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MUSICAL JOURNEYS: MUSIC THERAPY WITH LATIN AMERICAN
MOTHER-INFANT DYADS IN A SUBSTANCE ABUSE
REHABILITATION PROGRAM

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Department of Music and Performing Arts Professions

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Rebecca Ramirez Loveszy  September 22, 2005
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CHAPTER I

INTRODUCTION

... incubators with bright lights, holding premature infants, helpless and entwined in a web of intravenous lines, feeding tubes and monitor wires. Nurses bustle to respond as monitor alarms ring, disrupting the more normal cacophony that is the norm in this space. ... standing at the doorway peering in, one isolated mother, handkerchief in hand, her eyes swollen and red, and the dark circles underneath them, betraying their beauty by instead evincing her agony and pain...(Loveszy, 1984)

Over twenty years ago, I worked in a critical care pediatric hospital. I had developed a program in the neonatal intensive care unit (NICU) to decrease the outside stimuli and increase the connection of family members with their premature infants who were subject to this harsh introduction to the world. In the NICU, some of the babies were approximately one pound at birth, were on life support and had a tenuous possibility for life. Many mothers and fathers needed support simply to be able to connect with their infants under such stressful circumstances.

In this setting, music therapy provided a perfect tool for all involved. I first worked with mothers, and provided a place in which each mother could talk and relate to her infant through her voice. I then worked with the neonates, and placed an audio recording of each mother’s voice inside her baby’s incubator. I
also covered the incubators with lamb's wool in order to minimize the noise and bright lights – in other words, to soften the “feel” of the environment that the premature child was experiencing. The nurses worked in concert with me, encouraging the mothers to sit beside the incubators. When a mother was not there, the nurses turned on the recording of the mother's voice for each infant.

As a therapist in this NICU it was necessary for me to work first with the mothers and the infants separately. Later I was able to work with them together, as dyads. This experience clarified for me that there is much more to be learned, as well as to be gained, from working with mothers and infants together rather than working with each separately.

My experience as a therapist has been that most settings do not provide an environment where work is possible with mother-infant dyads. As a result, creating a musical environment in which mothers and infants can connect has remained a life-long passion. This passion led me to seek an environment in which I would be able to study the natural processes mothers and infants-at-risk go through to relate to each other within the context of music. The experiences of mother-infant dyads in such a setting are the focus of the present study.

When I came to consider topics for this research project, a colleague encouraged me to speak with the director of a program offered to Hispanic women and their infants. He did so because he knew of my interest in this area. The director to whom he referred me in turn put me in touch with the coordinator
in charge of a program that addressed the needs of substance-abusing Latin American women and their children-at-risk.

I was able to take advantage of the opportunity to work with this group, and offered music therapy to their participants. I was particularly interested in, as well as at ease with, this population because of my own heritage and bilingual abilities. This enabled me to establish the clinical research project, examined in this study, through an organization providing programming for these families. As I further examined the possibilities, it became evident that, just as I had hoped, I was being offered the opportunity to work with both mothers and infants together; as dyads. How that actually came about is discussed further in Chapter III.

Alvares (2001) states the importance of taking into account the symbiotic relationship between a child and mother when developing their treatment plan. This means that the needs of the mother, not just of the child, should be considered. She also makes note that she has observed that mothers of young children usually do not participate in their children’s music therapy sessions. In general, under those circumstances, the mothers take their children to therapy and meet with the therapist, but they do not have a direct role in the therapeutic process. My experiences have led me to believe that the most crucial time for intervention is before problems exist, and that it is more effective to work with both mother and child together. This might take place at the very beginning, working with a pregnant mother before a child is born, or working with newborns.
It is also my belief that infants are closest to the musical environment of the womb – the melodic, rhythmic movement of the mother’s body, the amniotic fluid, her heartbeat, and her voice. These sounds and rhythms along with many others provide a feeling of security and connection for each infant. All infants, whether at risk or not, need this musical connection with their mothers. Those at risk, however, are usually disconnected from their mothers at an earlier time. Many are dealt with medically and placed in an incubator, usually in an NICU, before being introduced to the safety of their mothers’ embrace.

The crucial period for parent-child bonding is a child’s first year of life. Without positive attachment, severe problems that relate directly back to this lack of attachment will usually begin. These problems are exacerbated when the element of cocaine abuse exists, which in itself creates a toxic environment for beginning attachments.

The relationship between mothers and their infants is profound. Research (Nocker-Ribaupierre, 2004) into prenatal physiological, hormonal, and psychological connections of mothers to fetuses in utero and the subsequent part mothers play after birth, indicates that the key to self-esteem may lie in the initial relationship of children to their mothers. The early bonding experience, a continuum between the prenatal and postnatal experience of mother-infant unity, suffuses a child with concomitant feelings of security, trust, and unconditional love which may go a long way toward sending a child on the path of developing self-esteem and self-worth (Verrier, 1993).
In the environment of prenatal substance use, there is potential for both mother and child to present negative interactive behaviors. Research indicates that the postnatal environment is a strong indication of the quality of mother-infant interaction in substance-exposed dyads (Johnson, 2001). It was my hope that the present study would provide support for intervening through musical communication early in mother-infant relationships.

My aim in the study was to elicit information that may assist mothers and families, both those who are using substances and those who are not, to learn of their natural abilities to help themselves through music while learning and bonding with their infants. As the project evolved, three of the possible participants who originally agreed actually went through the therapeutic program. Their journeys in music therapy are the focus of the present study.

**Research Questions**

The general question that guided this study was:

What were the experiences of three mothers in a substance-abuse rehabilitation program and their infants as they were engaged over time in the music therapy process?

The following sub-questions emerged during the course of the study:

How did the relations between the mothers and their infants evolve over time?

In what ways did the mothers’ relations with the therapist change during the course of the music therapy process?

How did the music evolve within the process of the therapy sessions with the mothers and infants?
In what ways did each mother’s history of substance abuse manifest itself?
CHAPTER II

REVIEW OF RELATED LITERATURE

The framework for the present study is drawn from theory and research in three distinct fields. The first of these is the area of psychology devoted to mother-infant relations. The primary theorists that provide analyses in this context are Winnicott (1965b, 1971, 1992) and Stern (1977, 1995). They examined the mother-infant relationship in an environmental, creative and interactional framework. The second field is that of substance-abuse treatment for low-income women and their children. The third is from the specialized discipline of music therapy, in particular therapy with mothers and their infants.

Although many music therapy theorists allude to mother-infant relationships and more are studying prenatal and mother/infant relationships, little research appears to have been done regarding mother/infant dyads who suffer from substance abuse. Recently, new literature has emerged within dyadic work with premature infants in NICUs and in medical settings (Nocker-Ribaupierre, 2004).
The Mother-Infant Relationship

The mother-infant relationship is vital to the strength of humanity. A mother is the foundation of mental health for an infant by providing what the psychoanalyst, Donald Winnicott calls, a “facilitating” environment (1992, p. 38). In this respect, the mother fosters a safe place for the infant to interact and explore his environment and himself. She is the “mirror” in which her infant first perceives himself to be; he is unified with his mother. Over time, he will be able to separate his identity from hers (Stern, 1989, p. 193). In the first weeks of life, the mother and infant are extremely intimate, sharing in eye contact, smell, nourishment and sounds. Through their senses, the mother and infant relate and communicate. This communication begins in utero and continues as the infant develops after birth (Fischer & Als in Nocker-Ribaupierre, 2004, p. 10).

The psychoanalyst, Donald Winnicott (1965a), has said that where there is a baby there also must be a mother. There is, he said, no such being as a baby. Babies are not singular nor are they individuals. They are profoundly relational and cannot exist as babies outside of relationship with the mother. Nor, for that matter, can a mother be a mother without being or having been in relationship with a child. From Winnicott’s perspective, life from the onset is communal and networked. In the “with-ness” and the flowing exchange of joys and care between a mother and infant, community forms because of the intrinsic bond that has, or should have, developed during the months after birth.
The mother, said Winnicott, can be thought of as having two dimensions: object and environment. There is the mother who is an “object.” The mother is an otherness who provides attentions. This is the mother who is “over there” and distinct yet available. As an “environment,” this mother is a presence, an atmosphere, a flow, or an elemental source whose being forms for her baby a sense of holding (Winnicott, 1986b, p. 90; 1992, pp. 62, 96-97). The baby is held not only in tangible and physical acts of support, but also in states of mind through intention, attention and in ontologic self-presentation. Along with being an “object,” the mother is also a “holding environment” (Winnicott, 1960, pp. 25-26). Winnicott’s concept of “holding” is often used interchangeably with the model of his predecessor, Bion (1967), of the “container-contained” (p. 106). These two concepts are used both metaphorically and literally: in the literal physical sense, a mother holds her infant in her arms, and also serves metaphorically as a “container,” providing the environment that holds herself and her infant.

It is this aspect of the mother-baby relationship that forms the most fundamental bond in which discrete acts of attention and care take place. The “holding environment” aspect of maternal care gives shape to community within which solitude is also possible. A mother who is both consistent as an object and also provides continuity of presence as a holding environment is “good enough” (Winnicott, 1987, p. 39). As “good enough,” the mother provides neither too
much, which would risk indulgent dependence or spoiling, nor too little, which
would risk the intolerable frustration of deprivation.

Attachment Theory: Toward the Growth of Independence

The study of attachment originated with the work of Sigmund Freud. Attachment is described as an emotional relationship involving mutuality, comfort, safety and pleasure for both caregiver and child. Freud’s work was expanded upon by John Bowlby (1969), who is often credited as the father of attachment research because of the extensive work he contributed to the field. The original attachment is not experienced by the infant as a relationship in the same manner in which we think of one. Rather, the mother first is experienced by her infant as being part of the infant. The “mother” is that part of the infant’s “self” that brings food, warmth, movement and laughter to the infant’s world. When the infant has a responsive and sensitive mother, he experiences himself as “empowered” since he can create pleasurable and interesting feeling states within himself by activation of the “mother” part of himself. An infant cannot produce the two primary positive emotional states – enjoyment/joy and interest/excitement– without the active involvement of the “mother” part of himself (Bowlby 1958, p. 358).

Attachment can be weak when the mother is not consistently responsive to her infant’s emotional, physical, sensory, and mental developmental needs, as is sometimes the case when mothers are substance abusers. When the infant’s initial
attachment to his mother is severely lacking, he is at risk for being unable to adequately recognize and respond appropriately to subsequent relationships with caring adults (Main & Solomon, 1986).

In the healthy bond there are thousands of minute but synchronized emotionally rich moments between a mother and her infant that feed the emotional and sensory aspects of the infant’s young brain and thus strengthen attachment. Central to these reciprocal experiences are sound, rhythm, touch, smiles, eye contact, facial expressions and movement. Early childhood researchers (Ainsworth, 1971, 1973, 1978; Belsky, 1988; Beebe & Lachman, 2002; Bowlby, 1969, 1973, 1979, 1988a, 1988b; Fish, Stifter, & Belsky 1993; Lieberman, 1986; Sameroff & Emde, 1989; Tronick, Als, Adamson, Wise & Brazelton, 1978) refer to these as moments of “affective attunement” in which the mother’s emotional state recognizes and mirrors the emerging emotional state of her baby. This experience of shared emotion nourishes the infant’s ability to feel enjoyment/joy and interest/excitement.

Without these countless experiences of attunement, the infant will not develop a core sense of self and will not be able to experience these emotions well or know that another person can be the source of such pleasure. These healthy experiences also inoculate the child from atypical behavior in later life. If the infant does not experience positive attachment, he will try to find his pleasure, small though it is, in ways that he can control (Ainsworth, 1989; Beebe &
Lachmann, 2002; Bowlby, 1969; Campbell, 1990; Fonagy, 2000; Hanson & Spratt, 2000).

When an infant has experienced a consistently attentive mother and has established stable early attachment, he will be able to accept and integrate the socialization demands that come with being a toddler. The mother is a guide for his social/emotional learning by teaching appropriate social behavior. The child is being taught that certain behaviors need to be limited, controlled and redirected. These experiences must occur for optimal development and a more fully developed attachment. Sequences of attunement, socialization with reassurance, and re-attunement integrate the young child’s needs for a secure attachment along with his needs for socialization and autonomy. He can be a special and unique individual within a social world while experiencing healthy, attached relationships with members of his family (Brazelton, 1992).

When a mother is attuned with her infant, the parent manifests an attitude that has five central characteristics. In general, she is able to maintain an attitude that is accepting, empathic, loving, curious and playful. She takes delight in and affirms sounds, emotions and movements her infant manifests. She comforts and soothes, she reacts with surprise and exuberance, she constantly communicates, both verbally and non verbally... and she hugs. She notices without judgment any actions her young child is demonstrating. The underlying attitude that these behaviors convey is ideally suited for facilitating an attachment with her infant (Sears & Sears, 2001).
Stern (1977) describes the earliest phase of interaction as the dynamic work of a mother, a unique, nonverbal interaction between herself and her infant. The concept of "interactional synchrony" (Bernieri & Rosenthal, 1991; Brown & Avstreich, 1989; Condon & Ogston, 1966) describes the extremely subtle subjective coordination of acts that are communications. This can be understood as a dance between mother and infant, in which each adapts and shifts eye gaze, head movements, body movements and vocal sounds in order to personally "fit" and "exchange" with the communicating partner. Mothers and babies negotiate and share a flexible musical pulse between them, constantly adapting their tempi, intensity, motion, shape and contour of their sounds, movements and gestures in order to "fit" with the communicating partner. It is interesting to note the number of researchers examining the development of mother-infant interaction who express their findings in musical terms (Beebe, 1982; Beebe, Jaffe, Feldstein, Mays & Alson, 1985; Brazelton & Cramer, 1990; Papousek & Papousek, 1981a, 1989; Stern, 1985; Trevarthen, 1993; Trevarthen & Aitken, 1994). Thus, music is an excellent vehicle to increase attachment in a poorly attached child, which is discussed in following sections.

Adults intuitively seem to fine tune to infants with nuances of rhythm, tempo, and intonation in what has been identified as infant-directed speech in contrast to adult-directed speech (Trehub & Trainor, 1993; Unyk, Trehub, Trainor, & Schellenberg, 1992). They show an innate capacity for enabling and inviting the infant to enter into interactional synchrony with them. Mother and
infant synchronize themselves, initiate with, and respond to one another. This direct, intimate emotional knowing of one another is crucial for the infant's biological, social, and cognitive survival. It is also imperative for the infant to access a communicative and expressive vocabulary for engaging reciprocally with the world.

As infants move from dependence to independence, mothers become facilitators while the infants become exploring toddlers. Initially, dependence is characteristic of the time period from birth to one year, during which infants need caregivers to “do it for them.” Later, as infants become toddlers in their second year, they move into the “I will do it myself” phase. Finally, a third phase, which most people do not recognize, is a much more mature phase of development that takes place as children become interdependent. It is characterized by “We will do it together.” This interdependent phase enables children to make appropriate choices and experience healthy autonomy (Sears & Sears, 2001, p. 21).

Substance Abuse Treatment for Mothers and Their Infants

Although there is growing recognition that chemical dependency is a serious and pervasive problem in pregnancy that accentuates the need for trained professionals who are able to work effectively with the clinically dependent population, there remains no distinct agreement upon state-of-the-art treatment strategies (Baker, 2000). Addiction, whether to alcohol, drugs, or any other illicit substance, is a multifaceted syndrome. Consequently, treatment must be based on
a comprehensive assessment to determine what genetic, psychological, and/or environmental factors are supporting the individual’s behavior, abnormal behavior or physical, emotional/psychological impediments (Johnson, 2001).

Over the past two decades, the number of individuals in this country who are using cocaine and other drugs has risen dramatically. The number of drug-exposed infants also has increased 65% to 87% because women of child-bearing age make up a significant proportion of those who use and become addicted to cocaine and other dangerous substances (Marquez, 2000). It is estimated, for example, that two to three percent of infants born in the United States are exposed to cocaine while still in the womb (NIDA, 2000). This significant increase in the number of cocaine-exposed infants has stimulated interest in the developmental stages of drug-exposed infants (Accornero, Morrow, Bandstra, & Anthony, 2002). However, due to the often chaotic, transient lives of these women affected by substance abuse, very few studies have been implemented to investigate mother-infant pairs after they leave the delivery room. It is interesting to note that although longitudinal assessments of cognitive development in drug-exposed infant have been conducted (Bandstra, Vogel, Morrow, Xue & Anthony, 2004; Azuma & Chasnoff, 1993) investigations of social-interactive development of substance-exposed infants are only now beginning to emerge in the literature (Johnson, Bandstra, Morrow, Accornero, Xue & Anthony, 2002).

A large body of research confirms the relation between mother-infant interaction and dimensions of child development in typical populations.
(Messinger et al., 2004; Seifer et al., 2004; Johnson et al., 2002). Likewise, early, impaired interaction in drug-affected dyads may presage later problems with social development. Recent literature is advocating for family-friendly treatment programming that addresses recidivism and works with the family to provide support networks (Massachusetts, 1997; Messinger, 2004; NIDA, 2000).

In any interaction, the behavior of each member of the pair needs to be considered to understand the quality of interaction. Psychological unavailability, depression, and poor parenting skills may negatively influence a mother's ability to read and respond adequately to infant cues in feeding and teaching interactions (Seibert & Hogan, 2003; Shankaran et al., 2003). Mothers with a history of drug abuse and poverty are at particularly high risk for the aforementioned behaviors (West, 2000).

Tragically, a pregnant woman's drug usage has a profound affect upon her baby, often resulting in such abnormal behaviors as irritability, muscle rigidity, and high-pitched cries. These behaviors, in turn, may inhibit optimal bonding and interactions (Singer et al., 1999). Sadly, the most fundamental and crucial bonds developed by high-quality interactions may especially be compromised in drug-affected dyads because both members of the pair are likely to contribute behaviors that inhibit reciprocity and attachment (Zeanah et al., 1997).

Many studies have been done on this subject. However, in recent studies, the outcomes for mother-infant dyads are found to be better when effective treatment programs are established. These studies outline the importance of
providing support for mothers so that they can be consistent caregivers for their children. The literature addresses the need for available community support systems for the dyads – both mothers and infants (Carnahan, 2001; Prevent Child Abuse America, 2001; Lecklitner, Malik, Aaron & Lederman, 1999; MacLeod & Nelson, 2000; National Child Abuse and Neglect Data System, 2000). The primary national issue addressed in the literature is the limited accessibility to federal funding and programming, specifically for mother-infant dyads (Center for Evidence-Based Practices of the Orelena Hawks Pucket Institute, 2003; Spitz-Roth, 2003; SAMHSA, 2000). Studies are currently being conducted to address this issue.

**Early Interventions Programs**

Most interventions for cocaine-using women have been directed at the prenatal period, with significant positive effects (Chasnoff, 1988). More recent programs feature postpartum intervention components (Young & Garner, 2002; Sontag, 2002). In contrast to the absence of data specifically on postpartum interventions for cocaine-using Latin American mothers and their infants, there is a rapidly growing literature on drug rehabilitation programs for cocaine-abusing adults in general. A recent review of this literature has suggested that outpatient infant treatment is at least as effective as inpatient treatment (Grella & Greenwall, 2004). The absence of data on interventions for cocaine-using Latin American
mothers, particularly teenagers, and their infants highlights the importance of further research.

Treatment Programs for Addicted Families

Most treatment programs across the United States are focused on the adult and not the children of the family. Infants are usually in the nursery or cared for by another family member while the mother is in treatment.

There are many studies regarding mother-infant interaction and communication (Beebe, 1982, 1986), yet few longitudinal studies exist for drug-affected families. There are many different treatment interventions attempted for substance-abusing mothers. Those take place in hospitals, clinics, emergency rooms, drug hotlines, schools, psychiatric counseling, jail and prison, social worker counseling, mental health clinics, AA and NA 12-step programs, rehabilitation, acupuncture, foster care agencies, proposed orphanages for drug exposed children and therapeutic communities. Most treatment centers operate on the philosophy of the 12-step program: habitual use of any mind-altering drug is an incurable disease for which the only control is total abstinence and recovery demands a moral rebirth (Marr & Wenner, 1996).

