his own isolated musical ideas. From the place of deep listening, the therapist plays without the distorting filter of his own thoughts about what he is hearing.

Horney (1987) coined the term “whole hearted attention” that speaks to bringing into play all aspects of the therapist’s attention, emphasizing the capacity of being absolutely receptive to impressions and feelings about the client. Horney’s conceptualization brings in the active, open, and receptive piece of the therapist’s attention, highlighting the therapist’s capacity to take in his own impressions and feelings. By attending simply to the present moment without the clutter of her own thoughts, a spaciousness opens up which allows the improvising music therapist to take in the client’s sounds. The inherent challenge and necessity of an unfettered attentional stance has been on the minds of therapists since the origins of psychoanalysis, remarkably dovetailing with aspects of mindfulness practices in Buddhist meditation.

As seen in the model, the music therapist in clinical improvisation embarks on a path of continually bringing his attention as fully as possible to the
present musical moment, without undue interference from the natural tendencies of the mind. The therapist moves from engaging in thinking about himself, the client, the music, and the process, to simply paying attention to the sensory, and especially aural sensations without preconceptions, judgement, or attempts to contextualize, theorize, and memorize. Suzuki (1970) explains that the thinking mind becomes stable in its capacity to observe and accept things without stagnation. The essential understanding is to have a smooth, free-thinking way of observing. He describes this way of thinking as the mind being “soft and open enough to understand things as they are” (p.115).

In this way, thinking remains even-tempered. The improvising therapist moves into the third space with an ever imperturbable way of thinking. He is able to listen to the client’s sounds and move from a reactive stance to a musically responsive stance. His listening deepens to become “soft and open enough” to hear the sounds as they are, without continuing to make interpretations or having thoughts about the music. He simply listens and responds. Inherent in meditation practice is the development of an observational stance. The practice itself is merely about bringing one’s mind to whatever is happening in the moment, to remain keenly aware of one’s thoughts and feelings as they occur. This idea can be extended to interactions with the client in the clinical improvisation, to include not just the therapist’s thoughts, feelings, and music, but to include the client’s music within the ever-expanding sphere of the therapist’s observational and listening capacity in the moment.
As the therapist brings his attention fully to the present musical moment, aspects of the self begin to come into question. The model portrays the process of the therapist moving through increasing concentration and awareness, to being mindful and engaged fully in the present moment. As well, he experiences a letting go process as he finds himself at the limits of thinking. He moves from being alone in *thinking about* to *being-with* to *being-for*. This continual practice of bringing himself into the present musical moment raises and uncovers several important questions in need of exploration: What is getting in the way of being in the present moment? What is being let go of? What happens to his sense of, and identification with, a self as he moves into the third space?

**The Path of Self in Clinical Improvisation**

Many interrelated ideas in Buddhist meditative practice come to the fore in cultivating an understanding of the therapist’s experience in clinical improvisation. The therapist’s mind can be distracted from or absorbed in the present musical moment. The tendencies of mind are in essence fueled and sustained by ways of thinking about oneself and the other. The mind can vacillate between clinging to and rejecting feelings and thoughts about oneself and the other person. The therapist’s mind can be engaged in dualistic and polarized thinking that separates him from his own experience in the moment with another person. The model suggests that the phases of the therapist’s experience are his continual journey of mind, moving to and from the point of being in the third space with the client.
Buddhist meditative practice deals with what and how we think of our self, and how the metaphor that we construct of the self is continually uncovered and challenged as we move into mindfulness and a direct experiencing of the present moment. Buddhism’s interpretation (and breaking down of the metaphor) of the self can provide insight into the improvising therapist’s experience in clinical improvisation as he moves through the phases shown in the model.

The ideas of self and emptiness are spoken of in tandem in Buddhist meditative practice. Emptiness of the self “is just a way of saying that this moment to moment experience is all there is” (Magid, 2002, p.57). Magid further explains that “to speak of the self as empty is to remark on the transience of all experience, without positing any permanent or observer set up in the background who watches it all go by” (Magid, 2002, p.57). This view of the empty self supports the therapist’s experience as he moves through the phases of clinical improvisation in how the therapist’s experience shifts from observation and self-aware participation to a direct experiencing in the present musical moment. In the third space, the therapist can be seen not as a fixed and permanent self that observes the musical interaction as an object, but rather a fluid and changing self sustained through his bare attention in the present musical moment. The formerly perceived observer-observed duality collapses into a unified experience, as the separation of the action into subject and object is dissolved in the moment’s activity. As well, the metaphysical bridge between the physical and psychological is completed to where a bridge is no longer needed as the two formerly separate notions of experience are one in the same. The former splits between mind and
body, subject and object, and awareness and its objects are dissolved through mindfulness. Doing and being become one. In this way, while the therapist’s skills have been honed to where she feels and knows music instinctively, as she approaches the point and moves into the third space, there is no sense of separation between her self and her skills. Defined as skillful being in the model, there is no discernible and perceived gap between being in the present musical moment and accessing and applying musical technique, resources or skill. The discipline of her musical training and mindfulness in practice in clinical improvisation result in the moment as an activity that is not just second-nature, but the nature of musical experience itself. Magid (2002) describes meditative practice in action in everyday life as “an unself-conscious and unreserved immersion in the particulars [which] becomes the mode of actualization of nonseparation” (p.50).

As the therapist moves through the point and into the third space, the transient nature of experience is realized: the therapist finds that he no longer holds on to, or keeps in mind, anything other than the momentary experience itself. His self is empty in that he does not cling or attach to thoughts and feelings about himself or any aspect and the moment to moment experience. He surrenders to the ebb and flow of the musical experience, thoughts, and feelings. Attachment is continually surrendered as the therapist opens more and more into direct experience.

As in meditative practice, the improvising music therapist practices the continual surrender of his attention to the present moment, thus, what he considers
his self, what he identifies as his self, is deconstructed through the practice of mindfulness in clinical improvisation. In Buddhist terms, “an awareness of emptiness is simply a nonresistance to the flow and transience of our lives” (Magid, 2002, p. 57).

Conversely, the therapist’s resistance to the flow and transience of the musical experience can be seen as manifestation of the sense of self to which he clings. The resistance to the moment that is uncovered through meditative practice, and the resistance to the present musical moment in clinical improvisation are parallel in how the resistance (and self construct) becomes the stumbling block to a more direct experience of the moment with the client. In other words, for the improvising music therapist, acceptance of whatever the present moment brings is nothing other than non-avoidance of what is happening in the present musical moment. The transience of the nature of self and the transience of experience are one and the same. The self is defined by the moment to moment experience and remains fluid and non-static in its nature. The self is capable of spontaneity and aliveness, a characteristic quality of being in the third space.

In Zen practice, dualistic images of the self and other, self and world, body and mind, inner and outer are directly challenged. Magid (2002) argues that “the true self of Zen is no self: simply the immediate, non-self-centered response to life as it is” (p. 79). Similarly, Rubin (1999) coined the term “non-self-centered subjectivity” as the loosening of the constricting sense of self while in a state of being of “non-self-preoccupation, non-self-annulling immersion in whatever we
are presently doing... as restrictive self-identifications are eroded” (p. 17). When taken as complementary ideas, the conceptualization of the self melds into an acknowledgment of a self that is not concerned with its-self as one engages fully in the present moment. The improvising music therapist, moving through the model phases of clinical improvisation, becomes more and more absorbed in the present musical moment and relinquishes the constraining sense of self, self-identifications, and self-preoccupations. Non-self-centered self and no-self highlight the paradoxical explanations of the nature of being in the present musical moment. Zen master John Daido Loori insightfully encircles these notions in one profound statement: “To study the Buddha way is to study the self and to study the self is to forget the self... to forget the self is to be intimate with the self, it is to really be yourself” (Loori, 1991, p. 9). Evident as the improvising therapist moves through the phases of the model, only when the therapist is fully aware of the forces and tendencies that pull him in directions of the self-centered way is he able to function non-self-centeredly.

Rather than supporting a view of the self as having limits or boundaries, meditative practice tends to “reveal another dimension of the self-experience, one that has to do with how patterns come together in a temporary and ever-evolving organization” (Epstein, 1995, p.142). In clinical improvisation, this is truly realized by the therapist’s experience of self, his client, and the musical experience. In moving closer to and through the point, this idea can be extended from his perception of the self to the musical combinations and structures created in the therapy dyad, which move through evolving and complexly organized
relationships that are heard as the dye or the aural manifestation of the presence, of the selves of the therapy dyad. The temporary nature and evolution create the unfolding musical path that is the impermanent dye of the present musical moment. The therapist and client become the musical moment.

As the improvising therapist’s experience reflects the loosening of self constructs, the therapist relinquishes dualistic and polarized thinking of the experience as he approaches the point and enters the third space. The creative process in this third space is nourished by this relinquishment of dualistic pictures of musical experience. The therapist hears the music as it is. His non-dualistic, non-polarized, and direct experiencing allow him to creatively respond to the client. The therapist is no longer enslaved within the boxes (as illustrated in the model) of tendencies of mind (including self-constructs and self-identifications), musical tendencies, and historical experiences.