Therapy usually involves group therapy in which patients confront each other and openly discuss feelings and thoughts. Most substance abuse treatments operate on the principle that drugs are a private, individual sickness, without acknowledging the social aspects of drug use. Also, most drug treatment
programs are geared toward men's needs and are confrontational. As a result, there is no ideal forum in which women may participate comfortably. In fact the child-welfare mothers are not inclined to stand up in an AA meeting or discuss in a group therapy that their child was taken and placed in foster care (Anonymous, 2002).

In Bronx, New York, the Lincoln Hospital treats 3,500 crack addicts annually with acupuncture. Their success rates are comparable with other residential treatment facilities. The philosophy of the acupuncture clinic is to reduce the need for use rather than focusing on strict abstinence from cocaine. The idea is that addicts are chronically ill, and although they are considered to be incurable, the victim's life does not have to be destroyed (Singer, 1996).

At Baby's Porch, an innovative 16-bed treatment center, women receive vocational training along with treatment. When a client leaves, a staff member helps her find an apartment. For the next two years, the women attend weekly counseling-peer group meetings. Eighty-four percent of the women in this program remain drug free and approximately 67% are able to maintain jobs following vocational training (Canino & Spurlock, 1994, p. 110).

The Montefiore/Ackerman program focuses on helping female crack addicts with newborn children to establish healthy lifestyles and promote the well being of their babies. It also seeks to reduce rather than eliminate drug use. Breaking with tradition, it views women addicts as needing to repair damaged family connections, instead of separating from them. This program intends to
improve relationships for these women with their children and their own mothers, to develop a sense of value and self-esteem that will ultimately enable them to abstain from illicit drugs (Spurlock, 1995). This initial goal strengthens the bond between a mother and her child and decreases the number of children needing placement in foster care. One tenet of this program is the belief that women do not respond well to the humbling techniques used in most drug programs. Using a public health approach, drug use is dealt with biologically and socially instead of as a sin and a crime which a “Higher Power” controls. The program provides concrete support in getting better housing, job training, and other social services (Grella & Greenwall, 2004).

The “Working Together Project” (Shabazz, 1996) is a comprehensive, one-stop-shopping program developed in Richland County, South Carolina, to address the multiple needs of substance-abusing parents reported for child abuse and neglect. It involves several agencies coming together under one roof and bringing their different policies together. The goal of this program is to provide intense case management to clients, which hopefully will reduce infant abandonment, prevent substance abuse, prevent child abuse and neglect, and the proliferation of the HIV virus. Multidisciplinary services are provided to clients all at one location from the Richland County Department of Social Services, the Lexington/Richland County Alcohol/Drug Abuse Council, and the Richland County Health Department. The multiple services are provided by a Family
Support Team (FST) to address multiple needs for these families with complex social and economic issues (Smith, Cole, Poulsen, & Coles 1995).

The Richland County Department of Social Services supervises the (FSTs). The agency is responsible for child protective services, foster care, homemaker support, day care licensing, adoptions, food stamps, alcohol, food and drug counseling (AFDC), child support, and work incentive programs. The Lexington/Richland County Alcohol/Drug Abuse Council provides substance abuse treatment. Services include the alcohol, drug, substance abuse and driving under the influence (ADSAP-DUI) programs, prevention services, an employee assistance program, counseling, medical/detoxification, outpatient community residential programs, and transition/after care support. This agency provides staff for the Addiction Specialist and the Prevention Specialist positions with the FST (Richland County Alcohol/Drug Abuse Council, 2003).

“Working Together” provides families that participate in the program with supportive resources necessary to remain intact as a family and become at least minimally functional to reduce risk to the children. Similar to the Montefiore/Ackerman program, it recognizes that it is impossible to separate the drug/alcohol addiction from the person and from the environment. Economic and social needs are recognized. The intervention provides services such as: intensive case management, substance abuse treatment, health education, housing assistance, parenting skills, supportive services such as homemakers, entitlement programs, and medical care (Shabazz, 1996; Shankaran et al., 2003).
The effectiveness of most approaches to substance abuse rehabilitation has not been fully researched, but available figures from the National Office of Drug Control Policy show that results appear to be related to the socioeconomic level of the user. The National Office reports the following findings: the employed, otherwise functioning cocaine user, shows a success rate as high as 65%; for the blue collar person with some social skills, the success rate is 40 to 45%. For the unemployed crack addict with low levels of education, the success rate is 20% and may be lower (National Institute of Drug Abuse, 2002).

It is important to note that, in general, women seeking treatment must overcome a lack of coordination among community services. Navigating the multiple systems to meet complex medical and social needs is often impossible for the addicted mother. As a result, the substance-abusing mother usually gets no treatment for chemical dependency and receives inadequate medical care (NCANDS, 2000).

**Music Therapy: Genesis and Development**

Since the earliest times, music and healing and their connection to mothering have been documented through art and the written word. "Music therapy" has been evolving since the turn of the 20th century. In 1903, the Society for the Culture of Musical Therapeutics was formed (Vescelius, 1903). At the time, it was considered by some to be a "cult." However, it was supported by the
elite of New York, including a host of physicians who were a part of "Materia Medica," a group of practicing neurologists, psychiatrists, and surgeons.

In an article in the New York Herald (1903) Dr. George Shrady spoke of a mother's lullaby, and made a direct analogy between the effect of color or music on human emotion centers:

Music and color have the same relation to the emotional centers of the human system. We know how the irritable child has learned to sleep by hearing the ditty sung by its mother. This is a matter that has been noticed in all races, savage and civilized. (p. 3)

Over one hundred years later, we continue to unlock more keys to the human psyche that allow the use of music therapy to expand. In the 1960's, after music therapy had been deemed a profession for sixteen years, Gaston compiled writings of theories and practices of music therapists and physicians across the United States and in Canada in his book Music in Therapy (1968). What struck me most in regard to the writings is the fact that the principles of therapy are time-honored and the use of music as a vehicle of expression is a tool in the therapeutic process. In his foreword Gaston states:

Not at any time, from the planning to the completion of this book, were suggestions made to any contributor as to the specific content of his writing. Clinicians were asked to write and present case histories from their particular fields of expertness. The treatment aims of psychiatrists and therapeutic teams had been stated before descriptions of clinical practice or case histories were written. Considering these conditions, it is remarkable that so many sources should agree so precisely about the importance of the three principles of therapy:

1. The establishment or reestablishment of interpersonal relationships.
2. The bringing about of self-esteem through self-actualization.
3. The utilization of the unique potential of rhythm to energize and bring order. (p. v)
There appeared to be great consistency through long-standing practice as similar elements emerged in the descriptions of each person’s work. Creativity, interconnectedness and relatedness are some of those elements.

**Process in Music Therapy**

Sears (1968) was one of the individuals who began the discussion and categorization of music in the therapeutic process. He stated that in most cases, only the word “music” has been used in reference to musical situations, although it may have four designations: (1) the music itself, (2) listening to music, (3) having music in the environment, and (4) the making of music (p. 31). The processes provide the reader the understanding of which one is being used at the time. The four categories he set forth were related to the experiences within the music/therapeutic setting, and those included experiences within structure, self-organization and relating to others. These categories provide the container for describing process in music therapy.

Many music therapy clinicians have written about psychodynamic music therapy process (Austin, 1991, 1996, 2003; Austin & Dvorkin, 1993; Bruscia, 1991; Hadley, 2003; Lehtonen, 1989; Pavlicevic, 1997, 2000; Robarts, 2003; Ruud, 1998; Sutton, 2002; Wheeler, 1981; Wigram & DeBacker, 1999). The unfolding of music within the therapeutic environment with various populations and ages is an organic process. Though Sears identified a structure within the process, there is an ebb and flow of that process within the structure, infinitely
connected to the relationship of self and the relationship to others. This movement within the context of relationship in the music, with the therapist and with self is a dynamic process. As defined by Austin (1996), psychodynamic music therapy is a creative process that utilizes music and words within a client/therapist relationship to facilitate an ongoing dialogue between conscious and unconscious contents (p. 30). Scheiby (1991) described her work in psychodynamic music therapy as a practice involving the symbolic use of improvised and composed music by the client and the therapist for the purpose of transformation, integration, enhanced self-awareness and self-exploration (p. 274). Many definitions exist within the field and are as personal as the therapists and clients who use this form of therapy.

Bruscia (1987a) provided a comprehensive reference on the use of musical improvisation in therapy. He compiled a detailed synopsis of over twenty-five modes of therapy that have been developed over the last thirty years. Within these models he provided a section on dynamics and process. That which Gaston and Sears began, Bruscia continued, thus honoring many therapists who have had years of practice within the field.

The models which speak most closely to mother-infant music therapy are those of Nordoff-Robbins (1977), Alvin (1976), Priestly (1975) and Riordon-Bruscia (1987).

As described in Bruscia’s Improvisational Model’s (1987), The Nordoff-Robbins Creative Music Therapy model, in particular, has provided useful
insights on the data in this study. Robbins and Robbins (1987) outlined five stages that involve the process as a child may go through while in therapy. These include (1) musical awakening while establishing a relationship; (2) musical responsiveness within an activity relationship; (3) musical involvement within a working relationship; (4) musical and interpersonal independence and (5) assimilation and closure (p. 65). The heart of this model is the belief that a child’s personality is developed from within using inner resources, rather than molded from without using external forces (p. 56). The same holds true for music therapy with mothers and infants in a dyadic model because their relationship is bound by an internal need for each other.

A new model within psychodynamically informed and psychoanalytic process in music therapy has recently emerged in the literature. Music therapist Diane Austin (2002) has developed a method of vocal improvisation that is analytically oriented. Specifically, her “vocal holding” techniques have assisted a broad range of clients, from normal individuals with neurosis to those who have suffered from sexual abuse or eating disorders. Austin has invited her clients to explore the wounded parts of the vocalizer and to emerge and receive support through explorative vocal improvisation. Her “vocal holding” describes two alternating harmonic areas underpinning a vocal interaction between client and therapist. Through a fluid and responsive use of unison, harmonizing, “mirroring” and “grounding”, the therapist helps the client to “give trauma a voice” and integrate a “fragmented self”. In group work, these techniques can be
demonstrated by a tutor working with a volunteer, and then can gradually be opened into dyadic work, which would be later processed through discussion.

Vocal holding techniques are introduced into the music psychotherapy session in a number of ways. Austin most often begins by breathing with the client. “Deep breathing is critical in focusing, relaxing, and grounding the client in his or her body. Breathing together begins the process of vocal attunement that continues as the therapist attempts to match the client’s vocal quality, dynamics, tempo and phrasing” (p. 239).

Austin’s current research helped to illuminate her intentions for using vocal holding techniques as interventions in the clinical process:

1. To build trust and create a positive mother transference
2. To soothe and comfort clients
3. To offer an experience of being seen and deeply listened to
4. To encourage vocal play and spontaneity
5. To work through resistance to feelings
6. To create an opportunity for the client to undergo a therapeutic regression in order to re-experience and repair early developmental injuries
7. To access unconscious feelings, images and associations
8. To release feelings
9. To lead into and out of free associative singing —“vocal holding with words” (Austin, 2003, p. 218-219)

According to Austin, our voices resonate inward to help us connect to our body-selves and they resonate outward to others.

Music Therapy with Pre-Term Infants

From the inception of human life, especially through to the third trimester of pregnancy, the unborn child experiences not only tactile and other sensory stimulation, but also experiences sounds: the sound of the mother’s voice, the
sound of her heartbeat, other internal sounds as well as sounds modified and transmitted through the amniotic fluid (Nocker-Ribaupierre, 2004):

The human fetus has a fully functional auditory system in the last trimester of pregnancy. The intrauterine environment is also acoustically very rich. … The prominent intrauterine sound however, dominating vascular digestive and extra-maternal sounds is the maternal voice. … Newborns recognize and prefer complex auditory stimuli they experienced repeatedly during pregnancy, i.e., their mother’s language, a lullaby their mother repeatedly sang in the last weeks of pregnancy, a specific musical sequence … or a specific story read to them … (p. 7).

Music therapy with pre-term infants is multifaceted. Researchers in this area have recognized that the therapy is not only with the newborn but also includes the parents, NICU staff, and the ability to work with the environment. Als and her colleagues have outlined guidelines for developmentally supportive NICU care (Als & Gilkerson, 1995; Als & Mcanulty, 2000; Fischer and Als, 2004). The design and layout of the NICU puts the focus on creating a space and atmosphere where the infant and the family may heal, grow and thrive. The area is kept calm and quiet, in order that the infant may hear the parent’s soft voice clearly, and parent and infant may sleep restfully. The lighting is muted and offers the possibility for individually adjusting to different levels for each infant. NICU activity unrelated to the infant’s care and wellness is actively kept away from the bed space. The structure and ambience of the NICU reflects the key role of the parents as the infant’s most important nurturers and co-regulators. The NICU provides physical and psychological space for peaceful closeness and intimacy of the whole family, including provision for parents to be with their infant 24 hours a day throughout hospitalization (Fischer & Als, 2004, p. 17).
There are a number of studies that address the challenges of working in an NICU setting (Graven, 2000; Shoemark, 1999; Standley & Moore, 1995; Standley 2000, 2001; Schwartz & Richey, 1998, 1999).

Further studies address sounds that are pleasing or displeasing to infants (Standley & Madsen, 1990), and the use of a standardized protocol for use of musical stimuli with infants in NICUs (Cassidy & Ditty, 1998). Many years ago in 1979, Owens involved 29 normal newborns who were all exposed to routine auditory stimulation. Another 30 newborns were exposed to taped musical stimulation. The musical stimuli were given regularly throughout the day at certain intervals. No significant difference was found between the two groups in terms of weight loss, percentage of babies crying, or percentage of babies moving their arms, legs, or head. More current studies have been done to address similar issues using musical stimuli and further clinical studies are being developed looking at stress behaviors, weight gain and caloric intake and the length of hospital stay of premature and low birth weight newborns (Caine, 1991; Standley, 1991; Cassidy & Standley, 1995). In the study done by Caine (1991), the auditory stimuli included lullabies, children’s music and routine vocal stimulation by family members and primary caregivers. In each of these studies the results showed that music had noticeably positive effects on oxygen saturation levels, heart rate, and respiratory rate. Standley’s (1991) study results indicated the need to develop early intervention techniques, that incorporate music. She also
discussed the role of music therapy in the development of comprehensive early intervention systems.

**Music Therapy with Dyads**

A review of the literature shows that little has been published about music therapy for parents and children together. Oldfield and her colleagues (Oldfield et al., 2003) describe this work as fairly uncommon. In her article she addresses three clinical examples to illustrate a range of approaches to working with children with autism and their parents: a group for children with autism and their parents in a mainstream primary school, short-term work with a 4-year-old autistic girl and her mother, and work with a mother and her two young sons, one of whom has Asperger's Syndrome. Her findings indicated that music therapy can help children with autism to communicate and interact and can build their self-confidence. It can also play an important role for parents of children with autism, who may be under great stress, by fostering relationships, developing positive interactions and helping them to feel contained and supported.

A study by Shiraishi (1997) involved a wide array of participants, both mothers and infants. Newborns were only one group within the experiments. The focus of the study was to use five psychological inventories to evaluate levels of depression and to examine any affect on increasing self-esteem.

It is interesting to note that most of the studies that have been done in the United States with mother-infant dyads are quantitative and behaviorally focused.
Though, most recently, Nowikas (2004) in a qualitative doctoral thesis, explored roles and relationships in a mother-son dyad in Nordoff-Robbins music therapy. The parent-child dyadic work that has been documented is primarily with older children, 4-12 years of age. In Norway, Australia and Great Britain many studies have been and are being done with a humanistic, qualitative, naturalistic and phenomenological focus (Wigram et al., 2002). However, no dyadic studies with substance abusing mothers and their infants at risk have as yet been done.

**Music Therapy in Addiction**

In the treatment of addictions, music has been established as an adjunctive, highly adaptable modality that is valuable in the holistic treatment approach recommended for addictions work (Tredér-Wolf, 1990; Soshensky, 2001). Because many researchers emphasize the need to treat the “whole person” as opposed to “their addiction” (Smith, Cole, Poulsen, & Coles 1995; Singer, 1996), music therapy is particularly suited to interdisciplinary treatment teams. Considering the diversity of both primary and secondary addiction-related problems, music therapy is well suited to meet a wide variety of individual goals. Patterns of addiction and defense mechanisms can be ameliorated by the creative experience involved in music therapy.

Music therapists can use the socializing influence of music, the imprinting of social messages reflected in the music, as well as the deeply personal association to the individual, to educate clients about substance abuse and
promote relationships to a group, or within a family, or even with a counselor. Music therapy uses the power of music to facilitate recognition of common ground upon which clients may acknowledge and disclose common beliefs and problems. This musical common ground will open communication necessary for both group interaction and personal change. Skills in relation building, such as self-expression, creative thinking, and communication rather than isolation, are important by products of the music therapy process, because they form cornerstones of health and recovery (Butterton, 2004).
CHAPTER III

METHOD

This study was designed within the naturalistic paradigm and employed qualitative methods. A naturalistic inquiry, as described by Lincoln and Guba (1985), is developed in natural settings; this implies that the research takes place in a non-controlled environment that would exist regardless of whether research is being conducted there (Aigen, 1993). In working with substance-abusing mothers and their young infants the musical, therapeutic process in this study was fluid and unfolded according to their needs. This is consistent with the position of Fornish and Lee (1998) who maintain:

qualitative research has an emergent focus or design, in which the research methodology evolves, rather than having a pre-set structure or method, thus allowing the process to determine the direction of the investigation. This particular concept is appealing to many music therapists because of the parallel emergent focus found in the creative process. (p. 143)

Qualitative research has been developing rapidly in the field of music therapy in the past two decades because of the creative freedom it provides and the results that have followed. “A new movement has arrived on the music therapy scene; one which challenges old norms while elaborating our choices in the practice of research” (Kenny, 1998, p. 201).
This study of the experiences of substance-abusing mothers and their infants-at-risk in the context of a dyadic model of music therapy required methods that provided freedom and space for the therapy process to unfold in an uninhibited way. Thus, the naturalistic, qualitative models served most effectively. As observed over time, the mothers and infants brought to their sessions different needs and ways of being, and needed to be tended to without a research agenda. Fluidity, acceptance and patience made the qualitative, improvisational elements of the method invaluable.

The therapeutic musical experience was structured loosely to bring each mother awareness and insights concerning her relationship to herself and to her infant. As well, it provided the infant an environment in which he felt secure, and thus would explore and develop freely within the safety of the therapeutic structure. This fluid method provided the flexibility to the participants and to me as the researcher to observe the unfolding of the mother/child relationship. It also allowed me to observe the individual growth of the participants. Studying the therapeutic process itself, not only as it unfolded but also through recursive analysis afterward, provided answers to the research questions set forth in Chapter I. The design and procedures adhered to the protocols demanded by sound research practice and were consistent with ethical aspects involved in doing therapy as part of the research.

Writing about the appropriateness of qualitative methods in music therapy research, Aigen (1995) commented:
Researchers tend not to follow one research paradigm completely, instead picking and choosing those aspects of different approaches that make sense for the needs of a given study. This pragmatic, flexible eclecticism is actually in the spirit of qualitative research approaches that argue that one’s method should never take precedence over the content of a study, but rather be flexibly adaptable to the needs of a specific research milieu. (p. 330)

As Aigen (1995) notes, “the qualitative approach to research has much in common with humanistic approaches to music therapy and explains the basic consonance between the two” (p. 309). Bruscia (1995) discusses the process of delineating particular phenomena for study. As this study progressed, I discovered that I was studying not only the journeys of the mothers and babies, but also my personal journey as their therapist, and the various paths that the music created in all of our journeys.

The Research Site

For this study I was able to secure the use of a facility that already existed, provided by a non-profit organization for the benefit of the Latin American community. The facility is dedicated to programming for Latin families, many of whom are new immigrants. This organization worked with community agencies and hospitals to provide social services. The program collaborates with physicians in the community as well as Head Start programs, Women Infant and Children (WIC) programs and various others. Government and private grants and donations funded the mother-infant program and all the programs of the
organization. For the purpose of confidentiality, identifying features of the site and names of all participants have been changed.