The Zen Buddhist concept of oneness means that the dualistic and artificial separation between self and world is absent. It is not imagined as a self that is devoid of structure and boundaries, but rather a self that is fluidly, spontaneously and meaningfully engaged in life (Magid, 2002). This experience of oneness is represented in the model in the third space. As explained in the Buddhist tenet First Door of Liberation (emptiness), by learning to see ourselves in things that we perceive as outside of ourselves, the false boundaries that separate us from others begin to dissolve (Hanh, 1998). Thus, the ideas of no-self and oneness continue to explain the experience of music therapists in clinical improvisation. Being fully present in the moment to moment music, the therapist
is grounded in the physical practice of making music with the client. From simply being in the music in this way comes what seems to be a profound sense of the world and the true nature of reality. Paradoxically, the world of possible experience is embodied in the momentary act of making music. By going deeply into the relative reality of the present musical moment, the therapist has the sense that he experiences and appreciates absolute reality of existence. The therapist listens “in the relative and absolute dimensions at the same time” (Hanh, 1998, p.128). He listens to the relative, concrete forms of the music, and also hears the absolute reality of the present musical moment that manifests all of existence. By going deeply into one moment, the therapy dyad is going deeply into every moment. Pervasive in the Buddhist teachings is the tenet of nondualistic experience and the sense of oneness. The improvising therapist experiences oneness with his world as he mindfully attends to the particulars of the moment, of the present music-making moment.

The Path of Emotions in Clinical Improvisation

The model illustrates the progression of the therapist’s emotional path. From being caught in the vacillation between clinging to and rejecting feelings, he finds that he is able to play music in the affective flow of the moment. As he moves closer to and through the point, and becomes more and more aware of his feelings, he seems to settle into them in a deeper way. His awareness of and bare attention to his feelings help him to move to the third space where he can be aware of his feelings and be with them fully. As well, in this process, he is
listening more and more deeply to the emotional quality of the client’s music. As
the therapy dyad approaches the point, the therapist finds himself absorbed in the
affect of the moment, playing, creating, and staying in the affective flow of the
music. Both he and the client are creating the affective flow moment by moment,
note by note, beat by beat. The therapist is able to detach, neither from his
feelings nor the client, nor as a form of denial, but from the “neurotic, self-
centered attempt to make things and relationships permanent or to have them be
just the way we want” (Magid, 2002, p.148). He is able to let go of agendas, goals
and pre-determined directions of the music. Through his deepening immersion in
and receptive stance of the client’s emotional expression, the therapy dyad moves
fluidly with the affective flow. “When the attention is trained on the emotion in
question . . . it gradually ceases to be experienced as a static and threatening entity
and becomes, instead, a process that is defined by time as well as space” (Epstein,

By looking deeply into feelings, the therapist discovers that they are
mental formations, and “learns not to identify himself with the feelings, not to
consider them as a self, not to seek refuge in them” (Hanh, 1998, p.178). When
the attachment and identification to the emotion is made aware to the therapist, he
no longer clings to, rejects or resists the emotional flow of the music, but rather
accepts and involves himself in the moment to moment shifts and turns. The
therapy dyad moves through a fluid process of deeply experienced subjectivity in
the moment without the distortion of attachment. In the third space, the affective
flow can be described as taking on the non-separation quality that was discussed
earlier. It is no longer possible to dualistically perceive the affect of the music as either mine or yours --- as something inside or outside of oneself, or even as ours --- something attached to the therapy dyad. In the moment, the therapist and client are the emotion of the music. In fact, when the therapist is fully mindful, the dualistic perception of the affective quality of the music is no longer an aspect of the clinical improvisation in the third space: the affective quality of the music is neither attached to, nor separate from the therapist and the client.

Compassion and joy were explicitly recounted as salient in the therapist’s experience and are features of the third space. For the therapist to listen deeply to the client’s music as the manifestation of the client’s presence challenges the therapist to take in deeply the client. The therapist allows the client’s sounds to penetrate and deeply impress him in the moment. However the client’s condition is defined, explained, or interpreted, the therapist has the opportunity in the present musical moment to listen to the client’s suffering. Practicing bare attention on the client’s emotional expression in music, the therapist guides himself to directly experience the client’s condition or suffering through his deep listening. However, the therapist’s emotional reaction to what he hears can impede his direct experiencing. So the therapist continually stays with his own emotional experience and continually takes in what he hears. Only by fully experiencing the affective content of the moment can the therapist begin to respond musically, compassionately, and fluidly.

The Buddhist meditative practice of tonglen corresponds to this active taking in of another person’s suffering as the meditator practices with each
inhalation to take in the suffering of another (Rinpoche, 2002). By deeply contemplating the other person’s plight, and by sustaining his bare attention on the emotional timbre, the practitioner can respond actively and compassionately to the other person.

In this way, the act of deeply listening to the client, and taking in his sounds can be seen as tonglen in the practice of clinical improvisation. The therapist does not simply arrive at a place of compassion, nor is it something that is placed over or injected into the therapist’s experience. It is a process of putting oneself in the client’s shoes, and deeply feeling what that may be like.

The continual practice of mindfulness in clinical improvisation enlists the active listening of the therapist, to himself and to the client. The therapist’s process of fully being with his feelings and his ultimate nonattachment and identification with these feelings, allows him to respond compassionately, not only to the client, but to himself as well.

What might this compassion sound like? A compassionate musical response may take on diverse and myriad qualities and may not sound like what one would assume that it does. The therapist’s compassionate response emanates from his continual awareness that his idea of ‘who he is’ is an illusory experience. ‘Who he is’ is not a rigid and fixed entity, but a self that is illuminated and awakened through what he directly faces and feels in the present moment. This continual awakening to the experience of a fluid self nurtures the realization of a fearless response to another: “to train in compassion, then, is to know all beings are the same and suffer in similar ways, to honor all those who suffer, and to
know you are neither separate from nor superior to anyone” (Rinpoche, 2002, p.204).

To listen deeply and openly to the client's music entails the therapist's capacity to hear his own music in his client's music. Music created in this way between therapist and client has the capacity to hold and express the limitless permutations of the equanimity of human emotion, our suffering and joy.

The *joy of this moment* can be an illusory expression though one that rings true when we are deeply involved in, and yet not identified with, the direct experience of the moment. As discussed earlier, the therapist's capacity to fully experience his feelings coupled with his capacity to realize that his feelings are not part of a permanent self allows the affective flow of the music. While creating and moving with the affective flow of the music, the therapist has the opportunity in the present musical moment to experience the joy of being present and alive emotionally as fully as possible as a human being.

His awakening to the depths of direct experiencing of feelings brings with it the joy of being awakened, of waking up to the present moment. His bare attention is the means to, and the experience of, being awake in the moment. Through mindfulness in clinical improvisation, the therapist awakens to the present musical moment, and directly experiences *all* that the moment brings. He comes to experience and move fluidly through the emotion of the music in the moment, whether painful, sad, angry, or peaceful, tranquil, and still. Through the practical action of making music, the therapist is active in and receptive to the emotional quality of the music. The combination of tones, melodies, harmonies,
and rhythms are a manifestation of an awakening process to the present musical moment. As he continually uses music to awaken himself and the client to the present musical moment, the therapist experiences the joy of being-with and being-for the client.

The Relational Path of the Improvising Therapist

In Getting To The Point, the therapist moves from thinking about to being with. In the third space, the therapist experiences being for the client, and the inter-being nature of the musical experience. Meditation practice, while it may be practiced in solitude or in the presence of others, guides the meditator into a deep inquiry of his mode of being. Resistance and impediments to surrendering to the flow of direct experience are continually uncovered. For the improvising music therapist, his awareness shifts from being aware of others to the ways in which his mode of being changes in relation to others. While the proposed clinical improvisation model addresses these and other aspects of mindful practice in the context of dyadic clinical improvisation, further exploration into the impediments and actualization of being-with warrants attention.

Seen through an existential lens, human existence can be paradoxically characterized as finding oneself inexorably alone, and with others in the world. These seemingly opposite poles are interdependent and at the same time inseparably unified. The Buddhist path is seen as a way to fully realize authentic modes of being with oneself and with others.
A distinctive feature of Buddhism is that this mode of being is within one’s human grasp. Active participation in the world is the visible expression of one’s entire being. In interactions with others, a way often opens up that allows one to more fully accept and have a greater concern for others, while at other times one either retreats from or closes oneself off from others (Batchelor, 1983). Batchelor’s summation of the dilemma, in his explanation of an existential approach to Buddhism, highlights the therapist’s plight in clinical improvisation. His capacity to be with the client and to be with himself remains a continual process involving these two polar yet unified aspects of human existence. As shown in the model, the therapist works toward direct experiencing, which includes being present for the client and being aware of his own feelings and thoughts. As he approaches moving into the third space, he develops a high degree of empathy, awareness, and concentration, and reaches the limits of thinking about. In moving through the point he finds that he is able to let go of attachments that formerly enlisted the client in service of the therapist’s desires, as well as his aversion to what is: how the client is and what she is playing in the present musical moment. He is able to sustain a true being with the client. Batchelor stresses that the attitude of self-concern, in the forms of desirous attachment or aversion toward others, remains “the root of all inauthentic manifestations of being-with-others” (p. 77).

In a related way, Epstein (1995) posits that mindfulness practice uncovers underlying narcissistic tendencies. These take on the form of distorted attachment, aversion, and identifications based on idealization and objectification, and keep
one from directly experiencing the world. Mindfulness practice provides a means of being with one's experience simply and directly without the usual distortions that regularly color one's perceptions. He views meditative practice as "a means of indefatigably exposing this narcissism, of highlighting every permutation of the self-experience so that no aspect remains available for narcissistic recruitment" (p.134).

In the third space of clinical improvisation, the improvising therapist's mindful practice allows him to continually face and uncover his narcissistic tendencies as he directly experiences the client's sounds through deep and open listening. Through his bare attention, the impediment and the means to being with and being for the client directly are simultaneously addressed in the present musical moment.

Taken together, Epstein and Batchelor's ideas point to distorted self-concern in the form of narcissism as an impediment to one's capacity of being with others. As a means of working through and dissolving self-concern, Batchelor (1983) emphasizes the importance of "equanimity" with others that can be gradually achieved through a "systematic and concentrated analysis of the relations that we currently conduct with others" (p.82). He explains that "continued perseverance" in the "sustained contemplation" of equanimity with others, allows one to reach a point of touching "that essential reality: we are with others" (p.84). Once self-concern is revealed as the distorted manifestation of being-with, the "range of possibilities of being with others is unveiled," and the
“passive being-with-others is inevitably transformed into an existentially active
being-for-others” (p.85).

Batchelor's proposed approach and process can be enlisted to account for
the movement of the therapist through the phases of the model, from thinking
about, to being-with, to being-for. As the therapist continually guides himself to
directly experience the client, a concentrated and persistent analysis of his
relationship with the client takes place, developing a relationship of parity with
the client. As he moves closer to the point, he sustains his contemplation of
equanimity, and senses the essential reality of being-with the client. In the third
space, the distortion of self-concern has dissolved and, what was formerly a
passive stance of being-with, has transformed into the active stance of being-for
the client. With the self-concerning distortion lifted through his direct
experiencing, the range of musical possibilities of being-with expands as he
moves into being-for the client in the present musical moment. This process of
mindful practice as explained by these ideas and portrayed by the model, accounts
for the therapist’s experience of the therapy relationship in the clinical
improvisation process.
The Nature of the Third Space

When we just listen, there is only the birdsong, no individual listener at all. (Magid, 2002, p.92)

The third space is illustrated in the model as a boundless sphere within which the therapist and client are in the music. It is imagined and depicted as a bubble in order to highlight its transience and malleability, sustained solely by the mindful presence of the therapist. The constellation of attributes of the third space are interrelated, and characterize the direct musical experiencing of the therapist. The mindfulness of the therapist suffuses the third space with the vitality and spontaneity of the present musical moment. The impermanent and transient form of the music is created and sustained moment by moment by the therapist and client. At any moment, the bubble can dissolve. The therapist realizes the inescapable fact of the impermanence of the music. He accepts that the music can fall apart at any moment and take on a life of its own in a sense. The creative process is nurtured by this realization of impermanence, and by the relinquishment of theory, agendas and goals, which are thinly veiled manifestations of control that work to inhibit the vitality of the present musical moment. A perspective that embraces the insubstantial nature of the musical moment accounts for the realization of creative potential in the third space. Boundaries and self-constructs and identifications are loosened, allowing the participants to breach former constraints of the self, and expanding views of how things are.
There is a sense in the third space that the music is playing itself. In a sense, there is music without the music-makers. With the loosening and perhaps relinquishment of self-identifications and attachment to emotions, and without the intervention of the thinking and critical mind, the musical space becomes a transitional and transformational forum. Epstein (2002) suggests a conceptual similarity between this kind of space that opens up in meditation and art to Winnicott’s (1971) idea of an intermediate space. Similarly, in the mindful practice of clinical improvisation, there is a spaciousness that opens up in the third space that allows the creative musical process to happen differently from the previous phases.

The therapist’s experience of music that plays itself speaks to the interpenetrating nature of all things, a major tenet of Buddhist practice. The selves of the players do not necessarily experience themselves as separate from one another or the music. The Buddhist practice challenges conventional notions of the way things actually are, highlighting the imprisoning concepts of inner and outer, self and object --- nothing exists in its own right, or has an inherent existence or a persisting individual nature. Everything is dependent upon everything else (Rinpoche, 2002).

As a foundational teaching of Buddhist practice, The Twelve Links of Interdependent Co-Arising, addresses this phenomenon. Interbeing and interpenetration are other terms used to describe the interdependence of all things. Cause and effect co-arise, and everything is the result of multiple conditions and causes (Hanh, 1998). The interdependent, or interpenetrating, nature of the third
space embodies the music and its participants as a whole entity. In this way, in the third space, the therapist does not experience the music, the client, and himself as isolated and discrete entities in the present musical moment. Furthermore, the music and the participants can be thought of as co-arising, meaning that the therapist does not experience a cause-and-effect phenomenon. The process of the unfolding music and the participation of the therapist and client inter-are. In the third space, the therapist cannot attribute his playing this to the client playing that or vice versa. In other words, he has the sense that "this is played, and that is played." There is the absence of a linear and temporal occurrence of musical events in the present moment. While music occurs in a temporal realm, the individual responses are no longer discernible as separate and isolated cause and effect events. The multiple conditions and causes of each moment co-arise and create the present musical moment.

The paradoxical nature of a tenuous and stable bubble of the third space illustrates the inter-being nature of clinical improvisation in the present musical moment. At first blush, the third space seems permanent and fixed until the central axis of mindfulness is disturbed. The inter-being nature of all the components parallels the inter-being nature of the music: no one part can stand alone, and without any single part the whole does not exist. Its integrity holds the infinite and absolute truths that are experienced through the momentary and relative practice of mindful music-making. The arrows in the model indicate its cyclical nature, indicating the possibility at any given moment of moving out of one phase into another. The continual invigoration of the present moment is
needed through the therapist's continual guidance of his attention to the present, and his allowance to experience it fully. The cyclical nature of the model highlights the nature of the work, the challenge of such work, as well as the path of such work. The third space embodies a salient feature of meditative practice. The practice is the practice, and there is nothing more to gain. As Suzuki (2001) states:

If you make your best effort just to continue your practice with your whole mind and body, without gaining ideas, then whatever you do will be true practice. Just to continue should be your purpose. When you do something, just to do it should be your purpose. (p.43)

Similarly, the practice of clinical improvisation becomes the purpose of the practice. When practicing being fully engaged, the therapist experiences creating music as the purpose of the present musical moment.
CHAPTER VIII
ELABORATING AND LINKING

Considering Clinical Implications

By infusing aspects of a spiritual tradition into its conceptual core, the model in Chapter VII introduces an integrative thinking system that can be helpful to music therapists in staying present with the oftentimes paradoxical and valuable dilemmas and enigmas of clinical improvisation. The therapist's capacity to bring his utmost attention to the present moment holds a central position in the model. As illustrated, branching out of the therapist's mindfulness are related phenomena that qualitatively characterize his conscious mind in clinical improvisation. Getting to the point of being mindful is an evolutionary path in the therapist's mind as he cycles through the phases of the model. The implications of mindfulness and its related phenomena concern and influence many clinical and musical issues, as well as the therapy relationship and process.

In thinking about how I have illustrated the experiences of music therapists in the model, I might suggest, as did Langan (1999) a psychoanalyst and practitioner of meditation, that therapists who may not have thought of their clinical work in this way may have been practicing meditation all along. The model brings into our awareness the quite common busy-ness of our thinking
minds and how we are actually distracted by our own thoughts and either cling to or reject our feelings.

The dilemma presents itself this way: our mind’s natural tendency is to think, yet in clinical improvisation we find that our creativity and responsiveness thrive when we are not thinking about what we are doing, but solely doing it. Our undisciplined minds create an endless trail of thoughts that can take us far astray from listening and responding to our clients in the present moment. This seems to be a fundamental aspect of our role and experiences as music therapists practicing clinical improvisation.

The model brings to light some of the possible content, and more importantly, the process of our thinking mind, as we move toward and away from the present moment. Challenges are inherent in sustaining mindfulness in the clinical setting. While our intention or desire may be to be as present as possible, we come to see that the intention or desire itself stands in the way of our direct experiencing of the present moment. We begin to see that by starting where we are, we are in the only place there seems to be, the present moment. So, we stay with our desire, and there we are, right here in the present. So, we hear our client’s first note, and off we could go, thinking about that first note and the infinite possibilities of what it could be mean, what we could play, or reacting without deeply listening to the client’s music. As shown in the data and thematic material of this study, we can hone our capacity to stay with our reactions, thoughts, feelings, and with the note, the beat, the chord: we stay with whatever is happening.

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Especially in clinical improvisation, there are infinite layers to which we can attend, as well as the visual and other sensory perceptions that are available to us. The challenge of the process, as shown in the model, is our capacity to ‘be with’ whatever is happening, even being with our inability to attend to the present moment. Paradoxically, by our awareness of our attempts, or feelings of inadequacy and competence, we are opening up to the present moment, however that may look, sound, and feel. Our resistance to jumping into the flow of experience becomes of critical concern to us as therapists. The resistance is part and parcel of the work of the moment, and can be addressed in the present musical moment by simply attending to the resistance as it manifests in emotions and feelings (easier said than done!). The historical content of the resistance can be addressed in other milieus if necessary, such as therapy or supervision. While holding out the possibility of being fully present and staying with the moment to moment flow of musical experience, the model addresses the cyclical and continual practice of mindfulness, the cornerstone of meditation.