The site is located off a highway in a highly populated area where there are several businesses, printing shops, auto care shops, gas stations, clothing and furniture stores and a small market as well as an elementary school and a park. The building is sandwiched between two others. It is five stories high with a basement. There are windows that face the street on either side of the building. However, most offices, meeting rooms and the playroom and nursery are windowless. The interior is painted in high gloss enamel with blue and pink as well as white. The temperature is difficult to regulate; when the heating system is on it is extremely hot and in the summer the air conditioning is not effective. The building is old and is slowly being repaired with what monies are made available. The building housed more than one program, but I learned only of the two that were introduced to me by my gatekeeper.

The gatekeeper was a social worker who was the director of the programs within the organization. She collaborated with the director of clinical services and the chief executive director. The gatekeeper and I met on three occasions. Upon the first meeting she informed me of the organization and I spoke with her about music therapy and the intent in doing music therapy with mother-infant dyads. During the second meeting she introduced me to two programs: a community outreach that provided education and support for breastfeeding women through the community, and a program for substance-abusing mothers.
She then introduced me to the program coordinators for both the programs. At the third meeting I provided a workshop for the staff on mother-infant music therapy. Following the presentation I gave the case managers and social workers from both programs recruitment flyers and an information flyer that defined music therapy (See Appendix A). Initially I intended to work with breastfeeding mothers and their infants. However, after speaking with the coordinator from the program for substance-abusing mothers, I realized that the structure of that program provided a forum for my proposed study. As well, the coordinator from the substance-abuse program kept in touch with me by phone on a weekly basis as she received the referrals, and I thus received more referrals from this program. She became my primary contact person. Furthermore, she arranged meetings with the case managers on a weekly basis to talk about the progress of each dyad.

Participants

The participants involved in this study were Latin American mothers who were/are abusing substances and their babies. They were among the 200 mothers and infants enrolled at various stages of the program based in that facility. The program director gave me verbal approval to do the music therapy sessions for the research at the facility. The sessions were to be a part of the treatment if the mothers chose to take part. In other words, the mothers were given points to attend music therapy. To enlist the participants I immediately provided a bilingual workshop for the staff at the facility and later a presentation to the
mothers. It took approximately four months from the initial acceptance by the
gatekeeper to the actual setup of the room. It took another month to schedule the
therapy sessions.

Recruitment

Recruitment flyers were posted at the sponsoring facility and given to
social workers to hand to their clients. An introduction to the therapist, music
therapy, and the purpose of the study appeared on the flyer. As part of the
recruitment process I provided an experiential session with a mother and infant
for those interested to observe. Following this session, I held a “question and
answer” dialogue. I also informed the mothers that they should contact their social
workers if they were interested in participating in the study.

Subsequently, the social workers gave me a list of the interested mothers
and I contacted them by phone and scheduled first sessions. Ultimately, six
mothers contracted for twelve sessions each. At the first meeting I gave each
mother a consent form to sign (Appendix B). Unfortunately, three mothers of the
six contracted could not fulfill their contracts prior to completing the twelve
sessions. This narrowed my group of participants to three sets of mother-infant
dyads.
Selection

My original plan had been to wait until the music therapy sessions were completed to decide which dyads I would develop into case studies. Given that only three dyad sets completed the study, I analyzed each as an in-depth case study. Fortunately, each pair brought very different circumstances as well as responses to the sessions. Each had different situations in life and consistency in attendance. One of the mothers, Rhea, was an adolescent. The other two mothers each had other children. Mona was 43 years old and had an adolescent daughter. Dee was 27 and had five children. The varying ages and specific life issues as well as the scope of musical interaction provided a variety of dimensions to the study. As mentioned above, the names of the participants have been changed to help provide anonymity.

Treatment Design

Environment

The setting for this study was a playroom adjacent to a newborn nursery for the substance abuse program. The playroom was a fairly spacious room with a carpet in the center. The room was lined with shelves of toys, including stuffed animals, dolls and their accessories, along with books and videos. Strollers and highchairs lined one wall where the shelves were set out of reach of the children. There were three small tables and a television that was often turned on.
I made the room functional for the therapy sessions by bringing various instruments. I also worked to create an atmosphere that would encourage trust and openness. The room housed a spinet piano along with an array of rhythm instruments, drums, a stereo and recording system. I would arrive an hour early to set up the space to engender a sense of comfort and relaxation. I made every effort to make the room feel like "home" to each of my participants. One of the ways I created that setting was to work with the social workers and ensure that there was quiet outside while the participants were in sessions.

I set up the furnishings in a circular fashion, placing the play carpet in the middle, moving the piano to the side of the carpet and placing the large bass drum to the opposite side of the piano with a small pillow and blanket on the inside of the drum. This arrangement provided for the "musical womb" strategy discussed in the next chapter. The recording equipment went on the shelf with a long cord for the microphone placed under the carpet. Mother, baby and I sat in a triangular pattern. I had rhythm instruments and small drums within reaching distance to use at any given time. My goal in setting up the environment in this fashion was to create a womb-like environment. I wanted the participants to feel nurtured. I did so because I believe that the feeling of safety lends itself to being more open and creative. I also believe that babies are alert to dissention and discomfort, especially when they are in a new environment and they are with people who are unfamiliar to them. The home-like environment was essential to encourage my participants to open up and benefit from the therapy.
Sessions

A session consisted of 45 minutes of therapeutic intervention. These sessions had a distinct beginning, middle and end. A priority was placed on meeting the therapeutic and physical needs of the mothers and infants. All sessions were conducted in Spanish because this was the birth language of the mothers and the primary language for two of the three participants. Improvisation was used extensively as a therapeutic technique so that I could follow the nuances of the interactions and expressions of the mothers and infants.

The environment of the therapy sessions was fluid in that it provided for the needs of the mothers as well as the infants in the study. The music was created from a free form improvisational structure that encouraged interaction. For example, if the baby made a sound, I would match the pitch on a melodic instrument while the mother would match the rhythm. These musical interactions ebbed and flowed according to each individual’s nature and participation within the therapy.

Research Design

The study began in September. Data collection started with a brief initial telephone interview with each mother. The interview was designed to elicit a partial history of the mother and information regarding the infant, including age, birth order, and birth experience. Over the course of the twelve weeks of therapy, the mothers became more relaxed and trusting in me. As a result, over time they
disclosed more details of their own histories. I transcribed all of the sessions including, of course, the spoken word and the music. Almost all of the sessions were conducted in Spanish and later translated into English (See Appendix C for a segment of transcript in Spanish with English translation). I also transcribed the music of each session (See Appendix D for an example). Following each session I wrote clinical notes regarding observations made within the session. The overall atmosphere in the room was described and detailed information regarding the extent of the mother’s involvement and interaction with her baby were documented.

**Research Log**

The research logs consisted of the following: musical and verbal transcripts of audio-taped sessions translated from Spanish to English; clinical notes from each session; notes from interviews with the social workers and the program director; and the preliminary interviews with each of the mothers. I also wrote analytic memos as I commenced the process of recursive analysis (see Appendix E for sample analytic memo).

**Data Analysis**

Using the written transcripts, I wrote side comments that were sometimes observational, at other times reflections on a session as a whole. For example, I would note when a mother’s comment in the transcript was inconsistent with her
facial expressions or tone of voice, how the infant’s or mother’s emotional state hindered their interactions and whether as the session progressed they would relax and begin to interact. The side comments served as the first level of analysis. They often clarified intuitive, affective responses to the material and led to the identification of tentative patterns and themes and to further questions. Ely et al. (1991) speak of this first level of analysis as “creating meaning units” (p. 88). These tentative meaning units helped to create a coding system. Early meaning units included such labels as “mother depressed,” “baby unresponsive,” or “playful interaction,” and “connection between mother and baby” (See Appendix C for example). Based upon a thorough analysis of these labels, an organizing system with tentative categories and themes began to emerge.

**Coding System**

Over time, categories that emerged frequently when the data were reviewed included the following: pauses, playfulness, laughter, therapist modeling speaking for baby, resistance, musical patterns, therapist as educator, trust, attachment, insecure attachment, separation anxiety, fear and dysfunctional family network. Some of these initial categories were eventually grouped together into larger categories that were to become sections in the final presentation or themes for further analysis.
**Thematic Analysis**

Ely (1984) defined a theme as “a statement of meaning that (1) runs through all or most of the pertinent data, or (2) one in the minority that carries heavy emotional or factual impact. It can be thought of as the researcher’s inferred statement that highlights explicit or implied attitudes toward life, behavior, or understandings of a person, persons or culture” (p.150). Examples of prominent themes that emerged are:

The techniques, the setting, and the therapy process provided a context in which the babies were free to express their natural curiosity and playfulness.

As trust developed with the therapist, the mothers gradually began to use music therapy time to talk about their personal problems.

The behavior of the baby is reflected in the emotional state of the mother.

The major themes that emerged in this study are rephrased and analyzed in Chapter VI.

When analyzing the verbal transcript it was also necessary to analyze the music since music and words were interwoven in most of the sessions. It was difficult to separate the two as most of the interactions had musical elements such as dynamics, inflection, or the rising and falling of tone and melody. Direct musical interaction and dialogue served to illuminate the avenues of communication used by the mothers and infants in this study. Detailed descriptions of these therapy sessions are provided in the “musical journeys” presented in Chapter V (p. 118-119).
Time is needed for integration of information and deeper understanding. It is during this period that findings become clear within the data. Moustakas 1990 writes, "... the incubation process gives birth to a new understanding or perspective that reveals additional qualities of the phenomenon, or a vision of its unity" (p. 28). It is this process that leads to the emergence of themes, metathemes, and the discussion of the findings.

Presentation of Findings

There is a mutual and interdependent relationship among qualitative analysis, the use of narrative forms of writing and trustworthiness (Ely et al., 1991; Meloy, 1994; Witherell & Noddings, 1991; Wolcott, 1990). Shaping data by re-writing text was a thoroughly enjoyable pursuit. It was also essential for helping me to get to know the data, for keeping my research spirit charged, and for sparking further ideas to explore. The process of working with the data triggered ideas about analysis, gave me feedback on my therapeutic approach with the mothers and babies and led me to greater depth through analysis and interpretation. The use of different and sometimes unconventional forms of narrative served to reflect and interpret the experience of each dyad. These forms and textual presentations of data may significantly influence the reader's understanding of research. Atkinson (1992) describes the responsibility that a researcher has not just for how readable the text may be but also for how the actors it portrays are "read" and understood (p. 6).
According to the epistemology of Lincoln and Guba (1985), interpretation is a necessary component of all knowledge acquisition in general and of research activity in particular. Additionally, this philosophical foundation holds that there is an interaction between the knower and known, which means that the findings of research are influenced by the personal attributes of the researcher. This is not a problem to be avoided but an inevitability the effects of which should be used and accounted for. In the naturalistic paradigm the reality studied by researchers is understood to be socially constructed and the researcher's task is to combine findings from research participants and the research process to create as full and thorough a portrait as is possible of the phenomena being studied (Atkinson, 1992).

Narrative Forms

Narrative allows the reader to meet the participants from the researcher's perspective. The participants became “real” through the description. I used anecdotes as a type of short story that encapsulated the research moments in time. These short stories lifted meanings from the interactions between the mother and infants and provided a tangible character for each dyad at that time of relationship. Layered poems, stories, and dramas gave form to the multiple challenges the mothers and infants faced. The layers of interaction linked the following levels of meaning: the participants' dialogue in the session, their dialogue with their babies and with me, the voices of the songs created, and my interpretations of all of the above as a therapist.
In this study, I have chosen to provide a case drama that is a creative depiction of the history of a mother and infant and the reasons they were referred to music therapy. I have also provided a three-person poem and a playlet. Narrative forms helped me to meet a primary purpose of this research document, which was to allow the reader access to each mother’s and baby’s experiences in the utterances, words and music, and the resulting therapeutic relationship.

In writing up this research I found it most useful to represent aspects of the work through drama, poetry, music and the other art forms mentioned above. The chapter on the participants’ musical journeys provided a space where the participants’ histories, interactions in the sessions and musical vignettes were woven into a literary tapestry that represents the musical relationship.

**Using Pastiche and Metaphor**

Pastiche assumes that the pieces that make up the whole communicate particular messages above and beyond the parts…pastiche directs the readers’ attention to multiple realities by combining various representations to emphasize the relation between form and meaning…each medium of telling makes reference to a different way of knowing or coming to know that adds to the fabric of total meaning. (Ely et al., 1997, pp. 97-98)

In pastiche and in braiding, a form of pastiche, I used the multiple perspectives of description, analysis, and interpretation. I added my observer comments to shed light on the different realities of the life experiences of the mothers and babies. This enabled me to understand their responses in the sessions. When some of the data of a mother’s reactions or lack of interaction with her
baby caused me distress, I wrote my response in the session notes – which later turned into a researcher memo with observer comments – to process my feelings. The memo would re-ignite memories of the sessions and the intense feelings I had at the time. It was at these times that developing a pastiche and using metaphor were critical to the development of the research. I used these tools as an emotional safety net that allowed me to understand intense feelings expressed by the mother, the baby or myself, and comprehend the reality of the dyads (See examples in Chapter V on pp. 87, 93, & 96).

This study touches the participants and researcher as human beings. It has expressed the suffering and joy of both. This methodology is a therapist’s method. It gave me eyes to look at my history, my motives and the way I was conducting the research while honoring the participants in their process.
The process of research and reporting in this study reminds me of the image of a garden:

The Garden

Digging deep into the earth
Taking out the toxins
Re-mineralizing
Look at the soil
Rich, black, brown soil
Glistening with the phosphorous material it contains
I take the seeds of truth, history, pain, experience, love
Plant them, water them, nurture them, talk to them, provide them sunshine

The garden begins to grow
Some seedlings are very slow
Especially those that I had buried deep and did not talk to as sweetly.
Finally there are buds everywhere.
As they open up I see that there are red, yellow, purple and pink ones
Oh yes, and there's that black pansy – oh, how painfully deep was that one!
   All the colors are brightly waving
   The sun nurtures them
   They are brilliant to view
   Many see its colors.

Stance as a Researcher

Years of working as a clinician and evolving as a person brought me to
this work. I chose to work with cocaine-addicted mothers and their infants at risk
because of my own identification with them, especially with the abandonment
they had suffered. I am a white Hispanic woman who speaks English without an
accent. I did not experience the judgments that many black Hispanic women do.
Shortly before I started this study I learned of my own history, which enlightened
my understanding of this population and also helped me to become more aware of
certain of my own biases.

Three years before beginning this study I learned that my mother had died
from a drug overdose. I had previously been told that she died of spinal
meningitis. She was 42 years of age and left five children, ages 3 to 17, for my
father to rear. This knowledge brought back a spectrum of feelings from my
childhood that I needed to be aware of as I worked with these mothers and infants.
I could thus better understand my feelings of protection for the babies and the
critical attitude I had towards the mothers.

Bruscia (1995) states:

To do research without self-inquiry is to ignore who we are as human
beings in this process; to do research without collaboration is to ignore
who the participants are as human beings in the process; and to do research without consultation is to ignore the fact that we are ignoring. To undertake research requires being as fully human as our potentials allow. (p. 443)

Rubin and Rubin (1995) maintain that neutrality is neither possible nor useful in qualitative research. Personal involvement is integral in this approach, but it also creates problems. The researcher must be aware of and sensitive to his or her biases.

I first tended to identify with the babies, wondering if they were being neglected, abused, or abandoned by their mothers. I think now that this was due to my close relationship with mother loss. Later in the sessions I began to perceive more from the point of view of the mother. My own role as a mother gave me more empathy for these mothers and their many hardships, as well as their concerns for their infants’ well being.

Rogers (1961) has emphasized that the empathic understanding of another person’s internal frame of reference is an essential condition of constructive personality change. Our most significant awareness is developed from our own internal searches and from our attunement and empathic understanding of others.

While writing dissertation journal entries I would conduct a dialogue with myself in the form of an analytic memo about my relationship with the mother and her infant. This dialogue helped me become aware of the times when I had become angry at the inconsistency of a mother.

At the time the music therapy sessions were conducted I was the mother of a newborn and my other two children were 3 and 6 years old. The participants
had seen my family meet me at the end of the sessions and some of the participants had met my children. The participants, both the consistent and inconsistent ones, kept coming back to the music therapy sessions because they had developed a degree of trust in me, perhaps in part because they knew I was a mother. I was consistent with them and I genuinely was interested in their well-being. Several of the mothers had similar histories of losing a mother and being parented by others or not being parented at all. I lost my mother at a young age, and music mothered me. Having the piano was like having my mother back through the music that she used to play.

It was suggested that I work with mothers who used drugs, and in looking back I now realize that perhaps my unconscious intention was to mother them through music so that they could mother their babies. My history of losing a mother at a young age due to a drug overdose and being a mother of a newborn contributed to the development and understanding of the research. The data and my history worked like a counterpoint melody to give me the answer to the questions of this research.

Trustworthiness

Establishing trustworthiness begins long before meeting the participants. The research must be carried out fairly, and this begins during the initial thinking of the actual questions. Choosing the site and the design was the beginning of setting up the opportunities to carry out trustworthiness. Because I am in a dual
relationship of therapist and researcher in the study, establishing trustworthiness was especially important.

As a therapist, ethical considerations were a part of the framework, as I would not guide the mother and baby in the session to confirm something that I wanted to confirm in the research study. The sessions were therapy sessions, and it was only after the sessions were over that the research findings were explored in depth through analysis. Utmost care was taken when the study was designed to maintain the integrity of the therapy sessions. In this manner I adhered to the ethics of therapy and trustworthiness regarding professional standards.

Participant Check

Describing the experiences of the mothers and babies as closely as possible was essential for conducting the research justly. Assumptions could not be made regarding what the mothers were experiencing or feeling. I needed to check with the mothers as the sessions progressed to see if my “hunches” were correct. For example, when one of the mothers was consistently late to the session or cancelled I checked to see if the mother was having difficulty attending. The mother confirmed this hunch as she told me that she felt singled out from her peers by receiving music therapy for her son. Circumstances made it possible for me to have conversations with two out of the three mother participants. I discussed with them my general interpretations of what had been
observed and the essences of my findings. This helped to insure that I was not misinterpreting what I observed.

**Peer Review**

My greatest allies in the area of trustworthiness have been my support groups. I have been and continue to be a member of a research support group. The first support group began when I completed Margot Ely’s course on qualitative research. This group helped me through the painful hurdles of the beginnings of the research. The members read my initial writings around site selection and gave support regarding consent forms for the process of addressing the human participants criteria. They also read the original transcripts and gave insights regarding categories that I was initially seeing. We disbanded when the stresses of daily life and the writing became too great for each of us, although we have maintained contact over the years.

My second support group has been with four music therapy colleagues. Each of these members has been and continues to be part of my process. Because all of us are in the field of music therapy, they were able to see my data with critical eyes and guide me with depth of knowledge. It is through the peer debriefing that I “exposed myself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within my mind” (Lincoln & Guba, 1985). We met on a bi-monthly basis, alternating sites. Staying in contact kept us abreast
of the evolution of our documents so that we could compare notes and keep each other writing. The critical feedback helped to guide my investigations and gave me a feeling of integrity within the work. They have been my companions on a very long journey.

Throughout the process, I have monitored my own developing constructions of the language and particularly the metaphors I use. In a sense I have collected information about myself as the human instrument. “It is precisely because the inquirer’s mind is not blank that we find him or her engaged in particular investigation” (Lincoln & Guba, 1985, p. 67). Understanding my own history gave me insight into my reactions, biases and ways in which I viewed the participants. Trustworthiness was a part of the study from its inception. However it became of utmost importance when I learned of my history and discussed it with my support group, as I then could understand my biases regarding mothering and the role that it played.