Powerful feelings can surge as we play music with our clients. Christensen and Rudnick (1999), in their writing on Zen practice and countertransference, speak to the spaciousness that emerges in the therapist’s mind as he attends to his feelings in the present moment. By simply attending to his present emotions, the therapist experiences this phenomenon of spaciousness which opens psychic space for his own feelings, allowing him to continue to take in the client. Similarly, Rubin (1999), in an article on the integration of psychoanalysis and Buddhism, explains that “as our awareness becomes clearer and more focused, we
experience a sense of psychological spaciousness: we do not become as entangled in reactive patterns of feeling and thinking” (p. 8). As we play music with our clients, our capacity to be aware of, observe and stay with our emotions, or cling to and reject our emotions, remains paramount in determining whether we respond or react to our client’s music. Magid (2002) posits that the psychotherapeutic aspect of Zen practice is the “structured relational context for eliciting, tolerating, and working through one’s patterns of affective experience” (p. 105). The continual discipline of returning our minds to the present moment, practicing mindfulness, enhances the likelihood of an emotional, musical response, rather than being enslaved by musical reactions that can account for habitual or automatic playing. In continually bringing our awareness to ourselves and to our clients, our clients become observers of themselves as well. Our music, when responsive, manifests our awareness of the client. In so doing, the client can become presently aware of themselves as well.

The model takes into account our fluid and paradoxical experience of self in clinical improvisation. At once, we experience bringing our individual selves fully into the music, yet we experience a sense of being one with the music and the client. The phases of the model portray the exposition of the metaphorical self, a fundamental tenet of all Buddhist meditation. As we play music with our client, the phases account for the movement to and from separateness, and the movement in and out of the realization of equanimity and universality in human experience. We can experience the dissolution of our self-identifications and self-constructs as we bring ourselves to direct experiencing of the present musical moment. Rubin
(1999) suggests that "when listening to a patient in therapy, observing art, or appreciating nature, we sometimes need to unconstrict our sense of self and see it as an open and unfolding process" (p.18). I would pointedly extend and apply his thinking to the clinical improvisation setting in which we and our clients are at once making art and listening to art.

Through our deep listening to the client's music, we bring ourselves to the present musical moment, and allow the client to become evermore aware of what and how he is playing in the present. Our responses, whether characterized as challenging, supportive, guiding, or otherwise, are in service of awakening the client to the present musical moment. The client can start to hear and uncover how and what he understands and thinks of his self which manifests through his music.

Similarly, we begin to hear our own metaphorical self in the music. As the therapist, we can allow ourselves to experience the impermanent nature of the self, to realize its potential fluidity, and allow the constrictions of our sense of a restricted and unchanging self to loosen. A hallmark of the third space is this flexible and impermanent sense of self in music, unfolding and changing fluidly and creatively. The possibility for the therapist and the client to move out of patterns of relating happens in the musical present. The directions and movements in the music embody the loosening self-constructs. The model suggests that through mindfulness which involves allowing ourselves to open ever more deeply to the nature of experience, we open ourselves to the possibility that we are not
who we think we are, that our clients are not who we think they are, and that our clients may come to realize that they are not who they think they are.

As posited earlier, our sense of self and our mental formations are one and the same. To say that our selves evolve musically moment to moment in the clinical improvisation brings us to the point of experiencing the musical moment directly, liberated from the thinking that we are a solid and permanent musical self. Adopting this middle ground that neither annihilates or reifies the existence of a self, can help explain our paradoxical sense of being fully ourselves in music, and being an evolving self as well.

The affective flow of music in the third space is the musical self, constantly changing and evolving in successive present musical moments. Cooper (1999), in his work on integrating Buddhist practice and therapy, states that the therapist can influence the therapeutic situation by “emphasizing the fluidity of self and focusing on the experience of emerging affects” (p.81). In so doing, the creative possibilities between us and our clients expand, as we experience ourselves and our client differently and more openly. Our capacity to release our selves from the bondage of self engenders an environment in which creative and musical possibilities can emerge. Langan (1999) explains the liberating moment as perhaps “living with some tincture of the realization that one is making oneself up as one goes along” (p.95).

In this way, the idea of self-expression through music means the moment to moment expression of an evolving self, rather than the expression of a fixed and isolated self. Musical expression embodies the fluid self that is created in the
interactive and relational musical world, which is different from understanding self-expression as the uncovering or discovery of an inner, hidden and fixed self.

In the third space, the musical self and the music are one and the same. As Dogen (1983) states: “To carry the self forward and illuminate myriad things is delusion... that the myriad things come forth and illuminate the self is awakening” (p.22). In this way, the music that we play with our clients, that is outside, is how we come to know our self as it is in the moment, rather than our selves coming forth from within and being expressed outside in the music. Morvay (1999), in exploring connections between Zen and psychoanalytic notions of the self, posits that “along with self-forgetting, people may also experience an inner core of creativity” (p.32). As we create music with our clients, the infinite possibilities inherent in the music in the present musical moment reflect the integration of these two notions of a forgotten self and the moment to moment creation of an ever-changing fluid self.

The model exploits the rift that exists between knowing and being. We are caught in the dilemma of letting ourselves and our clients fully experience the present musical moment, and holding on to our thoughts about the experience at the same time. We know intuitively that we cannot be fully in both ways simultaneously. So we are often caught in the gap. As musicians we understand how letting go of thoughts opens us up to the unfolding creative process. We are in music without thinking that we are in music, analogous to the fish in water that does not think water. As therapists we find ourselves wanting to hold on to some kind of thinking, to assure ourselves that we know and understand what we are
doing. In the model, we move through thinking about to being-with, relinquishing thinking and its consequential pinning down of a solid self. The model reflects how we constantly move through the tension of direct experience, and mediated experience caused by our thinking and our desire to acquire a particular form of knowledge about what we are experiencing. When we are able to guide our attention to the present musical moment, we are the experience. There seems to be no separation between our self and the actual experience. Cooper (2001) integrates the works of Bion (1965) and Suzuki (1972) to explain our experience of this “gap,” by saying that “we crave solid ground to stand on... [yet] we constantly find ourselves slipping off the edge” (p.356). We have the tendency and “intrinsic need” to maintain this gap by holding on to a fixed sense of self, “at the cost of psychological freedom and creativity” (p.347). Our existential anxiety keeps at bay our direct confrontation with the emptiness that we intuit exists outside of our mediated and constructed realities. Cooper’s thinking points to the void that opens as we relinquish our thinking and are poised at the existential abyss of not knowing what this present musical moment can be.

As improvising therapists, we are continually faced with and experience, in Cooper’s words, “slipping off the edge.” The solid ground that we create through our thinking about becomes less firm, and may even dissolve as we, therapist and client, are in the present musical moment. The cyclical and multi-directional nature of the model helps to confirm our anxiety, existential or otherwise, in confronting the unknown of the present musical moment. The moment of not-knowing “can be construed as an intimation of fundamental
voidness” facilitated perhaps by the presence of the therapist, whose “basic holding assumption” is that the client is there, which allows the client to let go of “the busywork of keeping yourself familiarly present… the letting go, the not knowing, is a small death of self… [which] allows rebirth and reconstitution of self” (Langan, 1999, p.95).

Our anxiety in facing the “fundamental voidness” can manifest in the music in myriad ways, as futile attempts to fill in the void musically for ourselves and/or the client, or backing away from the void altogether and returning to the illusion of familiar ground. Rather than backing away from the void, mindfulness allows us to embrace its indefinable and ungraspable nature. As we continually stay with our present-tense anxiety, we come to experience an increased capacity and tolerance for staying with the existential truth of the void. In the third space, our experience as therapists can be characterized as a “small death of self,” signifying a letting go of the anxiety and the subsequent flourishing of creativity. We come to see that change is happening in spite of our resistance to surrender to it.

In meditative practice, we can see how the Buddhist idea of karmic rebirth is relevant in the present moment: the practitioner observes his inhalation and exhalation as embodying the death and rebirth of the present moment. Similarly, as improvising therapists, we allow the present musical moment to dissolve, we directly experience what is happening (we are what is happening), leaving no psychic room to cling to a past or future musical moment. Each moment brings a new musical self, a continual playing on being. The continual movement from one
moment to the next that we experience in the third space can be understood through Suzuki’s (2001) explanation: “movement is nothing but the quality of our being” (p.105). The vital movement of music is nothing but the newly arising musical self in the present musical moment.

Concomitant to directly experiencing the present, we find ourselves “in a moment of complete incomprehension, where everything we know or expect suddenly no longer makes sense, and we may be able to experience everything afresh… not understanding a single thing, we are nakedly present in the moment” (Magid, 2002, p.108). In clinical improvisation, that means we therapists loosen our grip and let go of pet theories, psychological thinking systems, agendas and goals. The Buddhist notion of basic goodness entails our natural movement toward becoming more fully human, and thus renders therapy goals as “shortsighted,” except for our commitment as therapists to be as present as possible, and to deal with what is, not what we wish, imagine, or remember, or what would, could, or should be (Cooper, 2002, p.108). Being the naked present musical moment opens us as therapists and our clients to experience wonder, doubt, and surprise. Any solid body of knowledge if it is allowed to permeate the present moment will seal us off from wonder and forecloses creative moments (Cooper, 2002). In the third space, we can play familiar and learned musical structures as if we have never heard or played them before. Our musical resources are enlivened through our relinquishment of any solid body of knowledge about what is happening in the process with the client.
In clinical improvisation, we practice open listening. Our musical response to the client comes from our open listening in the present musical moment. There is the continual moment to moment renewal of each musical moment which brings the vitality of the present musical moment. Suzuki (1970) speaks of meditation practice that provides useful instruction to clinical improvisers: “The way to practice without having any goal is to limit your activity, or to be concentrated on what you are doing this moment... instead of having some particular object in mind” (p.75).