The analysis of the sessions and of the music turned into an investigation of the research process itself. It called for understanding my interaction with the mothers and the infants and theirs with me. The relationships described in the data provided me with a growth in understanding of myself both as therapist and as researcher. All of these ingredients provided a recipe for trustworthiness.
CHAPTER IV
MUSIC THERAPY: STRATEGIES AND TECHNIQUES

The purpose of this chapter is to describe the music therapy methods and techniques developed and used in this study and the rationale behind each of them. Approaches vary as to techniques in music therapy. Some music therapists use activities-based techniques where a specific programmatic format is followed. I used improvisation-oriented techniques that I believe allowed for more freedom within the therapeutic environment and also nurtured the spontaneous creation of melodies and songs from the participants.

The techniques described here have been developed over many years of practice both with infants and children and with adults but were sharpened or refined in the course of this study specifically for use with the mother/infant dyads. The setting up of a nurturing, warm environment played a large part in the actual execution of the techniques.

Musical Beginnings

Rapport is built in the beginning. Beginnings are often difficult times for individuals who are not certain about the nature or productivity of music therapy. Some of the mothers and babies were apprehensive or shy. One way of beginning
was for me to sit back and call them from the carpet where the instruments were set-up. Or, if I felt that they would be receptive to contact with me or the offering of an instrument, I might have gone up to them with a small instrument, such as an egg shaker, and offered it to them to come and play. Sometimes I asked in a spoken voice. Other times I asked musically by singing a descending third to the tonic note to give more of a sense of grounding or support. I did not ask the more tentative mothers and infant’s questions at the outset of the therapy sessions because I believed I might cause them to feel uncomfortable or self-conscious especially if they felt unequipped to answer.

When mothers and infants were more gregarious and open to involvement, I immediately engaged with them musically. Alternatively, I might have sung “hello” to them while at the piano or on the guitar. For more outgoing dyads who could handle a question from the beginning, I sang a tonic note and moved upward to a major third or fourth above. For example, singing “Welcome, what shall we do in music?” This created a melody of two quarter notes, then one quarter note with two eighths and three more quarter notes on the same third above from the tonic. Then, I sang back down to the tonic singing the word “music” from the tonic to the third of the scale ending the phrase. This became a march-like melody (do-mi, mi-do, do-mi) that encouraged movement forward to get involved in what was being offered. An open-ended question then would leave an option for the mother or infant to make a choice. I vocally engaged them by calling the infant’s name, sometimes speaking and other times singing -
explaining where we were, what day it was, what we were going to do and
introducing the instruments surrounding them. This reality orientation may be
used as an entrance and a “welcoming” for a therapy session to begin and for
relationships or roles to develop.

The Musical Womb

A womb, in a healthy mother, is a safe place, a place of nourishment,
sound, rhythm, and connection. The “musical womb” is my primary technique,
especially when working with mothers and young children. The “musical womb”
incorporates instruments and positioning of the mother and infant. In fact, the
infant or young child is encouraged to settle inside the primary instrument used
for this method—a large base drum with bedding inside. This physical
arrangement is consistent with my goal to design an overall feeling that simulates
a secure and “womblike” environment. In the music therapy setting, I recreate this
sacred place as best I believe possible through the use of a large bass drum and
some creative physical arranging. I turn the drum on its side and place a baby
mattress with a clean blanket on the inside so that a baby can be placed there.
Once a baby is positioned, I ask the mother to kneel in front of the open end of the
drum and I encourage her to hum, sing or speak to her baby. This creates a tunnel
of sound that bounces off the drumhead and envelopes the baby. I kneel next to
the mother, encouraging her. Then I might kneel on the opposite side, rocking the
drum back and forth to create the rocking motion of the womb. I rhythmically
match a mother as she speaks, humming or singing while patting the head of the
drum lightly; creating a heartbeat (See Rhea's journey, pp. 79-80, for an example
of the way this evolved within a session).

The drum is a tool that increases eye and vocal contact between mother
and infant. The babies in this study all seemed to enjoy this experience; the older
babies would actually crawl into the drum, assisted, and rock by moving from
side to side - humming, babbling, snuggling, and sometimes even shouting for
joy.

River of Melody

The sessions became a river of melodies through the chromatic intonation
of the Spanish language itself, along with the playful engagement of the infant.
There was a succession of musical interludes that provided a continuous stream of
interaction. Sometimes I played the drum, strummed the guitar and sang a
melodic line. Other times, I only played the piano, as background music, while
the mother spoke or the infant touched the piano. I did this with those individuals
who were shy, and were more inclined to drop their inhibitions if they did not feel
"front and center." That technique worked quite well. Often there was interruption
of laughter. At times, while a mother and I waited for the infant to respond during
a musical interlude, the mother might begin talking about difficult issues in her
life. The mother was often redirected from her thoughts about her circumstances
the moment her infant would play a note on the piano spontaneously. Then
laughter and further talking would guide the mother’s receptivity and awareness of her baby’s explorations and expressions. This technique provided a flow within a session. It kept the baby engaged and it seemed to be a vehicle to soothe the mother, making her feel more comfortable and giving her a vehicle for expression.

**Climbing the Ladder to Interaction**

A ladder to interaction is a technique that is helpful for modifying the environment and building trust with the therapist and furthering the relationship between mother and infant. Often I played one note in one phrase and then moved one semi-tone up. When working with an infant, this approach offers a feeling of leading the baby slowly, moving diatonically or chromatically as if climbing towards something exciting. The anticipation on the baby’s face reflects the music – he is expecting something to happen. This movement upward is also synonymous with forward movement. In therapeutic terms it would mean growth, movement forward and not becoming stuck or complacent.

**Rhythmic Synchronicity**

Repetition was important to establishing rhythmic synchronicity. This was similar to a mantra in which the rhythm and tone coincide. In the therapy sessions, the words, the rhythm and the melody provided an entrainment when the interaction was mutual and continuous. If the melodic line was dropped, the
rhythm or words still provided an opportunity to maintain the interaction. When working in this study, this created an element of surprise as the mother, baby and I were all waiting to hear the response. Sometimes the response came from the mother, sometimes the baby or sometimes, even, from me. This element of surprise kept the interaction interesting and alive.

**Rhythmic Reciprocity**

Rhythm, an essential component toward engagement, was the lure that hooked the mothers in this study into interaction, connection and communication. I often used triplets because triplets are a common rhythmic structure in Latin music. I also used more complex rhythms of two eighth notes against a triplet. This is also a common occurrence in Latin music. Reciprocity differs from synchronicity in that it is a mutual relationship in which both individuals involved are respectful of each other where as synchronicity can happen without that intimate relationship.

**Rhythmic Holding**

Rhythmic holding is a technique that is somewhat analogous to the musical womb. In that technique, the child is held in the physical instrument – the drum. In rhythmic holding, a sense of holding is created by the whole notes being held from one measure to another. This is an aural musical holding rather than a tactile, physical holding. Like the musical womb, it creates a container for
an infant and mother to interact. As I used this technique, I began by musically calling the infant’s name and creating a safe environment by having the mother present. The rhythmic component was important in creating the connection to the infant.

I would sing the first part of the infant’s name, then create an accent with a dotted eighth passing quickly to the next note, which I then held into the next measure to begin the name and same rhythmic structure on the second beat of the next measure. Sometimes a child’s name lent itself to this type of rhythmic structure, particularly when there were three syllables in the name. The structure of the language and the rhythm are synchronous. The baby can anticipate what will follow through the stretching and holding of the rhythm of his name.

**The Musical Surprise**

Singing a child’s name then breathing into a pause created the musical surprise. The surprise came with a quarter note pause and then the final down beat on the side of the guitar. After capturing a baby’s attention that way, I would then ask him, musically, if he would end the phrase with a melodic affirmation of “yes.” I would hum, waiting for the “yes” response, singing “yes” several times. Following this introduction, a playful rapport was built between infant, mother and therapist as they were curious as to what I would do next. However, they often waited for the surprise or for the held notes to slip into the music. The surprise element in sustaining a note and dropping it created a space for the baby
or mother to respond. It became a playful cat and mouse game. This technique was implemented very successfully in this study, and specific experiences will be described in the individual musical journeys in the next chapter.

**Repetition**

There is a Latin phrase: *repetitio studiorum mater est*. It means that repetition is the mother of learning. The repetition of lyrics two or three times assisted mothers and infants to hear the musical/lyrical phrase to engrain it and learn it. The goal in doing this was to create a pathway for the infant and mother to mimic the song or rhythmic component of an improvisation. If mother or infant hesitated, I would take the infant’s hand and model the rhythm while singing the song. An example of this technique may be seen in the musical vignette “the echo” in Mona and Rafael’s journey (p.118).

**The Musical Question**

In verbal questions there is an upward inflection of the voice. The musical question is similar as the melody of the lyrics rise up the scale. When the question is answered there is a descending melodic line. The following is an example of the use of this strategy documented in one of the sessions.

The infant and mother listened while I demonstrated using the guitar. I held the infant’s hand and together we strummed or rhythmically patted the front of the guitar. In doing this, I invited the infant to respond by asking the question,
“Can you play?” The infant reached out and pulled one of the guitar strings. Mothers are often concerned that their infant might break the guitar; however in my strumming lightly and modeling, mothers were assured that this was a part of learning and that the guitar would survive. The infant’s eyes were wide with expectation, and after he pulled the strings he was more curious and ready to engage than before. The gleam in his eyes said “I can do this and, yes, I can play.” I affirmed his intelligence by singing “yes.” The last lyrics in a descending third provided completion. There was no longer a question but rather the completion of the answer. At this moment the infant reaches out his hand to strum (See Mona and Rafael’s journey on pp. 120-121).

Musical Interaction within Song Creation

Every opportunity was taken to create a song around what the infant was doing. If he was walking in his walker I created a spontaneous song to acknowledge his actions. I also acknowledged relationships in the room such as the playroom staff, the mother and anyone who entered the space during the therapy session. This approach allowed individuals who came into the space to know that they were either included or intruding. However, it was done in a manner that was more teaching than admonishing.

For example, on one occasion, one of the mothers came into the playroom and she slammed the door. I sang “Ouch” and hit the drum singing –“Listen to the door – it is so loud, ouch it sounds like this...” The mother understood and left
quietly. At the same time, this technique provided continuity and a framework for the individuals in therapy. While infants were learning language, a parent often labeled that which the child was doing. I was using this labeling technique to encourage interaction, education and modeling for a mother so that after the therapy was finished, she would hopefully, continue to take every opportunity to teach her infant.

**Musical Doodling**

I used the piano as a springboard to help a mother focus on her infant and also on herself. I call this musical doodling. I played a series of notes on the piano in hopes that the baby would reach for the piano. The piano would become a focus as a result, and the mother then was able to use it as a secure object from which she could talk freely while I improvised and we both observed her infant. Often, when difficult emotions were addressed, it was important to have a focal point so that the mother did not feel that she was standing alone. The piano or other instruments can be used to give that security. All this can be done while incorporating the infant's babbles or exploration of the piano (examples of this can be found on pp.123 & 124).

**Playing with the Body**

Just as a piano player has kinesthetic memory (muscle/movement memory), it is my belief that a baby also has kinesthetic memory through his
hands, feet, and body. For this reason, I used instruments made out of natural materials. For example, the djembe, a West African drum, has an animal skin for the head. The baby and the mother could feel the texture. As well, the infant could play a rhythmic pattern with his feet. I often take off a baby’s shoes and socks so that he can have skin-to-skin contact with his mother as she moves his feet up and down or have contact with the texture of an instrument.

For example, the **guiro** is a Latin percussive instrument that is similar to the “washboard” with grooves on it. Sometimes I moved a baby’s feet up and down the instrument so that he could feel the texture and, hopefully, remember a rhythmic pattern. Another instrument I use in this manner is a large metal cabasa. However, I also use the cabasa for other reasons. In alternative medicine there is a technique called “brushing” with a natural bristle brush. The goal in brushing is to remove dead cells and assist the lymphatic system in detoxification. It is my thought that using the cabasa also massages the skin and muscles of the body and increases stimulation thereby increasing receptivity to that which is happening in the environment. This can be a bridge to a child’s awareness of his environment. I will further discuss this theory in chapter VII.
CHAPTER V
MUSICAL JOURNEYS

The overall goal of this work is to provide insights into relations between mothers and infants as they are expressed through music and develop over time in music therapy sessions. In addition to the interactions between mothers and infants, this chapter provides insights into the mothers' histories relevant to this study. These portraits are but a peek into the pervasive, broad spectrum of issues involved in working with this particular population. Pseudonyms have been used to protect the identities of the participants.

The participants' experiences are described in the first person. Their stories were constructed from interview data and confidences disclosed in the therapy sessions. In constructing the mothers' stories, I have used their own words and personal styles of speech to more accurately convey their personalities. I have structured these accounts to arrange events chronologically to give a more cohesive view of their lives and processes in music therapy (Atkinson, 1992, pp. 23-24). Following each mother's story, a presentation in a different literary genre has been included to evince some of the essential aspects of their experience and dynamics.
The third section of each portrait is a depiction of the therapeutic experiences within the musical journeys, the purpose of which was to guide the mothers and infants into connection with themselves and each other. It is this personally developed process within the therapeutic structure that is the focus of these narratives. In every music therapy session, the mother, infant and I undertook a journey toward bonding and understanding.

The therapy sessions began through referrals or request for referrals. Rhea was urged by her mother to participate. Dee’s participation was mandated by her case manager, and later by the court system. Upon observing one of her friends in music therapy, Mona asked her case manager if she could be referred to music therapy.

At the end of each musical journey, I summarize the progress of mother and infant through the metaphor of a tapestry. This metaphor best describes the weaving of melody, rhythms, vocal interplay, instrumentation and interaction among mother, infant and therapist. Each mother’s and baby’s tapestry differs, depending on their personalities, unique needs, and the progress along their musical journeys.

**Rhea and Matthew**

Rhea was referred to music therapy through her mother seeking a parenting class for Rhea. Rhea attended a workshop at the center for mothers who abuse substances. Reluctantly, she accepted being a part of the music therapy
sessions. The following opens with Rhea's telling of her own story. A dialogue that illustrates aspects of Rhea's relationship with her mother follows this. The central part of the section is an account of Rhea and Matthew's journey through the music therapy process. Finally, in "Rhea and Matthew's Tapestry," I reflect on my impressions of this therapeutic process.

Introducing Rhea and Matthew

Rhea is a seventeen-year-old, black, English-speaking, Puerto Rican adolescent born in the United States. She is approximately 4'11", petite, and was immaculately dressed, in ironed jeans and soft short-sleeved cotton knit shirt. Rhea, though born in New York, identifies with her family's roots in Puerto Rico. My initial impression of her is that she was light and bouncy, and talked about how she successfully managed her life with her eight-month-old son. She also lived with her mother, and assisted with housework in exchange for living expenses and childcare assistance. She is romantically involved with a new man who "treats Matthew as his own."

Initially, Rhea played with Matthew constantly. Rhea arrived with him in a stroller, set up with colorful toys on a tray with which he could play. She would sing a medley of songs while she clapped and interacted with Matthew. Her youth allowed her to be an energetic playmate as well as a mother.

Matthew is a robust eight-month-old, beginning to walk. He was smartly dressed in little boy faded blue jeans and a red polo shirt and matching red and
blue tennis shoes. He had olive brown skin and a nicely shaped light brown mini Afro. He giggled and laughed as his mother sang a hello song with me and continued to respond with delight as his mother performed her medley.

**Rhea Introduces Herself**

"I am 17 years old. When I was 4 years old my father left the family. I thought it was my fault. My mother and father were always arguing before he left. I would hear my parents say my name when they were arguing. I had 3 older brothers and I am the only girl. My brothers were teenagers. Two of them were already living on their own. When I was in grade school, maybe 9 years old, there was a guy who was really nice who used to come to the playground at school. He’d give us suckers and toy watches and games. One day he came by with something white and he asked if we wanted some special candy. This one, he said, you smell and it makes you feel good. I liked suckers better so I went back to play with my friends. When I was in 8th grade I was 13, almost 14; another guy came by with white candy. I decided to try it. I was with my boyfriend and we both tried it.

The guy that used to come to the grade school playground was right. It made me feel good. It also made me feel other things. This is when I became sexually active. I moved out of my mother's house when I was 15. She was always on my case about something. Asking me if I was using drugs. So I moved in with my boyfriend. One year after moving in with him I became
pregnant. I was almost 16 then. He was 17 almost 18 and he was almost finished with high school. He wanted me to get an abortion. I did not want to. So, I called my mom up. She was super angry, but she took me back in. We had a deal that if I came back I would have to stay in school and help her out at home with cleaning and other things. She put me on her medical insurance so that I could get pre-natal care. She also wanted me to give my baby up for adoption. My mom and I worked this out, 'cause I could not give my baby up for adoption.”

“What’s Fair?” A Playlet

Here Rhea is describing a conversation with her 50-year-old mother regarding child-care for her son. The setting is in Rhea’s mother’s apartment where she currently resides with Matthew. The conversation is just a small example of the dynamics between the two of them. It is a small snapshot of the challenges that Rhea and her mother faced within their relationship and the roles of responsibility and trust.

Rhea: Mom you’re not being fair!

Mom: Rhea, who is not being fair? Your choices are not fair to me!

Rhea: Mom, I cleaned the apartment and I want to go out with Frank tonight.

Mom: Rhea, I have a meeting at work; I can’t take care of Matthew. He is going to have to go with you.

Rhea: Mom, you know that it’s not good for Matthew to go out so late. You said you would take care of him.
Mom: Rhea, I have to keep my job. I did not expect to have a new baby to take care of at fifty years of age. Anyway, you are only seventeen years old. Why do you have to go out in the middle of the week anyway? You are not going to use are you?

Rhea: Ah, come on mom, you know that I am not using cause I’m nursing Matthew and I don’t want to hurt him.

Mom: Are you telling me the truth?

Rhea: Mom, look at Matthew, he looks great. He is seven-month old and doing good. I learned at school that seven-month old babies are doing all the things that he is doing. Actually, he is even ahead according to the books.

Mom: Well, I hope you are not going to go out with Frank and get pregnant again. I can’t take care of all the babies you plan to have. I’d like to retire one day and have you and everyone else out of the house. I want to have an old age and not be raising yet another bunch of kids!

Rhea: Ok Mom. I’ll take Matthew with me. Frank likes him a lot. He is like his stepfather.

Mom: Rhea, since you are taking Matthew, don’t stay out so late. You know he needs to sleep and the nursery you leave him at during the day does not need another cranky baby in the room because of an irresponsible mother.

Rhea: Ok Mom. Are you still on for Friday?

Rhea and Matthew’s Musical Journey

Beginning Sessions: Hiding in the Familiar

Rhea first bounded into the music therapy space pushing Matthew in a navy blue stroller with several colorful toys attached to its white tray. Matthew was holding onto the tray, grinning from ear to ear as if he were on a carnival ride. They came in so quickly that there was no time to inform Rhea of the purpose of the music therapy session and to ask her what she understands about
music therapy or the reasons she and Matthew were encouraged to attend. Instead her energy filled the room. She stopped just short of rolling over the instruments laid on the carpet. Rhea then quickly removed the tray, unbuckled Matthew and pulled him out and put him in the middle of the instruments. She then sat in front of Matthew, making little contact with me as she forged ahead. She appeared unaware of me as a person and came into the room as if running on a stage to perform.

Rhea immediately began by singing several medleys. Matthew was clearly conditioned to respond to this performance, and did so with equal enthusiasm. As a result Mathew fully performed to his mother's prompts.

Come on Matthew...are you ready? "The Wheels on the Bus"...[Rhea was then gesturing the motions of the wheels going around using her hands in a circular motion]. "I love you, you love me"... [Rhea sang the Barney song and made the hand movements with her index finger pointing to her eye and hugging Matthew during the word "love", and tickled him during the word "you"]]. Moving right along without taking much of a breath, she began "This Old Man" - the same melody as the Barney song - and then completed this medley with the "Ants Go Marching."