Our wish to be more attentive, for the client to feel better, to play differently than he is playing, to be less anxious, or to play more expressively are goal-oriented tendencies that not only take us out of our open listening stance, but also point us to our resistance to the present emotional moment. Open listening hears the emotional content of the client’s music, and lets it touch us without us grasping onto or rejecting it. Without our thinking minds intervening, we have the opportunity to be the present emotional-musical moment, and the emotion can just be. Without goals or agendas in mind, we maintain a mindfulness of the present musical moment and our resistance to it.

Epstein’s (1995) comments bring to light the potential effect on the client of a goal-oriented stance: “The therapist’s expectations and desires, however subtle, create a pressure against which the patient is compelled to react or with which the patient is compelled to comply... the analogy with the intrusive or ignoring parent cannot be exaggerated” (p.190). The client can feel the therapist’s posture that does not have an agenda, that does not try to force an experience, that
does not think that he knows what is going to happen or who this person is. The openness of the present musical moment arises out of the mindful goal-less presence of the therapist. Whether we are silent or playing with the client, the third space can be infused with the meditative quality of this stance: musical responsiveness out of our deep listening, and musical co-arising out of open listening.

Deep listening is shown in the model as occurring in Getting To The Point and entails a rigorous concentration on the client’s sounds that characterizes the client as the subject of the therapist’s intense listening. Open listening is shown to happen in the third space and reflects the experience of listening as interdependent and interpenetrating: there is no separation between listener and the listened to. Thus, any efforts on our part to change the client amount to “assaultive conversions” that foreclose any creative possibilities that might “derive through the free-play of wonder and doubt” (Cooper, 2002, p.113). Preconceptions and wishful thinking can inhibit the music therapist from directly experiencing the present musical moment. Attempts to impose goal-oriented thinking in the present musical moment may close off the creative potential in the music.

Working from this goal-less stance, the therapist, and subsequently the client, are involved in a therapeutic culture of listening. The underlying premise of mindfulness in music therapy practice is the predominance, nurturing, and progression of greater listening. In this way, the possibility exists of a culture in which deep listening activates responsive playing, and open listening sustains the interpenetrating nature of playing on being in the third space. Both therapist and
client can move into a way of being that evolves out of this progression of
listening. The therapist and client experience being heard to the point where
*listening to* and *being heard* are a resonant and singular pair. Paradoxically, by
listening to greater degrees, the players feel heard to greater degrees. The inter-
being nature of the music, by way of ever-deepening levels of listening in the
third space, is experienced as the phenomenon of hearing one’s self and the other
as inseparable in the music. In listening to the music being played by the dyad, the
client feels heard and understood by way of hearing himself and the therapist as
sharing the universal experience of being human. The I, you, and we who listen
are at once heard in the present musical moment as the musical one. We are
confirmed as individual selves who share our humanity. When the therapist
practices mindfulness in clinical improvisation there opens the realization and
actualization that music moves as the self moves, and the self moves as the music
moves.

The Model in Context: Theoretical Relationships

The taste of *mere* existence, I thought, and also the flavor of art.

( Epstein, 2002, ¶ 31)

Out of the straightforward interview question that asked therapists to
describe their experiences in clinical improvisation of when the music flows, there
opened a rich landscape of words, music, and insight. Without prior knowledge of
a particular theory of flow, the therapists were able to articulate their experiences around this notion of flow. While Csikszentmihalyi’s studies of flow experiences included a myriad of settings, this study centered on clinical improvisation and the therapists’ experiences and subsequent thinking around the notion of flow in their clinical work. Through the analytical process, I began to formulate a scheme that portrayed a process with three discernible stages. As I saw it, the clinical improvisation process as described by the participants related implicitly and explicitly to aspects of meditative practice.

The model of this study begins to explore the process of the therapist’s conscious mind in getting to the point where there is a qualitative shift in the improvisation with the client which the therapists described as when the music flows. Similarities and differences exist among the findings of this study illustrated in the model, Csikszentmihalyi’s thinking system, and the authors’ writings on music therapy and improvisation presented as part of the origins of the study.

The model centers on the therapists’ process and practice of mindfulness and their capacity to bring themselves fully to the present musical moment. Aigen (1995, 1996, 1998), Amir (1992, 1995), Csikszentmihalyi (1988), Elliott (1995), and Kenny (1989) consider experiences including those in music therapy and music that are characterized by deep involvement, absorption, total concentration, and living fully in the present moment. Aigen specifically recognizes these as characteristic of the clinical improvisation process in the Nordoff-Robbins’s Creative Music Therapy approach, and recognizes as one of the fundamental
tenets of Nordoff-Robbins music therapy the achievement of a “state of being
where both therapist and client are living as completely as possible in the music”
which involves the physical, emotional, and spiritual being as “becoming manifest
in the music” (p.12). The model acknowledges and expands upon these ideas in
its exploration of mindfulness as the cornerstone of the therapist’s process.
Through its three phases, the process traces the movement of the therapist’s
conscious mind from its natural tendencies of thinking and playing to a shift into
mindfulness, into being in the present musical moment. As illustrated in the
model, concentration is an aspect of mindfulness yet does not exclusively support
the notion of a singular focus on a particular object. The therapist’s attention and
concentration is on whatever is happening in the present musical moment, without
construing a particular and fixed focus as part of concentration. Ansdell (1995)
explains that a distinguishing feature of musical experience itself is the sense of
being involved, grounded, and “lost” in the present. He posits that music asks
present-tense “what? questions” about what is happening in the music and the
qualities of the music.

Aigen (1998) describes Paul Nordoff’s Zen-like quality of being in the
moment as a salient personal quality that characterized Nordoff’s seminal clinical
work in Creative Music Therapy. In culling foundational concepts of the
approach, Aigen (1996) discusses the therapist’s preparation before the session as
the cultivation of “an intense focus on the child with whom one is working”
(p.10). Paul Nordoff himself spoke directly to the therapist’s preparation, with the
suggestion to “meditate on the child before you come to the sessions” (p.10).
Aigen understands the preparation of clearing the mind of “any extrinsic thoughts, ideas and feelings” as one which allows the therapist to “completely be in the moment” (p.10). These ideas directly relate to the therapist’s capacity to be mindful during clinical improvisation. The model in this current study places the therapist’s mindfulness at the center of the phenomenon of when the music flows.

Furthermore, Aigen (1998) highlights Nordoff’s capacity to be fully present while creating musical forms that have direction and purpose. As illustrated in the current study’s model, skillful being happens in the third space and is characterized by the therapist’s capacity to stay in the present musical moment while creating musical forms. The therapist plays on being and continues to take in the client’s music and consider aesthetic form as part of the present moment. The constant re-creation of the present moment that is inherent in mindfulness involves the integration of prior experience into the present, rather than the annihilation of past experiences. In this way, the therapist relies on his present resources learned in the past to create musical form moment by moment.

Aigen (1995) addresses a key aspect of this study’s model when he proposes that, in the clinical improvisation process, the “duality of act disintegrates.” In essence, his thinking concurs with this study’s model that takes into account the experience of non-dualistic experience in which there is no distinction between the person making the music and the music itself. Aigen draws on Dewey’s (1934) ideas on aesthetic experience by stating that the musical encounter is an experience in which the two players are “so fully integrated that each disappears” (Dewey, in Aigen 1995). He posits that the clinical
improvisation process is an experiential medium and a mode of being in which there is “no fundamental distinction between one’s being and one’s music” (p.250). The music that is created mutually by client and therapist can be understood as a “unified entity” (Aigen, 2001, p.33). He extends this idea when he proposes that the “nature of the therapist’s music is a legitimate source of information of what is happening for the client” (Aigen, 2001, p.33). Taken together, Aigen’s ideas support those in this study’s model: the therapy dyad’s music is experienced as a unified phenomenon in the third space; there is no perceived distinction between the players. The inter-being nature of the third space delineates the universality and oneness experienced in the music.

Hesser (1982) posits that “our natural state is one where our actions are the manifestation of Being” (p.9). She contends that a split occurs between being and doing (action) at an early age, and that through clinical improvisation experiences in music therapy, “actions become more often the expression of our Being” (p.9). Her ideas relate to the current model in which the therapist moves from this “split” in its early phases, to the third space in which the action of making music is one and the same with the therapist’s being. Action and being are experienced as a unified phenomenon.

Levinson (1997) supports and raises relevant questions for this model in his conceptualism of “concatenationism.” He claims that musical understanding from the listener’s perspective essentially involves a sequence of “overlapping and mutually involving parts of small extent, rather than a seamless totality or an architectural arrangement” (p.13). For the purpose of this developing model, his
treatise highlights the apparent paradoxical nature of how the therapist can stay in the present musical moment and yet still create musical forms that have a sense of direction which implies a future-mindedness. At first glance, it seems implausible that the therapist can stay grounded in the present musical moment and be able to incorporate what has happened before, while in a sense, he anticipates and enacts the successive musical moment. While the workings of the human brain are well beyond the scope of this study, the therapist’s experiences in this study exemplify a present-tense nature, a sense of a musical unfolding moment to moment, while creating a coherent musical form. Levinson’s term “quasi-listening” places the music listener’s focus on small segments of music as they occur and on the “connections of such parts with immediately preceding and succeeding parts” (p.25).

The present musical moment is the centerpiece of this study and does indeed embody the past and future as in Andsell’s (1995) explanation of Zuckerkandl’s (1973) notion that musical logic gives the “experience of a present unfolding both backwards and forwards” (p.139). Again the reference is to the music listening experience, yet it still adequately portrays the phenomenon of present-tense playing and listening involved in the therapist’s experience. Ansdell (1995) provides yet another perspective in his proposition of musical thinking which accounts for the relinquishment of conceptual thinking for thinking in motions where the action and the thinking become fused. This highlights the therapist’s focus on the localized motion of the music which can be perceived moment to moment as Levinson purports as well. Furthermore, Levinson (1997)
adds that it is through following the motion of the music and the development of events in real time that its expressiveness is perceived, and that “synoptic” or “reflective” mental activity is not required to “register or respond to at least the great bulk of emotional content in music” (p.28).

As evidenced in the model, the improvising therapist brings in his musical knowledge into every moment of the music. I am making the claim that his musical thinking and his know-how acquired through musical training can be accessed moment to moment in clinical improvisation. The model in no way implies that the therapist is a blank musical slate or a passive musical partner, in fact, the converse is its clear implication. His musicianship, aesthetic sensibility, and knowledge can be employed without thinking about technique and musical concepts.

The components of the model rely interdependently upon one another. All the aspects of the phases are interdependent. When in the third space, the lower phases support its existence. His second-nature capacities in music are accessed spontaneously without a seemingly conscious intervention of his thinking mind. His perception of the moment to moment expressiveness of the music remains the paramount focus of his bare attention. The concept of mindfulness does not imply the absence of thought, rather, in the case of the improvising therapist, the absolute attention to his thoughts, feelings, and actions in forming music in the present musical moment. Embodied in the present musical moment is his thinking in motion that is not separated from his musical actions that he employs to produce the music.
Thinking in music as a form of musical intelligence is an idea that Aigen (1996) addresses through Paul Nordoff’s notion that when one has the capacity “to live in music,” there is a form of thinking that stands in contrast to “the logical thinking we might do in working out a problem and trying to think in terms of cause and effect” (p.13). The current study’s concept of musical co-arising takes place in the third space, is characterized by the absence of cause and effect thinking and perception, and is attributed to the mindfulness of the therapist.

Amir’s (1992) position that the therapist’s full participation embodies the sense of being what is happening speaks directly to the notion of mindfulness as the direct experiencing of the present musical moment. Her statement relates to the model’s exploration of the nonseparation between the therapist and what is happening in the moment. The therapist experiences the dissolution of the dualistic perspective inherent in subject-verb thinking. The model illustrates the process of moving out of the dualistic perception and separation between therapist and his playing, but also between the therapist and the client, and between both members of the dyad and the music. “Being what is happening” implies the cognate ideas of dualism, separateness, and polarity that are central features considered in the model.

In a similar way, Csikszentmihalyi posits that action and awareness become merged, that there is no separation between one’s awareness and one’s actions. The similarities to the Buddhist practice of mindfulness are clear, though Csikszentmihalyi expresses his ideas in psychological language. As these Buddhist concepts are situated in the process of clinical improvisation, the model
traces the therapist’s movement into mindfulness and direct experiencing of the present musical moment. Related aspects of mindfulness help to flesh out and expand upon the multiple facets of the phenomenon. Musical co-arising addresses the interdependence of events that dissolves thinking in terms of cause and effect. The interpenetration of all things, including people and events, permeates the model’s third space and is illustrated in its nature of inter-being: the therapist finds that he and the client share the universality of being.

Ansdell (1995) alludes to the parallel sense of flow of both the music and the self. The model addresses the metaphor of the fixed self moving into the notion of a fluid self. The moment to moment direct experiencing of the present musical moment is the fluid and ever-evolving self. The idea of playing on being in the model encapsulates this process whereby the therapist is playing music out of being and not out of who he thinks he is, or who he thinks the client is. His playing and responses come from his moment to moment listening. His movement into nonattachment to self-identifications allows his music to move and change, and feel creative to him.

Ansdell (1995) explains clinical improvisation as a present-tense phenomenon that allows a person to experience himself differently from his habitual state which clearly corresponds the model’s path of the self that moves from a fixed to fluid sense of self. Aigen (1998) emphasizes the creation of a self as a salient feature of Nordoff-Robbins Music Therapy. He explains that this notion of the creation of a self is often masked by prior writings on the approach that have emphasized observable musical goals as its primary focus.
The current model in this study looks at the creation of the self as a moment to moment phenomenon rather than the creation of a fixed self. This stance maintains that the experience of an impermanent self evokes and parallels the vitality and creativity in the music. The client (and therapist) through the phases of the model can hear their selves, bringing to the musical arena an aural representation of who they are in the moment, explained in the model as the impermanent dye of the dyad. Through getting to know themselves fully in this way, the dyad moves into the third space in which the ever-evolving musical form brings to their realization that who and what they think they are is an illusory fixed and static entity. It is through this realization and direct experiencing of the present music moment that the participants are able to move through the phases to becoming aware of the musical self as fluid, rather than having a sense of a fixed musical self. As Magid (2002) explains: “we share a universal capacity for a natural, fluid, and compassionate responsiveness when self-centeredness drops away” (p.92). What remains consistently present is our spontaneous responsiveness and functioning that is so much a part of our self that we do not possess it or even experience it as part of ourselves (Magid, 2002). In short, by becoming fully aware of and getting to know (hear) who we think we are, we find that we can let go of these mental formations to move into a more responsive stance to our world which is who we are.

Similarly, Csikszentmihalyi (1988) describes a transcendence of ego that allows a person to move beyond former habitual patterns. This can be related to the model in how the therapist loosens self-constructs and identifications to find
that his habitual playing moves to responsive and inventive playing. He also
speaks of a resultant complexification of the self that occurs as a consequence of
an experience in which one is not aware of one’s self, and the self is both separate
and unified with other people, events and entities beyond the self. While the
model does not propose a complexification of self as a theoretical consequence of
clinical improvisation, it proposes the dissolution of the metaphor of self in the
third space and illustrates across the phases of the model the relational path of the
therapist with regard to the paradoxical nature of being-alone, being-with, and
being-for. The inter-being nature of the third space suggests the union that
Csikszentmihalyi describes.

Csikszentmihalyi (1988) carefully distilled phenomenological
characteristics to define his development and understanding of the term flow. In
this study’s model, the point characterizes the therapists’ descriptions of a
qualitative shift in the clinical improvisation that includes a sense of timelessness
which relates to Csikszentmihalyi’s notion of a distorted sense of time, and a
sense of expending great effort which was experienced by the therapists as a
paradoxical sense of exerting great effort effortlessly.

In the discussion of the clinical implications of the model, the concept of
fundamental voidness is introduced as the not-knowing of the present moment
and as the realization of no-self that arouses existential anxiety in the therapist.
Ruud (1998) discusses a void that brings the participants in clinical improvisation
to a place of liberation from former boundaries and from which new meanings
come forth. In a different way, the model characterizes the void as a “small death
of the self” in which we are disencumbered by self-identifications and notions of a fixed and permanent self, and out of which creative possibilities blossom.

Balara (2000) recommended that further study was needed in the areas of listening, self-perception, and contextual characteristics in order to more fully understand flow experiences. This study’s model highly regards deep and open listening as a salient feature of the therapist’s mindful attention in clinical improvisation, and considers the therapist’s capacity to listen in the present musical moment as key in moving through the phases of the clinical improvisation process. Mindfulness clearly addresses the issue of how the self is perceived, shedding light on how the therapist’s experience involves a shift in perception of the self as a fixed entity to a fluid and evolving moment to moment flow in music, as well as the relinquishment of self-perceptions.

Coinciding with Balara’s recommendation, context is a central focus of this current study: the context of clinical improvisation was the primary milieu in which these experiences of musical flow were investigated. Related to Amir’s (1991) recommendation for further investigation of the conditions that allow moments in which the therapist’s “being what is happening” occurred, a primary condition illustrated in the model is the therapist’s capacity to bring himself to the present musical moment. The therapist creates the condition of mindfulness in the therapy dyad through his own practice of musical mindfulness. The therapist creates, models and supports an environment in which mindfulness can occur for the client.
Therapeutic presence has been addressed across therapeutic modalities, including creative arts therapy, as a cornerstone in creating a creative and therapeutic environment. The ways in which these authors interpret therapeutic presence correlate to the implication of mindfulness in clinical improvisation.

M. Robbins (1998) expounds on his therapy principles that hold presence and process as fundamental aspects. He finds that “for many clients, it is the therapist’s capacity to be deeply present with them that makes the most fundamental and lasting impact on their lives” (p.156). In so doing, he sees a successful therapy process as one in which the client himself develops a capacity to be present within a wider range of human experience. He relates good therapeutic practice to meditative practice in which the therapist places a primary value on staying with the moment to moment unfolding of the process “avoiding premature closure, explanations or interpretations” (p.157). As in meditation, the emotional current of the moment is experienced through a progressively heightened awareness.

Further, he highlights as fundamental principles in his work the understanding of the self as process and being attuned to the “creative ground of being” (p.158) that ensues through relinquishing the metaphor of a fixed and permanent self. A reactive mind can keep the therapist on the surface of experience and out of contact with the vital movements in the therapeutic setting (Robbins, M., 1998).

In music therapy, Scheiby (1998) describes her understanding of presence in service of navigating the relational territory of countertransference. Her ideas
address and coincide with aspects of the model’s focus on mindfulness: listening with all of one’s senses to the myriad aspects of the client’s music, authentically responding to the client from a non-intellectualized orientation which integrates the body and mind, and observing how a client handles an instrument, his use of words, and the inherent musical quality in his speech. The therapist’s heightened and pervasive observational capacity defines therapeutic presence and informs a responsive stance to the client.