During this initial meeting, it appeared clear that Rhea was the conductor, rhythmically and melodically guiding Matthew through her hand movements and engaging his interest with her presence. This role gave her control; she was the leader and could demonstrate her abilities within the session. She used pre-composed songs, as presented above, to seemingly give her comfort. She moved from one song to another while Matthew bounced as she sang.
Rhea's melodies and songs varied from week to week. This pattern occurred throughout the first four sessions. I gave her the space within the sessions to share, with me, her music and the music that she had been sharing with Matthew when they were at home. She used the medleys to fill up the sessions with music and only spoke from time to time in short sentences, giving tidbits of her history and sharing her feelings about life. She did not appear to be forthcoming regarding her history and seemed to be having a difficult time establishing trust with me as her therapist. Her full attention was on Matthew, so much so that it seemed that she was avoiding contact with me and used the songs as a buffer rather than an open avenue of communication between us. For this reason it took her a long time to develop trust within the sessions. As an outside observer it might have appeared that Rhea did not need parenting classes or music therapy. She appeared very connected to Matthew and was interacting with him. Rhea and Matthew may have been excellent candidates for a “Mommy and Me” program (a mother-infant music appreciation and developmental music class). However, that was not the purpose of the music therapy session.

It was not until the fourth session that she began to open up:

“I am the youngest and only one of my brothers has turned out “ok.” My father left us twelve years ago. My mom is always working to make ends meet. I am not doing so great. Matthew’s father was into drugs, and I got really into the scene.”

She appeared to be afraid of the legal system and stated that she did not want recordings of our sessions made because it could be used against her in court. She feared legal challenges to her ability as a mother. However, I
respected her request and did not record all of her statements. For the most part, original music did not begin appearing until the latter part of the twelve contracted sessions.

**Middle Sessions: Exploring**

It was not until the fifth session that Rhea’s relationship with me as a therapist began to surface. She spoke of her connection to her cultural roots and told me at home she spoke to Matthew in Spanish. It was in this fifth session that Rhea sang a traditional Puerto Rican children’s song.

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Cheki moreno, cheki
Cheki moreno, jue!
Que a donde esta ese
Ritmo caramba
Del mericumbe?

Un pasito alante,
Y otro para atras
Y dando la vuelta
Y dando la vuelta
Quien se quedara? Jue!
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**Translation:**

Shake it, brown boy, shake it,
Shake it, brown boy, hey!
Where’s (meaning, show us) that flashy (wild, exciting, WOW!) rhythm of the *mericumbe* (a popular dance).

One small step forward
And another small step back
Going round in a circle
Going round in a circle
Who will be the next?
“Cheki Moreno” is a popular song learned by children when they are four or five years old and played throughout the primary grades. It is reminiscent of the African-American song “Shake it Baby, Shake it,” and might have been adapted from that game by Puerto Ricans living in New York in the same neighborhoods as African-Americans. The word “cheki” is most likely a Puerto Rican-American adaptation of the words “shake it” (Campbell et al., 1994, pp., 66-67).

Rhea wanted Matthew to be bilingual and to identify with his cultural roots. She asked me for other Spanish songs that I might know to teach her and Matthew. Later these songs emerged within the context of the sessions depending on what Matthew created musically.

It was not until the sixth session when she spontaneously asked, “Can we record Matthew’s drum playing? I’d like to have a copy and share it with my boyfriend who also plays drums.” The musical transcription below demonstrates the playfulness between Rhea and Matthew. Matthew was Rhea’s playmate and toy. Within this relationship they played fully and later learned to be free to improvise rather than remain confined to already existing melodies and songs. The musical phrase below was born out of the playful interaction between Rhea, Matthew and me.
The Musical Trick

Following are the notes I made after the session that would serve as the basis for future planning:

This is a drumming and vocal theme. I invite Matthew and Rhea to play. Rhea picks up my rhythm as I sing, “Play, play, play the drum.” I play on the drum with eighths, a quarter, and a triplet, then a steady stream of eighths followed by the infamous pause. I became more energetic with the drum, moving from eighths to sixteenths. This activity on the drum and a pause at the end of two measure phrases leaves a window for Matthew to jump in. He then plays two-quarter beats that I mimic. Again Matthew plays two quarters beats that I mimic with two quarters. Then I take the lead, a quarter and four sixteenths. Matthew hits the drum on the third beat and I end the musical theme with a downbeat. But instead of my ending the phrase, I continue for two more measures first one full measure of two-quarter beats, four-sixteenths and one triplet. Then second with two sixteenths and a two and a half beat pause. He has the last word, hitting the drum on the final beat while I utter “oop” in response to his trickery in the music.

In the seventh and eighth sessions Rhea and Matthew learned several children’s Spanish folk songs and children’s songs. These included; “De
Colores” – A Mexican folk song on the topic of spring, “San Sereni” – mimes traditional occupations in Mexico and Puerto Rico, “Chiapaneca” – a hand clapping song from Mexico, “Jota Valenciana” – a Spanish dance, “Zacatecas” – a Mexican march, and “La Cucaracha” – A Mexican folk song. Rhea stated she had heard most of them but did not know the words and movements. Matthew readily integrated his play within the songs as we sang them. Sometimes he would bounce in rhythm, other times he shook maracas or played the drum. Rhea took Matthew in her arms and danced with him during “La Jota” and “Zacatecas.” She also clapped hands with him during “Chiapaneca” and moved his hands with a hand over hand motion for “San Sereni” as if he were a cobbler making a shoe. Matthew in turn smiled, babbled, shouted in pitch to the tone of the music and moved in rhythm with the music and Rhea (Campbell, McCullough-Brabson & Tucker, 1994; Amsco Music Publishing, 1950).

Final Sessions: Independence

In these sessions, Rhea appeared physically more relaxed. She did not seem to need to sing and play all the time with Matthew. Matthew was less watchful of his mother and more interested in the musical instruments. At the beginning of these last sessions he picked up bells and shook them, listening intently to the sound. He tried to put a rather large maraca (shaker) in his mouth – it didn’t fit so he moved onto a smaller willow shaker that fit perfectly. The
environment felt calm, more rooted in a secure relationship between Rhea and herself, Rhea and Matthew, and Rhea, Matthew and myself.

The following are session log notes from the ninth session:

Matthew was standing at the drum in the ninth session. He was watching his mother and me. Without waiting for any prompting from his mother or me Matthew independently tapped a rhythm similar to “La Raspa” – a traditional Mexican song usually danced by men called “Charros” who wore ornate black fitted outfits with taps on the bottom of their cowboy boots. Matthew began the rhythm by playing a semblance of it on the drum.

Matthew's "La Raspa"

As I began to sing in response to Matthew’s rhythm Rhea chimed in with a tambourine. This spontaneous trio began with Matthew being free musically.

Matthew’s independence shines in this musical vignette as he played the drum.
At the very end of this musical experience Matthew hit a large cymbal that I had placed near the drum. I was surprised that he could reach so high but he did it.

During the last three music therapy sessions there was more of an interplay between the pre-composed English and Spanish songs – some from Argentina, Cuba, Mexico, Puerto Rico and Columbia as well as original music created on the spur of the moment – primarily percussion.

Estoy Brincando

Matthew was on the drum while bouncing. His mother was holding his hands while he bounced and the above rhythm and tone was what was created by his feet and his mother's toning.

Matthew’s small legs were moving up and down in an eighth note pattern and with his mother holding his hands he bounced in a triplet pattern on the drum. Matthew was taking a leadership role in the play. He was exploring and Rhea was allowing that exploration without needing to be in charge of the process. She assisted Matthew, such as in the holding of his hands while he was on the drum. When he got off the drum I had moved it onto its side to make space within the circle of instruments for him to crawl around to the instruments he wanted to play. The drum was to the side away from the instruments he was going to. He settled upon a willow shaker and sat down. As he sat he looked toward the drum on its side with the head facing away. He quickly placed the willow shaker in his mouth
and crawled rapidly. He then placed himself inside the drum, taking the willow shaker out of his mouth, grinning from ear to ear. It has been my experience that some babies find security inside the drum and, when they are able to crawl, they like to independently get inside the drum. The drum creates a cocoon for the infant. When the mother nears the drum and speaks or sings to the baby in the drum, her voice envelops the baby in sound and rhythm. I have coined a metaphor for the drum, when the baby is inside and the mother is interacting, as “the musical womb.” The following is a playful, rhythmic piece that emerged when Matthew placed himself in the drum:

MAMI VEN! - Mami Come Get Me!

Matthew crawling to large bass drum and yelling...

Matthew kept bouncing while Rebecca mimicked his bounce with the "Ta Ta" song...Rhea patted her lap in rhythm to his bounce

These last sessions for Rhea and Matthew evolved spontaneously. There was a lot of laughter and joy. Rhea loosened the control she initially had in the session and seemed to have increased in personal self-esteem in her allowing Matthew more independent exploration. She asked me to be more of a teacher to her regarding the music. I introduced her to a variety of Spanish songs.
Rhea and Matthew’s Musical Tapestry

Rhea was a young mother. She seemed to need control from the very beginning of the music therapy sessions. She worked hard to maintain her role as mother. However, in this need to show what a good mother she was, she directed her young infant and looked more like a conductor with her neat performer close by to make her look good during the performance. Matthew, on the other hand, was an excellent performer. In the beginning he waited for his mother’s cues at all times. He was watchful, playful, and musical, however, later, when he saw an opportunity for freedom he let loose. The music therapy sessions with Rhea and Matthew felt orchestrated and limited at the beginning, but once trust developed there was more freedom in the music and within the roles.

Rhea and Matthew’s musical tapestry was bright, a picture of a carnival with balloons and carousels. Rhea’s mother was the reason their tapestry was still intact. She structured Rhea’s life and gave her responsibility, letting her know that she had already raised a family and that Matthew was Rhea’s to raise. Rhea took on the responsibility even though she had a child-like philosophy – if I play with him that is all he needs. The evolution of the music used mirrored the evolution of the relationship between Rhea, Matthew and me. In the beginning the need for structure and familiarity was important for Rhea, as was her need to be capable and in control as a mother. Matthew did not know anything else and he seemed happy within the structure of his mother’s control. As the sessions
progressed, a more fluid, interactive environment existed where trust appeared within the relationship between Rhea and myself. It was at this point, towards the end of therapy that Matthew began his exploration and journey towards autonomy and independence.

Dee and Angel

The case manager and the program director referred Dee and Angel to music therapy. Dee was being monitored closely in the day program she was mandated to attend because she had relapsed once within her two-month participation in the year-long substance abuse program. Her son Angel was in her care; however, child protective services were also involved. Dee attended music therapy reluctantly.

Introducing Dee and Angel

Dee is a twenty-six year old, Spanish-speaking, Dominican-born resident of the United States. She was 21 when she arrived in this country and then met her current husband and married him. Initially she told me that Angel was her only son. Later she disclosed that she had four other children, three living with her first husband in the Dominican Republic and one daughter in the care of her husband’s mother.

She was a tall (approximately 5’9”), stocky woman, with dark brown eyes and long, wavy, dark brown hair. She wore tight jeans and a shirt that
accentuated her bust line. She appeared angry and cautious, eyeing me with curiosity and a facial expression that conveyed the thought, "What can you do for me or my baby?" Dee stated that she is not musical and only listens to Latin music played at a bar that she frequents.

Angel was a plump two-month-old born in the United States. He had big gray eyes, a prominent nose and very kinky grayish brown hair. His skin looked sallow. He was seated in a car seat that could be taken out of the stroller and was dressed in jeans and a blue t-shirt.

Angel's large eyes widened when he saw the instruments. His mother stated that his uncle played Spanish guitar. When I began to play the guitar, he wiggled his feet enthusiastically and searched for his pacifier, gurgling happily. He responded quickly to instrumental music with a strong rhythmic base. He kept turning his head toward his mother who was sitting approximately three feet from him on the couch.

**Dee Introduces Herself**

I am 27 years old. I entered the system when I was two years old. I was placed in Foster Care with someone I had come to think was my natural family. There was a woman who used to visit me once a month whom I didn't understand was my natural mother. I had come to believe that my foster parents had brought me into this world, even though my foster father and a male friend of my foster family were sexually molesting me.
At this time, I was five years old and didn’t know that what was happening to me was called sexual abuse. I knew there was something wrong with it, but had not comprehended enough to disclose to the people who could protect me. By the time I had come to understand what was going on, which was a whole decade later, I had already been removed from that environment. This experience traumatized me. I was placed with five different families throughout the years. During this time I endured sexual, physical, emotional and verbal abuse. I was placed with an Italian family who used to call me “Spic.” All I thought about was if only I had a mother and family who could love me and understand me.

Finally, I was discharged to my biological mother when I was twelve years old. I had come to love her because she was my biological mother and that gave me a sense of belonging I had missed in my earlier childhood. However, there was no communication between us. We did not understand each other and we used to go to therapy together. I was afraid of her and did not talk much in therapy. My mother used to leave me alone with my five-year-old brother for days at a time. She would ask the neighbor next door to keep an eye on us and disappear for three to four days. She used to justify this behavior by saying that she was working to buy us toys and clothes, because her public assistance did not stretch that far. I later learned that she used to go bar hopping and that she was addicted to drugs. Eventually, she began to use drugs in front of me and even introduced me to drug use when I was merely twelve. She explained this action
by telling me that we lived in a drug-filled, violent world and that she preferred to be the person who taught me these things since eventually I was bound to do it. Soon, she began to take me bar hopping with her. She introduced me to men and they would be interested. She would advise me to see them for the drugs and the money, but not to commit my heart because love does not pay the rent. She encouraged me to use these men to get myself and her drugs and money.

I didn't much care for this, and I eventually ran away from home. I did not have someone I could turn to or any financial support for my survival. I turned to a man who married me. I converted to Christianity. Eventually, I felt depressed and felt I still did not have enough. I had been denied the notion of a family. I was depressed and felt I couldn't depend on anybody. I had to force myself to be a woman before I was ready. I felt the pressures of having to fend for myself, and I longed for a "normal" family. I was emotionally spent and I wanted to escape. Since I had been introduced to drugs, this seemed like the normal route to take, so I began to medicate my feelings. I was lonely, frustrated, angry, and often experienced flashbacks of the sexual-abuse experiences.

When I was finally a mother, I began to repeat the pattern. I had sworn I would never hit my child the way my mother used to beat me. I didn't realize drugs had made me emotionally vulnerable. I first came to the program for drug abusing women in March 1997. I am learning to face my past, grow, heal and gain hope for the future. I am working towards gaining full custody of my
daughter. My future goals include getting a college degree and maintaining a
drug-free lifestyle.

**Dee and Angel’s Musical Journey**

**Beginning sessions: Mami, are you there?**

Dee came sauntering into the room with a look of apathy on her face,
appearing angry and resistant. Angel was in a stroller seemingly looking like he
had been crying. There seemed to be no urgency in getting Angel out of the
stroller despite the time commitment. She was twenty minutes late for a forty-five-minute to one-hour session. A feeling of negativity filled the room. She
removed Angel from his stroller/car seat and placed him on the carpet in the
middle of the room then proceeded to sit on the couch with her arms crossed at
midline, to the far left of the room – approximately 12 feet from where Angel was
seated. She sat quickly, angrily, crossed her legs and her arms and eyed me with a
look that said, “How dare you.” Angel, on the other hand, was a docile, chubby
two-and-a-half-month-old who, after he was settled on the carpet, appeared
content – looking at me without reservation and even smiling upon the first
meeting.

Since the energy in the room felt hostile I began the session quickly and
took out the bass hand drum. I took Angel’s hand and rubbed it on the drum-
head, then began to pat a rhythm welcoming him and Dee. I kept the corner of
my eye on Dee as I played the drum with Angel. She was swinging her leg in
rhythm to our welcome song. As I sang with Angel, Dee’s resistance seemed to
be diminishing. She had uncrossed her arms and held them to the side, allowing
for more openness. Angel, though he was so small, kept turning to his mother,
checking on her and then looking at me as I sang his name. He appeared to be
fearful of loosing sight of his mother. The entrée to the beginning of Dee and
Angel’s sessions seemed to be very fast or, to use a cliché, fast and furious.

In this first session I worked to change the atmosphere in the room and to
engage Angel in the hope of connecting with Dee. Below is a session note
following this first encounter:

Angel’s mother appeared angry as she entered the room with him. I
sensed resistance to beginning therapy and possibly resentment towards
me as a therapist offering the program that she was mandated to attend.
Angel, on the other hand, looked plump and as I began singing his name
he appeared interested in what I was doing. Dee remained in a resistant
pose (arms crossed over her ribs) sitting at a distance from Angel and me.
She sat glaring at me. I improvised a song to attempt to draw her in
“Angel is playing, Mami is watching, Rebecca is playing”. Dee did not
move until it was time to leave. She appeared uninterested in learning
about music therapy and did not give me permission to communicate with
her or to let her know that the sessions are not only for Angel but also for
her.

As noted above, the beginning of therapy for Dee and Angel was very
difficult. She did not show up for the second session and I spoke with her case
manager to ask if this was her typical behavior regarding scheduled appointments.
The case manager said that Dee needed to be called and reminded. She has
difficulty with consistently attending the program for substance dependent
mothers as well as anything that is scheduled after program. The case manager
recommended that I call her at home in the morning to remind her of the
scheduled appointment. I did so for the third session and Dee confirmed that she would be there.

I arrived early to make sure everything was arranged properly before she arrived. I waited. Fifteen minutes into the session time she had not arrived. I checked with the case manager to ask if she had attended program, and the case manager said she had. I had not seen Dee take Angel out of the nursery, so apparently – because the program was over at 1:30 PM and our session was at 2 PM – she must have left immediately after the program and did not stay for music therapy. On the fourth session I called her again in the morning, she said she would be at program, and I arrived before program finished so as to catch her and Angel before they left. This seemed to work. She saw me and looked unhappy. I moved on to invite her to the session with Angel. She complained that she had to get home because her husband needed her to wait for the electrician to come to their apartment. I suggested that we have the session immediately and that she tells her husband she could be home by 2:30 PM. She agreed, and we had the music therapy session. The following is a partial account of this fourth session:

I must have made a connection as Angel was bouncing when he entered the room. Dee did not look happy but she also did not seem as closed to interacting with me as she had been upon our initial meeting. I took this opportunity to engage her and Angel immediately before they had completely settled in. As Dee walked through the door with Angel I had a small willow shaker in my right hand and a tambourine with a drumhead on it in my left. I began shaking both instruments as I sang “Mami and Angel are coming to music...we are going to sing and to play...we are going to jump and dance”. This approach seemed to set a more positive, interactive, environment to begin the session. I handed the tambourine to Dee and the willow shaker to Angel. I continued to clap in rhythm to the song as I guided them to the carpet together. As Dee took Angel out of his
stroller I was proactive and asked her to stay with us on the carpet and sit next to Angel or to hold him. She chose to sit next to him.

A Bouncing Rhythm

As the session progressed it seemed as though Dee was becoming engaged in the music and beginning to let down her guard. Approximately thirty minutes into the session she excused herself and said she needed to fix Angel's bottle. Dee left the room and did not return until the closing of the session as I was singing a farewell song.

These sessions were difficult in the beginning because Dee's resistance and the intensity of her anger hampered both her own involvement and that of Angel.

Middle Sessions: The Lost Voice

It was not until the fifth session, when Angel was almost five months old, that Angel was responding in the music rather than my creating the music around him as had been the case in the fourth session. By now I had become quite concerned because Angel had changed from a chubby, babbling two-and-a-half-month-old to a withdrawn, thinner, quiet, five-month-old.
The following is an excerpt from the session where Angel was playing with his feet. It became an analytic memo from my session notes of the fifth session.

Angel was very quiet. In the previous sessions he was babbling and cooing. He was very quiet. He looked a little gray, had a bump on his forehead that was a greenish purple color and when I took his shoes and socks off later in the session to play the drum his feet looked wrinkled and dry with red splotches on them. When I held his hand to reach the piano I noticed that his hands were wrinkled and dry as well. He looked like a little old man today. I was concerned that he was dehydrated so I asked Dee if he was drinking enough liquids and eating well. She stated that he was.

Dee arrived late, she looked worried, and Angel appeared to have been crying. He looked gray. I asked Dee if he had caught a cold or if he had a tooth coming in. She denied both. I did not address the tardiness but rather began by bringing her and Angel to the drum. As mentioned in Rhea and Matthew’s journey the drum becomes a “musical womb” where the mother and infant can connect and relate. As well, I find this instrument to be versatile when a mother and infant are having a difficult time. Mother can support the infant either in the drum or on top of the drum. I chose not to place Angel inside the drum but rather sit him on top of it, as he did not look like he felt well. I guided Dee to support Angel with her arms by kneeling behind him at the drum while I took off his shoes and socks. The following is an excerpt from my notes for this session:
His mother and I place him on the bass drum. He was not quite sure what was happening. He had just learned to sit up independently and seemed anxious that his mother would leave his side. He had been crying. The cry was not of hunger or fear but seemed to be that of fatigue; he was missing his nap. However, his behavior appeared to also be more than that of missing a nap. He was more sensitive when his mother moved away. I removed his shoes and socks so that he could feel the drumhead with his feet. I sang the following lyrics. “We can sing, sing, the song of the drum, singing with our feet, singing with our feet.” The use of long whole notes leading to a rest created space for Angel to respond. I took his feet and played the drum with them. By the second half of the measure he played eighth beats on his own by pulling in his legs, kicking up and out, and letting his feet drop. I affirmed his ability to sing with his feet with triplets.

Angel was regressing and appeared physically ill. As I was attempting to draw more information from Dee and to remain a confidant and not a threat, I needed to be diplomatic while piecing the bits of information she gave. Over a series of sessions I observed the many facial expressions that Angel presented as well as the full range of feelings that both Dee and Angel brought to the sessions. It was through the recursive analysis of these facial expressions, the music and the feelings as well as the bits of history that Dee gave that urged me to give voice to both Angel and Dee. In one particular session understanding became clearer.
The following three-person poem is an attempt to weave the information given by Dee in that particular session. I gave voice to Angel; this voice emerged from the quizzical look on his face as I interacted with his mother. Towards the end of the therapy sessions there was a more complete story. The poem is the window that gave light towards understanding in the final sessions. The three-person poem became a part of the data as I analyzed the middle sessions.

**Three-Person Poem**

The three-person poem brings the reader into the experience and process of the music therapy session. Through the characters the reader hears the primary issue at hand. Langer (1953) states in *Feeling and Form*: “The poet’s business is to relate the appearance of ‘experiences,’ the semblance of events lived and felt, and to organize them so they constitute a purely and completely experienced reality, a piece of virtual life” (p. 212).

Such a poetic dramatization provides a glimpse into relationship giving feeling, power and form around a specific issue. Ely and her colleagues (1997) write:

Drama brings into immediate focus the conversations, human responses, and actions that accompany or dramatize events. It achieves immediacy difficult to replicate in other forms because the medium of dialogue isolates time into a ‘present’ moment. That sense of the present, however, is tinged with next or future moments that give dramatic form a unique power of presentation (p. 123).
When reading this poem the tempo is fast, with each person speaking quickly, over the last word of each other. The baby is constantly questioning while the mother is matter-of-factly telling of the scenario that caused a bump on her son's head. The therapist is attempting to understand and piece together the information that the mother is giving while observing the baby's facial expressions. I gave words to Angel's expressions in the poem.

Dee's life as it is unfolded in this poem differs from the story she had originally told me in important ways. It was not until later, in the sixth session of her troubled therapy program she seemed to trust me enough to tell another, fuller, more accurate version of her life.

Dee (Mother): Dammit, I need a fix, but it's time, always time for other things - music therapy, ugh, music therapy

Angel (Baby): I feel sick. Just put me here on the floor. Let me just look straight ahead - music therapy, maybe, music therapy

Rebecca (Therapist): Hmmm, mom is angry, she doesn't want to be here. Angel looks gray, no life, no babbling - music therapy, yes, music therapy

Rebecca (Therapist): Did he bump his head?

Dee (Mother): He bumped his head

Angel (Baby): Yeah

Rebecca (Therapist): On the floor?

Dee (Mother): On a guitar

Angel (Baby): What?
Rebecca (Therapist): On a guitar?
Dee (Mother): Yeah
Angel (Baby): Oh no, you dropped me
Dee (Mother): At his Uncle's
Angel (Baby): What Uncle?
Rebecca (Therapist): You have a brother?
Dee (Mother): His father's brother
Angel (Baby): What Uncle?
Dee (Mother): He plays guitar
Angel (Baby): What Uncle?
Rebecca (Therapist): Oh.
Dee (Mother): He has a daughter.
Angel (Baby): What Uncle?
Rebecca (Therapist): A daughter?
Dee (Mother): Yeah.
Rebecca (Therapist): Oh?
Dee (Mother): She's three.
Angel (Baby): What Uncle?
Rebecca (Therapist): Oh.
Dee (Mother): She pushed him.
Angel (Baby): What Uncle?
Rebecca (Therapist): Oh.
Dee (Mother): He hit his head.

Angel (Baby): What Uncle?

Rebecca (Therapist): Oh.

Dee (Mother): On the guitar.

Angel (Baby): There's no uncle
She's my sister.
You dropped me.
I feel sick.
I'm hurting.
I'm hungry.
Play the drum with my feet? Oh yeah.

The day before the sixth session was to occur; Dee called me and was crying. The call confirmed my concerns. Social services had arrived late at night prior to the sixth session and removed Angel from the home. He had been placed in foster care. When I arrived at the program site the following day I met with the case manager. She told me that Dee had relapsed. As I walked out of the case manager's office I saw Dee sitting on the couch. She had arrived for the sixth session that I was supposed to have with her and Angel. She asked me if I would help her. I had no idea how I could help this mother who had been resistant during the sessions. She also asked if she could continue attending music therapy even though Angel was not with her. I agreed. In this sixth session we began by talking about the reasons that had precipitated the relapse and also worked on a plan of action to help her to somehow stay connected to Angel. I suggested she and I record songs for Angel, and she thought it might be good to play the tape when she has her visits with him. She chose Latin songs from her childhood,
Salsa, and I suggested some of the songs we had done in the music therapy session as well as some current Spanish children’s songs. I had written session notes that became an analytic memo I called “The Lost Voice” when I analyzed the data.

It was during this four-week period that I saw a decline in Angel as well as an increase in the need to re-engage Dee. She appeared frightened and distant. My concern with this was confirmed when the case manager informed me that Dee had relapsed. The day after Angel was taken by social services from her home Dee came to music therapy. She had come to ask for my help. She wanted her son back. She asked me to write a letter in support of her and Angel. Dee had a difficult time with consistency, but she had come a long way, from never being present in the session to engagement with her son. As well, while Angel was in foster care, Dee continued to come to music therapy to create a recording for Angel. This recording consisted of music from Dee’s childhood and culture, as well as Dee singing with me Spanish children’s songs. After completing the recording she informed me that she took it with her to her visits to the foster family where Angel was placed. Though Angel’s voice was lost the recording maintained a connection to the therapy process.

Prior to the sixth session Dee had often spoken of Angel’s Uncle and three-year-old female cousin. I came to find out during the sixth session when Angel was no longer with us, who the little girl was. She was not a cousin but rather her daughter. This she told me as a side note during the following interaction:

Remember when I told you about my past? Well, I also struggled with the use of alcohol – not only cocaine. Before Angel was born I had a little girl. She was a two-year-old when she was removed from my care because I began to use corporal punishment. I had promised myself that I would not hurt my children the way I was hurt. This is when I re-entered the system in 1994. I have been struggling with my sobriety ever since. Now that Angel is in foster care I want to get both my children back.
She had a goal to accomplish in coming to therapy even though the court mandated her to attend. This interaction enlightened me to previous information that Dee had given and helped in having a more complete depiction of the challenges she had to overcome.

**Final Sessions: Returning to the Chorus**

Dee had the court hearing within two weeks of Angel being placed in foster care. Dee was given daily visitation and the court mandated her to bring Angel to music therapy weekly. She had a total of three individual sessions with me and then Angel returned. He was nearing seven months when he returned to music therapy with his mother. The following excerpts are taken from the eighth and ninth sessions with Angel:

When Angel returned he was again plump and seemed to have regained what he had lost before he went into the foster care system. I had a different connection with Dee. She was much more involved and no longer had the severe anger and resentment that she carried in the beginning sessions. She seemed to have developed a rapport with me during the time she had individual music therapy. She also related better to her peers in the program and was following through with the assignments given by the program director. She appeared more consistently involved in the program groups that she attended prior to coming to music therapy. The foster care system required a few trial music therapy sessions
where the foster parent brought Angel to the site. Later Dee was allowed to pick
him up and bring him to music therapy.

Listening

In the eighth session Angel responded to his mother’s tambourine playing.
He has been in custody of social services, and only recently has been allowed to
join his mother for music therapy. His foster parent dropped him off at the
doorway. He entered the music therapy session in a walker with wheels. From
across the room he saw the music equipment, his mother and me. He bounded
towards us like a rabbit, sing saying, “ha” in a descending fourth pattern then he
paused. I mimicked his initial burst to say “We are here.” He then followed with
an “eh” as if to ask the questions, “Are you really there? Will you mimic me with
this?” I reciprocated and laughed. His face was beaming. His mother picked up
the tambourine and hit it once, as if to affirm this playful interaction. She yelled
out a joyful cry as if to say “I love you and I am here.” I sang “I say” in Spanish then, “Here, here I am”. Angel responded with an “eh” and rested. I affirmed his “eh” by singing “Here I am.”

There were instances within these sessions that Dee and Angel sparked each other’s musicality. Dee looked happy for the first time when she was in the music therapy sessions with Angel. However, closure was difficult for each session because she would have to hand Angel back to his foster family. There were several moments when Angel and Dee were rhythmically synchronous. The following excerpt depicts a time when they were in tune with one another:

**Rhythmic Synchronicity**

I slowly played, creating the space for Angel to be a part of the music. He would interact with the music and me through his bursts of sound. I then began to play a much more upbeat tune with more rhythm. Mom began to play one of the instruments I had laid out on the floor – it was a shaker made out of bamboo – she patted it with her hand in rhythm to the guitar. Then after singing I would sing his name and stop abruptly to make a space for him to come to join me.

He would do his “eh” interplay… We continued to play with the “eh” sound. He made me laugh; he had a rhythmic interplay going between himself, his mother and me. He knew that all the attention was on him and he basked in the glory of having us all in his circle. He was grinning like the Cheshire cat and
waiting for the response to the cues he was giving us. He was the director of a synchronous musical interplay.

Later I wrote:

I began to play with the music and with the sounds of the guitar. Strumming and playing... I elongated the notes where they overlapped a measure. I felt like I had cast a reel into the ocean of interaction and tried to catch this little one and reel him in. I knew he was on the hook but I wanted to get him closer musically and in the reciprocal play. The music was engaging – full of sound. I would take the first beat and hold onto the note vocally, maintaining the rhythmic underlay of the guitar. Then let it drop a descending third and begin again – I wondered if intuitively I was hoping that when I dropped the note I would be able to have him join me where I picked up. I used the same words over and over...

The repetition was important to the rhythmic synchronicity, as it was similar to a mantra. The words, the rhythm and the melody provided an entrainment where the interaction became circular and continuous. If the melodic line was dropped, an opportunity to engage through surprise and keep the interaction alive and interesting arose.

Re-joined

In the last sessions a new person emerged in the picture. When Dee fought to regain custody of Angel she was also given custody of her three-year-old daughter whom I had not known existed. I had originally asked Dee if she had more children, and she said that she did not. During these last sessions I learned that Dee had four other children besides Angel. She had three children in Latin America being raised by her ex-husband’s mother, ranging in ages from 6 to
10 and she also had a little girl who had been taken away from her for the same reason that Angel was removed from the home.

Dee and Angel were re-united in the therapy environment, and they appeared to be much healthier and happier. In the ninth session I met Angel’s three-year-old sibling, whom Dee had originally said was her niece. The courts had given her custody of both her children. Erin was Dee’s fourth child who had been taken away at two-years of age and was being raised by the paternal grandmother. The two youngest siblings were re-united through the court system. Her first husband and his mother in the Dominican Republic were raising Dee’s first three children.

Angel was in a sitting position and he desperately wanted to stand up and walk over to stand by the guitar. The only thing is that he did not know how to walk yet and he could not figure out how to get out of sitting position with the instruments around him and with his body – he seemed stuck and not happy in that position. I helped to reposition him. He continued to call out for his mother. (Session 10)

When Dee left the room he interacted with me but appeared to be concerned about his mother’s disappearance. When she returned his body seemed to relax and he began to say “ama” and mother began to repeat mama to him. The music returned as the environment relaxed once there was re-connection.

The Musical Triangle

The musical triangle is best described as moments in time when a musical interaction binds mother, infant and therapist. I created the triangle with Dee and Angel by encouraging and drawing Dee in at all times. I will focus on the clearest
triangle within the sessions where Dee, Angel and myself used specific instruments. Dee primarily used tambourine or shaker, Angel used the drum and I used the guitar. However, in several places Dee strummed the guitar, modeling for Angel, and then Angel strummed or pulled the guitar string. There were many variations in these triangles. Sometimes Dee was fully present; other times the triangle existed among Angel, the music, and myself. At one time Angel and Dee strummed the guitar and I fingered a chord. Another time Dee drummed and I played the guitar. Angel reached to play the guitar and drum. The last triangle included Emily (Angel’s sister), Angel and Dee, the following is a transcript excerpt.

The next to last (11th) session that I saw Dee and Angel gave significant data regarding the music triangle. There does seem to be interplay between the musical, physical and vocal playfulness – it seems to be a triangle, trio etc. I am actually having thoughts at this point of the fact that I would love to see the melodic intonation of Angel, Dee and myself. I wonder if it actually creates a musical triad at some point. This is fascinating to me, it relates to Stern (1978) and Winnicott’s (1969) ideas regarding reciprocity and playfulness. I am also very interested in trying to separate out what I am creating due to comfort of a specific key or interval. What is truly coming from the baby? What is coming from the personal interaction and the therapeutic environment in itself? What will it tell me once I separate it out? Providing an avenue for spontaneous creativity and expression can give mother and baby permission to be playful and leave their immediate problems aside so as to exist in an environment of joy acceptance and creative expression.
Playful Musical Interaction

Beckoning and calling is critical to this theme. The breath and pauses allow the infant or mother to join the musical interlude. In this session both the infant and mother are hesitant. Since I am near to both I model the playing of the drum by taking the baby’s hand to play the drum. The infant does not resist. After asking him to play with me several times and doing the hand over hand he takes his hand and slaps one down beat on the drum while I sing “yes.” There is a celebration, the mother clapping, kissing her infant, and beaming with pride at her son’s response.

The final session never occurred. Dee cancelled the last session three times. It seemed that she was unable to put closure to our relationship. She seemed to not be able to say goodbye.
Dee and Angel’s Tapestry

In the above section we have seen how Dee moved from resistance and anger to a feeling of rapport and a desire to work with me. Angel was originally a rosy-cheeked, plump, babbling newborn, and then appeared to be a sad, thin, ill infant when his mother relapsed. He suffered from separation anxiety due to loss of his mother and within time, and assistance from foster care, he regained his health, vitality, and joy.

Dee and Angel’s tapestry was not clear; there was no definite pattern, certain sections were threadbare. The colors were muted, at times dark and at other times with a hint of bright color – especially towards the end; yet, it was unfinished. Threads were missing from their tapestry when Dee relapsed and Angel was not present in the sessions. Before he was removed from his mother’s care his music had stopped. He literally became mute and then was taken out of the musical tapestry. After the lack of clarity of Dee and Angel’s tapestry, towards the end it seemed that brighter colors were being added. Dee seemed to have begun to connect with herself, her children and with me. She was better able to share her own reality with more depth, yet, in the end, she was unable to experience closure. Dee and Angel never came to their last music therapy session even though I attempted to reschedule several times. Their tapestry is threadbare, with a hint of color and strands waiting to be woven in.
Mona and Rafael

Mona requested music therapy on her own after speaking with a friend who was involved in the music therapy program. She asked her case manager if she could also attend music therapy because her son, Rafael, loved music. She often played Salsa music when she was doing her housework, and while she cleaned he danced. Rather than completing the housework she would end up dancing with Rafael. Mona was interested in learning about music therapy and was hoping to enhance Rafael’s experiences in life. Music therapy appeared to be an opportunity she wanted to provide for her son without realizing that it was an opportunity for her as well.

Introducing Mona and Rafael

Mona is a 45-year-old, Spanish-speaking, Dominican-born resident of the United States who immigrated in 1990. She has children who are young adults in the Dominican Republic. Their paternal grandmother raised them. She is married, living with her husband. Her occasional use of illegal substances brought her into the program. She is somewhat overweight; approximately 5’ 8” in height, with long, bleached, auburn hair, and she dressed casually in denim pants and a white cotton blouse. Mona appeared to be self-conscious, speaking in a low, deep, broken Spanish. However, when speaking to her son her voice was much more animated.
Rafaël is a dark skinned, round faced, stocky, eight-month-old. He has dark brown eyes and the whites around his pupils are very bright. During our first meeting he watched me with intensity as I took out the guitar and placed a bass drum, rain stick, shakers and bells around us. As I began to sing a hello song in Spanish, his hands moved rhythmically up and down.

I placed a tambourine near him and handed Mona the drum. We began to play. The mother’s demeanor dramatically changed while making music with Rafaël. She beamed and looked youthful, the wrinkles on her face smoothed out. It was refreshing to work with a mother who had chosen to come to music therapy.

Mona Introduces Herself

I am 45 years old. I immigrated to this country when I was 29. I am from Latin America. My paternal grandmother raised me because my mother left the family when I was three years old. In my family there was a lot of fighting. My father was very strict. He hit my two brothers and me a lot – for things that were part of growing up, like learning how to use the toilet. I thought all fathers hit their children like my father did. My grandmother allowed him to do this and said we were his children and needed to learn how to act. When I was growing up, becoming a woman, my father’s brother, my uncle, sexually abused me. He said that it was better that I learned about it from family – this was safer. He was a lot like my father; he was rough with me. I thought that this was normal.
As I started dating men I ended up with rough men. I did not know any different, as my grandmother let my father and uncle act like that. I did not have a mother to model a male-female relationship so I got married to the first man who asked me. I married at the age of 21 and had my first child 9 months later. My husband worked hard but when he came home he would drink. He complained that I did not do the housework as well as his mother and that I did not care for my baby's needs. At 23 I was pregnant again and trying to be a "good" wife and mother. I was having trouble with the criticism from my husband and his family. They saw me as incapable. After my second child was born I began to drink. It helped me to forget about the pain I experienced by being made fun of and feeling out of place in my own family. When my children were 6 and 8 years old someone was looking for a housekeeper in the United States. I decided to get a working visa to the U.S. and work for a while and then send for my children and husband. When I came I was 29 and alone. New friends introduced me to the U.S. By the time I was ready financially to have my children and husband join me I was 33. Shortly after my husband asked me for a divorce and said that he had another woman in his life and he and the children would not be coming to the U.S. At that time I began to use cocaine. I met a new man when I was in my 40s. I was still using while we were dating. We got married when I was 42 and, by surprise, I became pregnant at 43 ½. Even after our son was born, when things got bad I turned to drugs. It turned out that I
married another man who drinks too much and gets angry and is rough. But this one has a good heart and he loves his son and me.

Mona’s Drama

The following case drama is presented to give the background to the situation that led Mona and Rafael to the program where I worked with them. This history was given in bits and pieces within the therapy sessions over time. Mona had undergone much abuse. The drama depicts a realistic view of her life prior to her music therapy sessions. During sessions she often contradicted her history by making statements such as “My husband is a good man and he loves me and Rafael.” It seemed that Mona made statements out of hope and to fulfill her greatest desire – to live with a husband who was loving and not abusive. The following drama occurred approximately one month before I met Mona and Rafael at the program.

The setting is Mona’s apartment; a police officer is knocking on the door due to a neighbor’s complaint of possible domestic violence.

SCENE 1:  The scene opens with a loud knock on the door by a police officer. The neighbor had reported hearing screaming, the throwing of objects, and a baby crying.

Mona: Yes officer. No, nothing is wrong. My baby is colicky and my husband is having a difficult time with the crying.

Police: Are you sure that you and your family are all right? I hear your baby crying.
Mona: I’m sure.