Forinash (1992), in her study of therapists’ experiences in clinical improvisation, asserts that there is a “multidirectional flow” (p.133) in clinical improvisation among experiences of spontaneity, creativity, intuition, rationality and conscious choice. Her findings suggest an interplay and movement through these multiple levels of the therapists’ experience. She explains these three levels as, first, the therapists’ capacity to connect with the client with total focus and without ‘thinking about’ what they are doing; second, there is partially conscious thinking about musical choices; and third, where the therapist is clearly thinking and planning. Forinash’s three levels of experience roughly speak to aspects of this study’s model in which the therapists move through the three phases from thinking about the clinical-musical encounter, to being completely mindful in the present moment without extrinsic, non-musical thinking involved.

Bruscia (1995) formulates a theory that explicates *modes of consciousness* which the therapist experiences in Guided Imagery and Music (GIM), a music therapy approach that involves the client and therapist in a music listening experience, guided by the therapist through verbal interventions. Bruscia’s main
purpose in developing his theory through self-inquiry is to explicate what it means for a therapist to ‘be there’ with the client. His theoretical tenets speak broadly to this study’s findings that delineate therapeutic presence on the part of the therapist.

While he does not examine a music improvisational approach, Bruscia delineates three worlds of consciousness that involve the therapist’s conscious experience in the therapeutic encounter: the therapist’s world, the therapist’s personal world, and the client’s world. Bruscia explains in his theory that the therapist “expands, centers, and shifts his consciousness” (p.169) while guiding the client in the music listening. Related to this study’s model is Bruscia’s focus on the process of the therapist’s conscious mind and how the therapist carefully observes and takes in fully what is happening in his own thinking in the moment with the client.

However, his theory departs dramatically from this study’s model in that the therapist in GIM allows spontaneous elaboration and exploration of his inner psychic life in the presence of the client, and this activity is deliberately employed to influence his clinical direction throughout the process. This significant difference may be attributed to the fact that the therapists in GIM are not actively playing music, in contrast to the participants of this current study who are actively creating music in clinical improvisation. In the model presented in this study, the therapist actively guides attention to the present musical moment without personal exploration and elaboration. However, the sense of reverie that is encouraged in GIM relates to the therapist’s experience depicted in the first phase of this study’s
model as tendencies of the mind. In contrast to Bruscia’s depiction and the first phase of this study’s model, the therapist in the second and third phases of the model is guiding his attention to the present musical moment. However, the idea of the therapist guiding his conscious attention amongst these three worlds relates to the model in how the therapist moves through its three phases: from thinking about, to letting go, to being mindful in the present musical moment, and in a sense, thinking and feeling solely in music.

Amir (1995) and McMaster (1995) explicitly and implicitly refer to spiritual tenets as they focus on the therapists’ presence engendered through the act of listening. Amir pointedly suggests that a new vocabulary is needed to “capture the essence” (p.56) of the music therapy experience. She specifically refers to the spiritual aspect of the experience as one that has been neglected due to the insufficiency of language to describe its place in music therapy. Amir further states that the paradoxical “state of being” that arises in musical experiences cannot be explained in “classical terms” (p.56). Amir’s ideas point directly, though not explicitly, to meditation practice in her description of the therapist’s attentional stance that entails the capacity to “‘be with’ the music” (p.53).

McMaster (1995) refers to listening as a “sacred act” as she explains: “Something sacred there is about listening when the whole of our Being is tuned to resonate with all that enters our field of experience” (p.72). She posits that an “alert curiosity and ready acknowledgement” of all that is happening in our perceptual field is possible when the therapist attends to the client from a “still
center” that is vulnerable and open (p.73). Bonny (2001) who uses Guided Imagery and Music as her primary treatment method has devoted her professional efforts to the recognition and integration of spirituality in music therapy processes. She contends that the letting go process is an important part of spirituality which has its counterpart in the GIM method as well. Amir’s (1995) ideas on presence and the need for a vocabulary to describe spiritual aspects of music therapy, McMaster’s (1995) spiritual intimations in her treatise on listening, and Bonny’s (2001) explicit acknowledgment of spiritual experiences in music therapy are well represented and have been expounded upon explicitly in this study’s model.

In art therapy practice, Marek’s (2001) integration of aspects of meditative practice in his approach to art and art therapy entails “fresh ways of paying attention” (p.68) as he illustrates in the form of questions: How do you express yourself, hold the brush, see, touch, listen and respond to an image, color or shape? How can you bring yourself back to the concrete nature of your experience when lost in a stream of thoughts or fantasy? This study parallels Marek’s thinking that through the practical, one is awakened to the vitality of the present moment. Paramount to his approach of fully paying attention is trusting that technique will be available when it is needed, and that the freshness and vitality of art arises out of being awake, dropping the discursive mind, and just listening. He finds that he relinquishes thoughts of himself as a painter (letting go of self-identification and self-constructs), and finds that he paints as if for the first time, allowing the vitality and freshness of each moment create the same in the form of
art (Marek, 2001). His inclusion of Buddhist meditative aspects to his art work intimately relate to the model of this study.

Implications for Educating the Clinical Improviser

The model might be a useful paradigm in the education of music therapists in clinical improvisation. While it was developed from the experiences of ten seasoned improvisers with a high degree of musical skill and clinical expertise, it may serve to inform improvisers at all levels of several salient characteristics of clinical improvisation.

The model pointedly places the therapist’s capacity to be mindful in a central position. While a music therapist may think analytically and incorporate theoretical constructs in his understanding of the therapy process, the model explicitly cites the relinquishment of such thinking in service of letting the clinical improvisation unfold musically. The music therapists described experiences that profoundly influenced their development as musicians and people. These kinds of experiences that have been characterized as moments when the music flowed can elude or remain ineffable to the improvising therapist in clinical practice. The model addresses the conscious process and conditions of these experiences and allows the music therapist to take a look at his or her own role in cultivating a therapeutic environment in which mindfulness becomes the cornerstone of the process. A music therapist learning to be an improvising clinician often finds difficulty in applying and integrating technical proficiency and musicianship on
his primary instrument to clinical improvisation, which in part may be attributed to resistance to the flow of the unfolding musical experience.

In looking at the model, I can appreciate the experience of a musical and clinical glass ceiling that improvising therapists may come up against, when they are unable to move through the playing glass, as did Alice in Wonderland, and into the qualitatively different third space. The passageway through the point may elude them in clinical improvisation yet they may be familiar with experiences characteristic of the third space.

The education of the improvising therapists might include aspects of meditative practice to bring the therapist’s attention to the process of his thinking mind. His heightened awareness of thoughts in the moment can bring a disciplined and gentle approach to training his musical mind. Using meditative techniques may enhance the therapist’s ability to listen more deeply and to stay with the flow of affect and sound in the improvisation milieu. In conjunction with therapy and supervision, the integration of meditative practice into musical and clinical education might shed light upon the therapist’s resistances to jumping into the flow of musical experience. A musician inherently performs when there is another person who, at the very least, is a witness to his playing. In the therapy situation, the client can become a potential audience to the therapist. The narcissistic injuries from musical training and past playing experiences can be acutely and chronically part of the therapist’s block toward creative freedom in clinical improvisation. Being ever mindful in one’s conscious process may be key in finding a way to greater musical freedom and inventiveness.
The therapist’s capacity to bring himself to the present moment and to attend to whatever feelings and thoughts he is having has been shown to be critical in its effect on the clinical improvisation process. The improvising therapist often struggles with what to play, when it may be a question of how to play. The continual and deep listening to the client’s sounds can help the therapist awaken to the present musical moment, and may allow the therapist to respond musically from a place of being in the present, rather than reacting in a habitual way. Staying with musical reactions can lead to insight into the basis as well as the way through the impediments to being in the present musical moment.

Theorists and clinicians in a multitude of therapeutic approaches are explicitly suggesting and applying spiritual traditions in the education of therapists (Aigen, 1998; Marek, 2001; Robbins, S., 1998; Twemlow, 2001). The innate paradoxes that the therapist experiences as part of his practice of clinical improvisation can become part of the therapist’s working vocabulary in music therapy. The Zen and Buddhist practices speak to the ineffable nature of the therapist’s experiences in clinical improvisation. The confounding questions that surround the process of isolation and relationship, self and other, and the nature of existence can be brought to the fore when a therapeutic training and practice addresses the interpenetrating nature of being. Perhaps the study of meditative practice or the integration of meditative principles into the improvising therapist’s musical practice can help to close the oftentimes and perhaps inescapable gap in completely understanding the connection between the physical act of making music and the experience of mind. The perception of a nondualistic mind-body
realm, rather than the perpetuation of the mind-body split, speaks to the lived clinical improvisation process as experienced by the participants in this study.

Looking Toward Future Research

The practice of clinical improvisation involves bringing the mind to the present active moment, as does the practice of meditation, as does the practice of writing a dissertation. The process of writing this study has infused my clinical practice with newfound facets. Practice infuses thinking, as thinking infuses practice. The integration of spiritual tenets into the practice of clinical music-making opens possibilities, not solely to explain or better understand, but also as affirmation for the practitioner of music therapy. The participants revealed their lived experiences, and I have discovered new facets in thinking of my own clinical experiences. The process of description does its best to honor the complexity, while the attempt to explain begins to distort. What these participants in this study revealed in their music and words continues to inspire and leave me awestruck. Their words and music resonated with my own experiences and have left me feeling more at home in some of the seemingly ineffable aspects of clinical improvisation.