The door closes. Mona’s husband arrives in the living room speaking sternly. He is drunk and begins to berate Mona with condescending comments regarding her inability to mother.

Husband: See, it’s your fault. If you knew how to take care of your baby maybe we wouldn’t have policemen coming to our door and wondering if you are ok. You don’t know how to be a mother, see that’s why your ex-husband’s mother – that old lady, is raising all your other children. You can’t even keep a child.

Husband pushes Mona into a corner, hitting her. Mona cringes, attempting to cover her face. Baby continues to cry from the bedroom. Mona is beaten until she is unconscious.

SCENE 2: Mona revives sometime in the early morning hours, around 2 A.M. She painful rises from the floor. She walks to the bathroom. Her hair is disheveled, face bruised, one eye is shut from the swelling. In that moment she reaches for the medicine cabinet. There is Tylenol with codeine left over from her c-section with Rafael. She reaches for it. Then, she remembers. Rafael, where is he? He is not crying? Has he been hurt as well? Is he alive? She runs to the bedroom where his crib is. He is there. He seems to be sleeping. A calm comes over her despite the pain. She picks up her seven-month-old son.

Mona: Oh my little son. How can I allow you to grow up in this mess? I need help. I need to take care of you.

Rafael: (Snuggles into mother’s arms seemingly peaceful). Gurgles.

Mona places Rafael back into his crib. She goes to the bedroom to check on her husband. He has passed out on the floor. She makes a decision at that time to seek help. She gathers her baby up and leaves the house to go to the hospital. At the hospital emergency room she is x-rayed and checked for any broken bones. Her baby continues to sleep peacefully.

Nurse: Explain to me what happened?

Mona: My husband drinks a lot. When he is drunk he cannot handle Rafael’s crying. He has always been a baby that cries a lot. I cannot keep him quiet. He is not easily pacified. He will cry
himself to sleep. The doctor told me that when he turned 3 months old he should get better. But he hasn’t. So, when my husband gets upset he begins to hit me and tells me that I am not a good mother.

Nurse: Have you ever contacted the organization for women and children who are experiencing domestic violence?

Mona: No, I did not know that there is an organization like this.

Nurse: Yes, there is, and when the doctor finishes talking with you I will give you the phone number and a contact person. You know, there are people who can help you.

Mona: Thank you.

The nurse leaves the examination room and the doctor comes in.

Doctor: Hello Mrs. Garcia. It looks like you have been quite hurt.

Doctor places the x-rays up for viewing.

Doctor: Your jaw and cheekbone have fractures. If you can see here, there is a hairline fracture on your cheekbone. You may experience pain and soreness as well as the swelling that is already evident. However, you may need surgery on the jaw because you will have difficulty eating due to the fracture.

Mona, upon hearing this, begins to cry.

Mona: I can’t afford to have surgery. I have my baby to care for. We do not have insurance. My husband is looking for work. He was laid off.

Doctor: I’m sorry, I can only tell you what you will need to take care of this injury.

Doctor walks out. Mona is left crying. The pain begins to increase. The nurse returns sometime later. Mona has had time to compose herself.

Nurse: Here is a prescription from the doctor for Valium. And, here is the number of a woman who is a part of a specialized program for mothers who are experiencing domestic violence. This organization caters to women who are of Latin descent. They
speak Spanish there so it might make you feel better to speak in you birth language. I have heard that they have a lot of programs there. Call them as soon as you can to get some help.

Mona manages to get herself home. Rafael is awake and wanting to play. She is hurting in body and spirit and is worried about going home to her husband. She opens the door. It is 10 A.M. The house seems quiet. She makes her way to the kitchen to feed Rafael. She hears rustling. Her fear expands. It is her husband. He gets up and comes to the kitchen.

Husband: So, where is breakfast? Can’t you do anything, you lazy bitch!

He storms off. Mona thinks silently, “at least he did not hit me.” She hears the front door slam and breathes a sigh of relief. She continues to feed her son while feeling weak and in pain. Putting Rafael down for a nap she goes to the bathroom opens the medicine cupboard and reaches for the Tylenol with codeine. Taking a handful she goes to the bedroom where Rafael is napping and lays down beside him.

SCENE 3: Police arrive at the house. The neighbor called once again because she heard a baby crying for a long time. The police had broken open the door. The baby is still crying. Mona was lying beside her crying baby, unconscious. The police call EMS. Mona is taken to the hospital, her baby placed in foster care by social services. Scene opens with Mona at the hospital.

Mona: (Asking a nurse who entered the room) Where am I?

Nurse: You are in the hospital.

Mona: Why? Where is my baby?

Nurse: We almost lost you. You took a lot of medication. Were you trying to end your life?

Mona: (Quizzically) No? (She seemed to remember all the horrors of the day) Ouch, I was trying to get rid of the pain I was experiencing. (Mona asks again) Where is my baby?

Nurse: He is safe in foster care.
Mona attempts to get up. She feels nausea. She is in more pain than before. She lies back down. She is severely depressed. She remembers the number that the emergency room nurse gave her. She asks the nurse for her pants.

Mona: Can you get my pants?

Nurse: You are not going anywhere. You are here for evaluation.

Mona: No, you don’t understand. I went to the emergency room after my husband hurt me, and the nurse there gave me a number of someone who could help me.

Nurse: Oh, in that case let me get them. Here you go.

Mona calls the program and asks for help. She tells the social worker, to whom she was referred that she is in the hospital right now but when she is out she would like to be a part of the program.

SCENE 4: The program social worker makes a visit to Mona in the hospital.

Social Worker: Hello Mona, my name is Grace. I will be your social worker if you choose to enroll in the program.

Mona: Hello Grace. (Immediately she asks several questions) How can I get my baby back? I cannot live without him. I also don’t want to go back home unless my husband gets help for his drinking.

Grace: Well, first of all, you have to be able to take care of yourself and find a safe place to stay before we can get your baby back.

Mona: So how can I do this? What are the programs you have to offer?

Grace: We have a new group for women who are experiencing domestic violence. We also have a relapse group and one for drug education. We have education groups to increase life skills, like drivers’ education, reading, English as a second language and computer skills. This way the mothers have a chance to work to support their children. Oh yes, we also have a person from one of the universities who is doing a research study with music therapy. You and your baby can take part in that once he is back in your care.

Mona: It sounds good. Can I start with the domestic violence group?
Grace: Yes.

Mona: Do you have classes for husbands?

Grace: We do. We also have couples' counseling, parenting skill classes and AA. Your husband and you can take part in all of these.

SCENE 5: One month later. At the center where the programming takes place. Mona had enrolled and had been attending faithfully since her discharge from the hospital. She lives in a shelter for battered women and children. Her husband is also enrolled in the program and has been attending the work re-entry program and the AA program. Rafael is living with Mona in the shelter until her husband makes significant steps toward sobriety and they continue to receive marital counseling. The program coordinator, Lucy, introduces Mona to the music therapist. The social worker, Grace, is also present during the introduction. Rafael is in the nursery napping. He is now eight months old.

Lucy: Mona, I'd like to introduce you to Rebecca. She is the music therapist who is doing research here with the mothers and babies. You had asked me the other day what she was doing and asked if you might be able to take part in the research with Rafael. So here is Rebecca and you can talk with her about taking part.

Rebecca: Hi Mona, as Lucy said, I am working with the mothers and babies here with music. It is a research study providing babies and the mothers the opportunity to communicate through music. Have you ever had any musical training?

Mona: Hi Rebecca. No I haven't had any musical training. But, I love Latin music and often while I am cleaning the house I turn it on and dance to it. Rafael also loves it. He wiggles his body to the rhythm. I would like to come to you. Can I?

Rebecca: I would be happy to have you take part. I have a flyer and a consent form. In the consent form you contract for 12 sessions with me. The best way to complete these 12 sessions is scheduling a 45-minute session weekly with me. Can you commit to a weekly session?

Mona: Yes, I will try.
Grace: It will help you in the program. You will receive points for coming to the music therapy session.

Lucy: Yes, and it will be fun!

Rebecca: It was nice to meet you. Let me give you the flyer and the consent form to sign. Thank you for taking part.

Mona and Rafael’s Musical Journey

Mona and Rafael entered the music therapy session with a high degree of caution. They were timid and tentative in their response to my introduction. I was careful not to scare this mother and infant and to provide a welcoming atmosphere. I held myself in reserve, taking my cues from them for how much contact or interaction they could handle. Mona stood at the door waiting while I came to her and Rafael. I welcomed them verbally, and when they still seemed tentative I went to the carpet, got an infant-sized shaker and sleigh bells, and went back to the door with them with a small hand drum. I began to sing Rafael’s name and then Mona’s to invite them into music. As often happens, the baby warmed up to my musical offerings first. Rafael took the small gourd shaker and began shaking it with energy. His mother made comments about his playing and soon took the sleigh bells. All this was done in close proximity to the door. They were not quite sure. I used this opportunity to talk with Mona, to give her more information about music therapy while all of us played the percussion instruments. I then invited both Mona and Rafael to sit on the carpet in the center of the room where the instruments were laid. Rafael immediately gravitated to the guitar. I sat with them and took hold of the guitar. I began to sing.
Beginning Sessions: Music is Good

Although Mona had asked to come to music therapy, she was having a difficult time trusting me as well as my motives in the sessions. Over the first few sessions Mona kept saying, “Music is good for my son,” as if to reassure herself that this was the reason why she was coming to “therapy” with Rafael. I responded to her, “Music is good for Rafael’s mother,” so that she could hear that the music and the therapy were not only for her son but also for her.

During these sessions she talked about how she dances with Rafael when she is taking a break from her daily chores. She also gave family history as it related to Rafael’s and her own musical development. For example, she met her husband at a Latin discothèque, she loves to dance, and her husband will dance once he’s had a few drinks. She spoke as well of other family members who were musical - her grandfather played the mandolin and an aunt played the piano.

During the first and second sessions there was an air of caution at all times as well as an air of becoming acquainted. There was an improvisatory melodic beginning within most sessions, a warm up to the more involved, increasingly active experiences within the music as the sessions progressed. This initial connection occurred in each session in different ways. The time involved in “making comfortable” diminished as Mona and Rafael became accustomed to me. The following vignettes are examples of this “getting to know” time. The first vignette is “Beginning,” representing the set up of the musical environment in the
first session and how this supports the beginnings of interaction between Mona, Rafael, and me. Just as the large bass drum is used as a musical womb – so too is the environment and the music. There is safety in the environment, in the musical structure and the use of the therapist’s voice. This combination of elements is part of what Austin (1996) described as “vocal holding,” a “free associative singing,” which involves creating a consistent and stable musical holding environment using two chords (p. 33-34). These techniques provide a forum for integration within the session. As a result the metaphor of “musical womb” can be applied to a physical environment, such as inside of the drum, to the auditory environment – the musical structure – or to a secure human relationship where the infant and mother feel held by the therapist. The following excerpt is the beginning of that “musical womb” for Rafael and Mona:

Beginning

\[\text{As noted above the "holding" concept is expressed musically moving from tonic to the interval of the tri-tone implied by the dominant 7th harmony. Holding, yet moving forward, coordinated with the rhythmic upbeat, lifting and drawing the baby in and increasing tension, expectation and excitement.}\]
Sitting on the carpet, with guitar in hand, I provide a constant melodic, rhythmic or tonal center for Mona and/or Rafael to jump in or out of whenever they liked. In this theme, there is a dotted eighth followed by a sixteenth that then moves to two tied half notes that holds Rafael in suspense as he hears his name. I clearly use a diatonic progression. The semi-tone which can be seen across the bar lines from measures two to three, i.e., from F# to G creates anticipation and Rafael reacts. The “anticipation” is also generated from the harmonic context applied in the implied V 7 chord (E E G), where G to the implied C#, i.e., a tritone interval, is a tension and excitement, provoking element. It is then resolved to the F# which is implies a tonic D harmony. The music leads Rafael slowly, as if climbing a stair towards something exciting. His face reflects that excitement. The creation of the womb-like environment begins with musically calling the Rafael’s name and creating a safe environment with Mona present. The rhythmic component is important in creating the connection to Rafael. Extra emphasis is achieved by the dotted eighth passing quickly through the sixteenth proceeding to the held-out tied half notes. In this, Rafael and Mona anticipate what will follow. After the second singing of his name, the breath comes with a quarter note pause and then the final down beat on the side of the guitar. After capturing Rafael’s attention, I ask him if he would end the phrase with a melodic affirmation of “yes.” I then hum, waiting for the “yes” response, singing “yes” several times. Following this introduction, a playful rapport is built between Rafael and Mona as they are uncertain what I will do next musically, but they wait for the surprise or
for the held notes to slip into the music. The surprise element in sustaining a note and dropping it creates a space for Rafael or Mona to respond. It becomes a playful cat and mouse game as Rafael, Mona or I wait, and then respond.

During the second and third sessions there was a lot of playfulness and getting to know through using Rafael's name and a call and response as well as drum playing. The following excerpt is an example of these musical interludes.

The Echo

Beckoning and calling is critical to this theme. The breath and pauses allow Rafael or Mona to join the musical interlude. In this session both Rafael and
Mona are hesitant. Since I am near to both I model by taking Rafael’s hand to play the drum. Rafael does not resist. After my asking him to play with me several times and doing the hand-over-hand he takes his hand and slaps one down beat on the drum while I sing “yes.” There is a celebration, Mona clapping, kissing her infant, and beaming with pride at Rafael’s response.

**Middle Sessions: Musical Interaction**

Mona and Rafael’s musicality became more apparent with each session. Mona was becoming freer in her interactions with me and with Rafael. Initially her eye contact had been poor – when she would talk with me she kept her eyes focused on Rafael or she would look at the floor. She continued to maintain a reserved manner. Now, however she was making more direct eye contact with me. She was beginning to open up more and was rejoicing in her son’s openness within the sessions. During these middle sessions Rafael explored everything. He was nearing nine months of age and he was an able crawler. He also pulled himself up to stand by the large bass drum. He explored the drum, the guitar, and all the rhythm instruments – many of which ended up in his mouth. He also explored the piano although it was not as accessible for him so he usually stayed on the carpet near the instruments he could get to. His mother kept a careful eye on him, often telling him to be gentle with the instruments. I let her know that the instruments are well made and that he could play them freely. The following vignettes are examples of the exploration and of the musical interaction between
Mona, Rafael and myself. The fifth, sixth and seventh sessions were more fluid and free with less of the protectiveness that Mona maintained in the beginning sessions, and with more trust.

Musical Exploration – Session Five

The musical environment is calm. Rafael and Mona listen while I demonstrate using the guitar. I hold Rafael’s hand and together we strum or rhythmically pat the front of the guitar. In doing so I invite him to respond by asking the question, “Can you play?” He reaches out and pulls one of the guitar strings. Mona is concerned that Rafael is going to break the guitar; however in my strumming lightly and modeling for him, she is assured that this is a part of learning and that the guitar will survive. His eyes are wide with expectation, and
after he pulls the strings he is more curious and ready to engage than before. The gleam in his eyes says, “I can do this, and, yes, I can play.” I affirm his intelligence by singing “yes.” The last lyrics in a descending third provide completion. There is no longer a question but rather the completion of the answer. At this moment Rafael reaches out his hand to strum independently.

The Musical Triangle – Session Eight

In this episode, Mona, Rafael and I are kneeling around a large bass drum. Mona plays the drum in a syncopated beat to what I am singing. I sing about how Mona is playing. By the fourth measure they are both playing strong quarter notes on the bass drum while I sing “Mami is playing, Rafi is playing,” acknowledging their interaction and our music. Laughter breaks out from the three of us. This musical theme emerges later in the session rather than in the beginning. Mona and Rafael are communicating via the music and with me. It is a triangle of communication with openness for exploration and trust.
Final Sessions: Unity

In the last sessions Mona and Rafael had many moments where their rhythm was reciprocal, playing with one another. Rafael crawled around the carpet to all the instruments while Mona and I followed his lead. There were many moments where Mona would mimic me or Rafael and Rafael provided the grounding. It was interesting to see how Rafael was a grounding energy for his mother. She seemed to be secure in her mothering; however she was insecure in life and with adults. I observed her interactions with her son. She was intuitive and expressive. In the therapy setting I let her know what a good mother she was. She always seemed embarrassed by this and had difficulty taking a compliment. Rafael was thriving; he was almost 11 months old. Mona appeared to be integrating the coping strategies for remaining drug free and was taking parenting classes with her husband. The last two sessions were difficult. Mona and Rafael had become aware of their strengths in the musical relationship. Since Mona was a quieter, more withdrawn type of person, I could tell she was having a hard time saying goodbye.

In these sessions the technique that arose most often was that of a river of melody and the babbling brook. Mona was using the melodic interlude to talk with me and Rafael was trying to talk and sing, in pitch no less! As a result the music was quiet and pensive even when Rafael was babbling. The next three vignettes depict music in the last sessions.
Rhythmic Reciprocity

I beckon to Mona and Rafael with a triplet rhythm. Mona joins with a dotted sixteenth and the Rafael grounds the rhythmic play with a strong downbeat. I played two triplets and a quarter on a hand drum. Mona strikes the tambourine, mimicking my rhythm, and Rafael lifts his hand and plays three down beats on the bass drum in rhythm to our playing. The technique allows Mona and me to mirror one another and Rafael to make a statement and connect with both of us. Mona is listening and mimicking me as I attempt to engage Rafael. It is wonderful to see and hear Rafael grounding the interaction as if to say, “I am here and I am the reason for the connection.”

The River of Melody and The Babbling Brook
In this theme I do not sing any lyrics. The melodic line is repetitive and the implied harmony moves from the tonic note to the dominant. It changes in the last few measures as the baby enters the play. I have been singing “da” and humming. Rafael responds with two “ha’s.” Mona definitively joins by telling Rafael to look at the piano as I play. Her melody is a perfect descending triad on the tonic chord that directs both the infant and me to the keyboard. During this session Mona was preoccupied with thoughts of one of her peers whose son had died. As a result she was not focused on the session. She seemed detached. In the moment where she focuses on Rafael, the music shifts, she is engrossed in the piano, and both of them connect and we work as a team.

I’m OK and It’s OK – the Piano

This theme developed after several offers to move to the piano. It took time before my offer to switch instruments was acted upon. In this session it seemed like both Rafael and Mona were having difficulty moving from the drum. Rafael often went to sit in the drum, the “musical womb,” so that his mother would sing to him. It was security for both of them. As a result, in these last
sessions they were going to the instruments that provided comfort. I was gentle with him as he had difficulty with transitions. It seemed that in many ways Rafael mirrored his mother musically, especially when she was more withdrawn. The transition to the piano at this time was important because it was a way that we could say goodbye joyfully.

As soon as we arrive at the piano he plays a low G, and I say, “Ay, this is your instrument!” The use of the movement up the scale invites him to play another note. He is tentative and does not play until much later. However he is laughing and bouncing up and down on his mother’s lap. The music later develops into a very bouncy song. The chords are lush, with minor seconds that open to thirds then to fifths and octaves with a rolling feeling. I am not transcribing the full piano score; only giving a sense of what the score is like. The music sounds very contemporary as Rafael plays tone clusters and I sing with him. I return to the alternating fourth between the low G to middle C. He happily plays the lower notes. His mother is surprised at how he took to the instrument during this last time together.

During all of the sessions with Mona and Rafael, Mona was present, loving, and actively engaged with her son. She became able to confide in me as a therapist, educator and mother. Her history provided a window of understanding behind her guilt, sadness and lack of confidence. She and her husband had developed better coping skills and worked on their relationship. Her husband would come and pick her up after the music therapy sessions when he was
finished with his own therapy. They both seemed to be much more at peace and appeared to be parenting Rafael together. In spite of her fears and feelings of guilt, Rafael reached developmental milestones at the appropriate time as indicated by reference to the Bayley Scales of Infant Development (Bayley, 1969). He was able to hold the agogo (South African bell similar to the cowbell), a two-handed instrument and played it dynamically with intent. My last memories of Rafael are of watching him wobbling to and fro, walking, and finally reaching the drum and playing it with great delight. The last session was very difficult. Mona cried as she said goodbye. She stated that she had a hard time saying goodbye and hoped that our paths might cross in the future. Though Mona was crying during the last song Rafael on the other hand was bouncing, lively and playing. Through her tears, Mona smiled as Rafael played the drum during the goodbye song. He had grown up so much in the three months of music therapy.