The experience of spontaneously making art with another human being is the process of clinical improvisation. As I have interpreted the data in my findings, it plays out and sings out the paradoxical nature of our human experience and existence. The therapists’ experiences speak to the complexity of lived experience that seems to be at once distilled and expanded through musical
experience. Being in musical experiences reflects and embodies the questions around the ways we think about ourselves and others. The therapy relationship that lives in the present musical moment could only have been described in ways that span the realms of perception and thinking. Writing this study has been a paradoxical and perplexing experience at times. The map is indeed not the territory. The words, charts and diagrams are not the experience. It seemed as though the more I tried to slow down the process, look at its parts, or investigate a developing idea, the music-making phenomenon would seem to lose some of its vitality. Yet, for these same reasons, the practice of writing and thinking about clinical improvisation has made the musical experience evermore unique.

Even at the end of this study, my own fascination with clinical improvisation continues. The more I have written, the more I am intrigued. There seems to be no end to a qualitative study and no ending point other than a collaborative decision that these attempts to illuminate the process and the relationship between being mindful in the present musical moment and when the music flows have been reasonably exhausted. The researcher also!

Future researchers who wish to continue this line of inquiry, as I have continued from previous researchers, can direct their efforts toward the clients’ experiences in clinical improvisation as the other side of the story. What is their experience of a therapist who works toward maintaining a mindful stance? What would the clients consider in their accounts of when the music flows?

While the question of the role of the client was included as one of my initial research questions, it became apparent to me that there was a world of
insight solely in the therapists' experience that could be addressed in one
dissertation. This current study's focus narrowed in this way, and with good
reason. At best, the therapists could make inferences about the clients' experience,
and this became less and less of a viable way to proceed. As well, future
researchers may see the need to look into the specifics of the music in more detail
than this current study. The explicit and formal analysis of music was not my
primary intention, though the therapists did speak directly to some specific
aspects of the music. I followed their lead and focus, whereas a future researcher
might be inclined to analyze the music on his own, apart from their interaction
with the participant in the interview setting. My interest primarily centered on the
therapists' perspectives of the music. I found that the process of the therapists'
*playing on being* became a veritable universe to explore in its own right.

I end by sharing with the reader a passage that points to my coming full
circle from the beginning of the research to its end, though with a renewed and
deepened appreciation of studying human experience. At the onset of this study, a
friend and colleague sent this quote to me after we had had a very lengthy, but not
uncharacteristic, chat one sunny autumn afternoon in a park. He seemed to hear a
door opening, and could envision possibility for this study. Perhaps long before I
could.

Seek the truly practical material life, but seek it so that it does not numb
you to the spirit which is active within it. Seek the spirit, but not in passion
for the supersensible out of supersensible egoism, but seek it because you
must apply it selflessly in practical life, in the material world. (Steiner, 1946, p.147)
REFERENCES


APPENDIX A

CONSENT FORM

You have been invited to take part in a study to learn more about flow experiences in music therapy clinical improvisation. Flow experiences in music therapy, as defined for this study, are highly collaborative and creative moments in musical improvisation between therapist and client, as interpreted by the music therapist. This study will be conducted by Joseph F. Fidelibus, from the Music Therapy program in the Department of Music and Performing Arts Professions in the Steinhardt School of Education at New York University. This study is being conducted as a part of his doctoral dissertation. His faculty sponsor is Barbara Hesser who can be contacted at NYU Music Therapy Program (212)998-5452.

If you agree to be in this study, you will be asked to do the following:
1. select a musical improvisation from a video or audio taped archived session of a former client of your choosing.
2. listen to the audio portion of the musical improvisation along with the principal investigator.
3. identify flow experiences.
4. participate in one interview to discuss your experiences of flow as you have identified them on the taped session.

Participation in this study will take about 3 hours of your time. There are no known risks associated with your participation in this study beyond those of everyday life.

Although you will receive no direct benefits, participation in this research may help the participant as well as other music therapists to increase their understanding of flow experiences in music therapy clinical improvisation.

The investigator has explained this study to you and answered your questions. If you have additional questions or wish to report a research-related problem, you may contact the researcher at (845)279-0698 or joseph.fidelibus@nyu.edu.

For questions about your rights as a research participant, you may contact the University Committee on Activities Involving Human Subjects, Office of Sponsored Programs, NYU at (212)998-2121.

Participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty.

The principal investigator will strictly maintain confidentiality of your research records with the following exception: the researcher is required by law to report to the appropriate authorities, suspicion of harm to yourself, to children, or to others. No identifying information will be included in any of the data materials that are shared with the investigator's support group or academic supervisors. Only aggregate data will be used or reported.

Your interviews will be audio taped. You may review these tapes and request that all or any portion of the tapes be destroyed.

You have received a copy of this consent document to keep.

Agreement to Participate

Participant’s Signature ___________________________ Date ___________
APPENDIX B

CLIENT CONSENT FORM

Your former music therapist has been invited to take part in a study to learn more about flow experiences in music therapy clinical improvisation. Flow experiences in music therapy, as defined for this study, are highly collaborative and creative moments in musical improvisation between the therapist and the client, as interpreted by the music therapist. This study will be conducted by Joseph F. Fidelibus, from the Music Therapy program in the Department of Music and Performing Arts Professions in the Steinhardt School of Education at New York University. This study is being conducted as a part of his doctoral dissertation. His faculty sponsor is Barbara Hesser who can be contacted at NYU Music Therapy Program (212)998-5452.

By granting consent, you agree to the following:
1. To allow the principal investigator to listen to the audio portion of a musical improvisation from a video or audio taped archived session of your completed music therapy.
2. To allow the principal investigator to listen to the musical improvisation along with your former music therapist.
3. To allow your former music therapist to select the musical improvisation that will be listened to, though you have a right to request that a particular musical improvisation not be shared with the principal investigator. You will be notified of the particular musical improvisation that is selected before it is included in the research for your approval.

Only the time required to sign this consent form is needed from you. There are no known risks associated with this study beyond those of everyday life. The focus of this study is primarily the music therapist.

Although you will receive no direct benefits, this research may help your former music therapist as well as other music therapists to increase their understanding of flow experiences in music therapy clinical improvisation.

Your former music therapist has explained this study to you and answered your questions. If you have additional questions or wish to report a research-related problem, you may contact the researcher at (845)279-0698 or joseph.fidelibus@nyu.edu.

For questions about your rights as a research participant, you may contact the University Committee on Activities Involving Human Subjects, Office of Sponsored Programs, NYU at (212)998-2121.

Your consent is voluntary. You may refuse or withdraw consent at any time without penalty. No loss of services to which you are otherwise entitled will be affected.

The principal investigator will strictly maintain confidentiality of your research records with the following exception: the researcher is required by law to report to the appropriate authorities, suspicion of harm to yourself, to children, or to others. No identifying information will be included in any of the data materials that are shared with the investigator's support group or academic supervisors. Only aggregate data will be used or reported.

You have received a copy of this consent document to keep.

Client’s Signature ____________________________ Date ____________
APPENDIX C

PARENTAL PERMISSION FORM

Your child’s former music therapist has been invited to take part in a study to learn more about flow experiences in music therapy clinical improvisation. Flow experiences in music therapy, as defined for this study, are highly collaborative and creative moments in musical improvisation between the therapist and the client, as interpreted by the music therapist. This study will be conducted by Joseph F. Fidelibus, from the Music Therapy program in the Department of Music and Performing Arts Professions in the Steinhardt School of Education at New York University. This study is being conducted as a part of his doctoral dissertation. His faculty sponsor is Barbara Hesser who can be contacted at NYU Music Therapy Program (212)998-5452.

By granting consent, you agree to the following:
1. To allow the principal investigator to listen to the audio portion of a musical improvisation from a video or audio taped archived session of your child’s completed music therapy.
2. To allow the principal investigator to listen to the musical improvisation from the session along with your child’s former music therapist.
3. To allow your child’s former music therapist to select the musical improvisation that will be listened to, though you have a right to request that a particular musical improvisation not be shared with the principal investigator. You will be notified of the musical improvisation that is selected before it is included in the research for your approval.

Only the time required to sign this consent form is needed from you. No time will be needed from your child at all. There are no known risks associated with this study beyond those of everyday life. The focus of this study is primarily the music therapist.

Although you or your child will receive no direct benefits, this research may help your child’s former music therapist as well as other music therapists to increase their understanding of flow experiences in music therapy clinical improvisation.

Your child’s former music therapist has explained this study to you and answered your questions. If you have additional questions or wish to report a research-related problem, you may contact the researcher at (646)279-0698 or joseph.fidelibus@nyu.edu.

For questions about your child’s rights as a research participant, you may contact the University Committee on Activities Involving Human Subjects, Office of Sponsored Programs, NYU at (212)998-2121.

Your consent is voluntary. You may refuse or withdraw consent at any time without penalty and with no loss of services to which your child is otherwise entitled.

The principal investigator will strictly maintain confidentiality of your child’s research records with the following exception: the researcher is required by law to report to the appropriate authorities, suspicion of harm to yourself, to children, or to others. No identifying information will be included in any of the data materials that are shared with the investigator’s support group or academic supervisors. Only aggregate data will be used or reported.

You have received a copy of this consent document to keep.

Parent/Guardian’s Signature

Date

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