Mona and Rafael's Tapestry

In the above section we have seen how Mona and Rafael moved from being cautious and tentative to experiencing more connection and gaining confidence in the music. Mona’s self esteem appeared to have increased as demonstrated by her more active involvement and improved eye contact with adults – her case manager and myself. Within the sessions there were many opportunities for Mona to be applauded for her sensitive mothering. Rafael was able to make transitions more easily. He had been exposed to a variety of
instruments and musical creations and had grown from a crawling infant to a walking toddler. Rafael was beginning to form words and he was repeating semblances of words, primarily vowel sounds, in Spanish and English. Some songs created in sessions were related to learning of body parts. For example, for “eye” I sang or said in Spanish “ojo” and in English “eye.” He would look intently and form an “o” for ojo and he would say “ay” for eye. He was active and musical.

Mona and Rafael’s tapestry was dark and detailed, possibly because Mona was a subdued, seemingly depressed person, reminiscent of a Peruvian wall hanging. The “darkness” is not a negative quality, but rather one that creates warmth and depth within their relationship. Mona and Rafael’s mother-infant relationship was much more defined than that of the other participants. Mona encouraged Rafael to play and to be a part of the music. She was his protector, watching to make sure he was safe, guiding him. Rafael knew who his mother was. He was secure in her and looked to her for guidance in the music. She was present with her son, although she seemed insecure with adults.

Postscripts

Stories go in circles. They don’t go in straight lines. So it helps if you listen in circles because there are stories inside stories and stories between stories and finding your way through them is as easy and hard as finding your way home. And part of the finding is the getting lost. If you’re lost, you really start to look around and listen. Deena Metzger (1986)
It took me a long time to begin to look and listen to the melody within a melody of these mothers and infants. Fear can affect every fiber of our beings and empathy and a non-judgmental listening ear can soothe. By the end of the writing of this document I was able to piece together the stories within the stories with the assistance of the mothers and infants. The health professionals working with the mothers and infants also provided understanding regarding the mother and infants’ stories.

The program in which the mothers were enrolled has several levels. After the mothers finish the year-long commitment they have the opportunity to become peer facilitators and are encouraged to continue studying in some capacity. Those who would like to begin working are assisted through a work-study program. The program initially keeps in touch with the graduates on a monthly basis, then quarterly, then bi-annually and then they have a yearly reunion. As a result, the program staff are often the first to be called if something happens. I maintained contact with the institution, first by being hired for one year after doing the music therapy research there and then by checking in at three years and then finally at five years. The program coordinator has been my primary contact. We called each other yearly. I spoke with her in September and made a five-year follow-up to find out how the mothers in this study were doing. The following paragraphs include follow-up information given to me by the program director.
Rhea and Matthew

Rhea and Matthew's case appeared straightforward on the surface. Rhea wanted to be seen as a capable mother. She performed for me in every session, and she always arrived with Matthew dressed impeccably. She wanted me to see how secure and happy her son was. She was well informed about parenting. She informed me that the reason she began sleeping with Matthew was because she was concerned about sudden death in infants (SIDS). She realized her baby was healthily attached and happy. She did not want anything to happen to him. Rhea and I had an instant rapport as mothers. She had taken advice from professionals that suited her life style, to sleep with her infant, breast feed him and play with him. She worked her life around her choices. Matthew was thriving, and she was doing the best for him. Being a good mother does not have an age stamped on it, or a life situation, some mothers are innately good mothers. It seemed at the time that this mother fit that category.

Five years later, I was surprised by what had happened with Rhea. Three years after the music therapy when I checked with Rhea she was in school, she had just remarried and Matthew loved his stepfather who was a musician. Rhea's goal was to open a day-care center for unwed mothers. Two years after that I was saddened by the fact that the coordinator told me that she dropped out of school, had a second child – and, Rhea is now in jail. I do not know the details of her incarceration. Apparently Rhea was involved with the wrong crowd and she was at the wrong place at the wrong time. When children are involved, the court
system favors placing children with a biological family member rather than the foster care system (Brodinsky, 1987, 1998; Goege, Wulczyn & Harden, 1994; Christian-Parilla, 2000). Consequently, Matthew and his sister are in his maternal grandmother’s care. He is said to still be a well-adjusted child, playful and musical.

**Dee and Angel**

I learned the most from Dee and Angel. I never knew from session to session how Dee would respond – whether she would be angry, avoidant, resistant or present. Towards the end of our sessions, Dee had developed more trust in me as a therapist and a caring professional. For this reason I believe that she was unable to say good-bye. She did not want to have closure. It is my assumption that she wanted to leave the door open; she has contacted the director over the past several years and asked how I am. None of the other mothers have done this. I am the one who usually checks in on a yearly basis.

Five years later the program coordinator informed me that Dee lost custody of both her children. She divorced her husband and has a restraining order against her to stay away from her children. She relapsed several times over the past five years. She cannot stay away from drugs or prostitution. Angel is said to be doing very well. He is in first grade and is also a very smart child. The coordinator stated that he is a very serious, borderline sad, child. He has consistency in his life with his grandmother – his father’s mother. Although
Angel appears to be doing well, his father is in jail and it will be five years before he is up for parole. The coordinator did not inform me of the grandmother’s appropriateness for parenting Angel. I do know that the grandmother is a quiet, loving person.

**Mona and Rafael**

Mona and Rafael appeared to be the most securely attached. Mona was authentic when she related to Rafael and he was secure in her authenticity and love. Mona’s apparent lack of self-esteem with authority figures as well as other adults diminished over the course of music therapy as she gained confidence in herself and her innate mothering skills. She seemed to blossom over the three months and was able to maintain her personal growth as life progressed. Rafael continued to look to his mother for guidance, yet also became more independent as he developed in age and ability.

On the five-year follow-up the program coordinator informed me that Mona remained free of drug use and continued to receive the assistance available to her through the Latin American community. She is currently working as a secretary and Rafael is in first grade. The program director said he is a very intelligent, loving child with a special attraction to music – especially Spanish guitar. The family is still intact. Mona’s husband continues to be a part of AA and she participates in Alanon. They have family support, as most of their family – parents and siblings – have immigrated to the US and are assisting one another.
CHAPTER VI
THEMATIC ANALYSIS

The purpose of this chapter is to identify, analyze and discuss the various themes that have evolved during the course of this study. A theme may defined as "a statement of meaning that runs through all or most of the pertinent data or one in the minority that carries heavy emotional or factual impact" (Ely et al., 1991, p. 206). Themes emerge from recursive analysis of the data. Based upon my analysis I first present themes related to the infants and then those related to the mothers. These theme statements, although phrased in the first person, are not actual quotations but are constructed from the data to present the essence of the findings (Atkinson, 1992). Following the themes, three metathemes that emerged from the analysis are presented. Metathemes are defined by Ely et al. (1997) as:

... major constructs that highlight overarching issues in a study, which may be considered against extant literature and experience. They sometimes also have the "meta" twist of reflecting back on the research process as well as on the findings. Because there are often countless themes embedded in any one body of data, it probably goes without too much saying that we will be concerned with statements of what are to us important meanings, essential to understanding what is perceived as the heart of the culture or experience being studied. (p. 206)

A discussion of the findings in this thematic analysis is woven through all the themes, but particularly in the presentation of the metathemes and in the final section of this chapter.
The Babies' Themes

Playfulness

Theme One: “When I am in this place I can have fun and to play with the instruments as much as I want to.”

In an early session with Rafael the combined use of the musical surprise technique, along with his naming everything he was doing, created a collaborative setting within which he could play and feel uninhibited. In the session documented below Rafael continued to explore and gained recognition from his mother and me by playing a large Irish hand drum. I affirmed his actions by playing the hand drum as well and by singing:

“We will play, we will play, with your hands, with your hands, yes.” Rafael responded by laughing joyfully and purposefully. With a deep belly laugh, he hit the drum with his hand. He then kicked out his foot and made another sound on the drum. Again, he laughed a deep guttural laugh with delight. “Playing with one hand, yes. Playing with two hands, yes.” I played a drum roll with both hands. He laughed again and then reached out to play. (Session II of XII)

As depicted above, songs emerged throughout the process as Rafael continued to playfully reach out and make contact with us through the music. The following excerpt is another example of Rafael’s playfulness at the piano:

Rafael and his mother sat beside me at the piano. Rafael reached out his hand to touch the piano with his right fist. He began to play two notes at a time, hitting the black notes with his fist. I proceeded to follow him on the piano. In response, he began to jump up and down in his mother’s lap and reached as far as he could, up or down on the piano, playing random clusters with his right hand. He then lifted his left foot and hit the white keys. He appeared to be physically stuck at one moment, and so I ran down the keys with my fingers and pretended as if I had caught him and then tickled his toe. He giggled and the game began again. I called this
the “Cat and Mouse Game.” He repeated this several times as he became more confident of a playful response from me of being caught and laughing. (Session VI of XII)

Each of the infants expressed his natural playfulness differently. Rafael watched for his mother’s and my reactions. Angel, on the other hand, was more cautious. He needed more time to be drawn in musically. For example, I suspended the second part of a word or a phrase in different songs to add suspense and draw Angel into my musical sphere. I used sighs to engage Angel while looking at him and smiling, directing his focus towards the instrument through vocal outbursts of sounds and pauses. It took Angel quite some time before he began to emerge playfully. In retrospect, it appears possible that his initial ability to play naturally was inhibited by the turmoil in his life due to his mother’s painful and tumultuous emotions.

Angel finally expressed his natural playfulness toward the end of the music therapy sessions when he appeared to be more secure in his relationship with his mother and comfortable with me, the environment and musical techniques. At one point, Angel bounded into a session in his walker, and he seemed to be looking for a response from one of the adults in the room. He began yelling/singing from across the room – “Eh”. He had just begun to use the walker and he was still not adept at walking forward, so he would go backward and then forward two steps. The following is an excerpt from a session transcript:

“Let’s see? Come here sir…” I brought my voice down as I was inviting him to come – my voice sounded commanding. It seemed that he was being playful in that he was responding to me. He had a tendency to go
backwards in his walker, the couch was blocking him... he could not figure out how to go forward once he was up against the couch.

Rebecca: Come here.

Angel: Eh, eh.

Rebecca: (Singing) Mister come here, come here mister
Now to play, play
Play (sung invitingly with softness and intent)

Angel: Ah, eh.

Angel was responding with such energy. He had a full-bodied sound. The vocal interplay continued with “Ah’s” and “Eh’s” and then moved to his jumping in his walker. By the time he finally made it to the carpet with the instruments he was fully dancing.

On another occasion Angel showed not only his playful side but also his ability to get the people around him to be playful. The following description of Angel engaging playfully with his mother was recorded in the very last session. However, there was one newcomer to our session --his newly found two-and-a-half-year old sister. Angel was watchful of his sister during this session. I was not sure if this was because she was such a ball of energy or because she had been taking his toys, his bottle and his mother’s attention. His actions clarified my uncertainty:

Angel: (Watching)

Emily: (Angel’s new-found sister – running around the room)

Angel’s familiar attention-getting grunts became a part of his watchfulness. Angel was seated on the carpet with the drum, guitar and instruments at arms reach. He began to look around at the instruments.
He picked up a small, lightweight, gourd shaker (I at first thought he was going to put it in his mouth since he was teething) and when his sister came running around he reached his hand out to give her the shaker. She ran a couple of circles around the instruments, the carpet and Angel and finally plopped down and received his offering. Angel began to shake his arms up and down when she took his offering. I placed a drum under his shaking arms and Angel began using his arms to hit the drum. It became a rhythmic body dance while his sister shook the gourd shaker and his mother began a rhythmic pat on the tambourine. Angel appeared to be a conductor in his orchestra of instruments and loved ones. He kept this up for some time until he appeared tired. (Session XI of XII)

Unlike the other two babies, Matthew played at all times because he was his mother’s playmate. She treated him almost like a doll. When he saw the guitar he began bouncing up and down and reached out for instruments around him. The following transcript excerpt is an example of his playfulness within his mother’s direction:

Rhea: Matthew. Wheels on the bus?

Matthew: Hmm, hmm, hmm, hmm. (Moving his hands in a circle and bouncing as he makes a noise similar to the beginning of the song in a hum.)

Rebecca: (Playing the guitar) The wheels on the bus go round and round...

Rhea: (Singing and making the movements to the song.)

When the song was ended, Matthew took hold of a drumstick and hit the bongos to the side of him. He began his own percussive interlude as he continued the celebratory playful experience that had begun earlier. (Session VI of XII)

On this occasion, however, he initiated the experience rather than taking his mother’s lead. This was the first time that he initiated rather than allowing his mother to dominate what he did in the session. Another memorable occasion
when Matthew played with carefree abandon was with the large bass drum. He stood, supporting himself beside the drum, and played the drum rhythmically with his arms. In that same session Matthew had ambled to other instruments. When he did this, I moved the large bass drum and stood it on its side with the open end facing the circle of instruments by which we were surrounded. The following is an excerpt that describes his playful explorations in this experience:

Matthew played the tambourine while his mother sang a Spanish song she had learned from her own mother. At one point, he stopped playing and looked around the room; he was looking for something. While listening to Rhea, I observed Matthew's curiosity. Within seconds, he turned himself around and crawled purposefully toward the drum. I had left a baby pillow on the inside of the drum that I had turned on its side. Matthew crawled inside and sat down grinning like a Cheshire:

Matthew: Mama, Mama, Mama (bouncing in rhythm to the syllables of his vocalization)

Rhea: (Speaking in a high inflection) Matthew!

Rhea moved closer to the drum facing Matthew as he continued saying "Mama." I began to support the interaction by playing the guitar in a 2/4 rhythmic pattern matching his vocal pitch while he began to play with his mother. Once a melody was established I abandoned the guitar and patted the drumhead while Rhea and Matthew continued their free-spirited, rhythmic and exploratory play. Matthew turned his body when I began to pat the drumhead. Then he faced his mother and threw his head back to play the drum with his head. The following is the song that emerged:

Mama, Mama, I play the drum
Mama, Mama, I play with my head
Mama, Mama, you play with me
We can sing
We can play
Happily

I can sit, I can lay, I can play, with my hands all day
I can sit, I can lay, I can play, with my feet all day
I can sit, I can lay, I can play, with my head all day
I can sit
I can lay
I can play
All the day.

Rhea allowed Matthew to explore and be playful while she was engrossed by his total immersion in the physical experiences within the drum. Matthew’s voice as he said “Mama” echoed in the cavernous enclosure of the drum while Rhea’s voice responded to him with his name.

**Exploration**

Theme Two: “We have come here several times, and my mother seems happier now to let me explore on my own.”

This theme of each baby’s awareness that he was free to explore and play, with his mother’s unspoken approval, became apparent as the sessions progressed with each mother-infant dyad. It was particularly evident during the final sessions. This theme tended to overlap with the first theme. The emphasis in that theme, however, was on the pleasure the babies exhibited in the music therapy session. The emphasis here is on how the mothers supported the babies’ natural development. The babies were no longer two-and-a-half months old – they were now becoming nine months to one year of age. Much occurs developmentally in infants during this period. It was refreshing to see the beginning of autonomy -- a person emerging within each baby. They were no longer only looking to mother but had definite preferences and sought to engage in the therapy process through those preferences. Viewed within a framework of infant development, this stage, which spans the first month out of the womb to the tenth month, is a time for
symbiosis (1-4 months), the beginning of differentiation and individualization (4-8 months) and then of further curiosity and space investigation (8-10 months). Furthermore, from ten months to two years an infant normally continues to investigate his environment, explore his body, self, and the developmental and environmental limitations placed upon him (Sekeles, 1996, p. 68-69). The excerpts in the subsections below illustrate this individualization, investigation of the environment, exploration of body and self and the limitations that each baby experienced.

During the final sessions, Matthew began to push away instruments offered by Rhea and chose instruments he wanted to play:

   Rhea: Here Matthew (handing him a bell).

   Matthew: (pushes away the instrument and reaches for a small cabassa) Ah, ah, eeh!

   Angel no longer seemed anxious when his mother was not in sight. On the contrary, he was so involved with the musical environment and his exploration that Dee had to be close by him before he would turn and acknowledge her. Even then, he would crawl off to play another instrument. This happened most frequently in the last sessions:

   Dee: Hijito ven – little son come! (Dee pleaded for Angel to turn in her direction so that she could play a small hand drum with him).

   Angel: (Casually looked up and proceeded to crawl to the guitar and plop himself beside it ready to pluck the strings.) Mama, Mama, Mama. (Angel appeared to be saying mama but was actually humming – using the syllable of “ma” while he blew bubbles with his mouth).
Dee began to laugh at his mumbling and humming, which made Angel increase his volume. It seemed, in that moment, Angel and Dee had reached a different level in their relationship. She seemed to need to interact and “be” with Angel more than he needed her.

Rafael, like Angel, was becoming more and more his own person. He would come into the music therapy space and head straight for an instrument without looking back to see where his mother was. He often started with the guitar and rhythm instruments and would end up with the piano. He was walking but still unsteady so he would put himself on all fours and crawl very fast.

Matthew would lay himself down in the middle of all the instruments and use his arms and legs to touch the instruments. Sometimes he would lie on top of the instruments – especially the lollipop drum – or place his feet on the drumhead and lift his leg and drop it down.

Angel was often in his walker. He especially enjoyed rolling his walker toward the carpet and then using his feet to kick the bells on the floor; or he would reach his toes out and touch the side of the tambourine. Sometimes he would roll his walker into the tambourine and push it into the middle of the carpet where it would hit against another instrument. Rafael was the crawler, and would crawl from instrument to instrument, sometimes tapping with his fingers or hands, sometimes pushing, other times crawling on top of an instrument and becoming an acrobat looking upside down at the instrument.

During the exploration of their bodies it was amazing to see how all three boys used their bodies to create music. Matthew lay down with his right foot
touching the large cabassa. He took his foot and placed it on top of the cabassa, proceeding to roll it while he laughed. Then he got up, crawled over the cabassa and lay on top of it. It seemed as though this would be painful because it is a metal instrument. He did not appear to mind, however, and pushed himself backwards and forwards on the instrument, making a swishing sound.

Angel placed himself below some chimes on a stand and bounced up and down hitting the bottom of the chimes with the top of his head. He did this with grunts and giggles, sometimes moving his head up and down in a “yes” motion and at other times shaking it side to side as if to say “no”. This caused him to play different chimes at different times. On another occasion Angel placed his head on top of the drum and patted his hand up and down. He appeared to be listening intently to the sound and feeling the vibration he was creating on the head of the drum.

Rafael was very funny during his exploration as he took the tambourine and placed it over his head and swayed from side to side. At one point he lost his balance and went toppling over but picked himself back up and proceeded to make his tambourine sing. During another session Rafael found a child’s mirror on the floor near the bells. He saw his reflection and sat down. He then picked up the hand bells, but instead of playing them he stuck out his tongue and looked in the mirror. He then put the bells to his tongue while he watched himself.

Matthew learned that if he made a noise inside a pan drum it echoed. He did this a few times and then would stop to listen. At one point, he was so
mesmerized by the sound effect that he kept staring at the drum as he held it in his lap. He must have sat with the drum for five minutes or more, smiling at times, then looking puzzled. Matthew’s mother often had him strapped into his walker. Since the walker had a non-removable tray, Matthew could not get close enough to the instruments on his own unless his mother took him out of the walker. Angel, because of his limited motor agility, would get stuck in a sitting position and not be able to reach a desired instrument without assistance. Rafael was too short to reach the piano independently. On the very last session, after coming away from the piano and beginning to say goodbye with the guitar, Rafael attempted to get back to the piano. He crawled to the piano and pulled to a standing position to reach the keys. He got on his toes in order to reach up and was unable to reach without assistance.

All of these examples address the need to provide environments that are infant and mother friendly, encouraging independence rather than dependence. In this way the infant can master the world around him and feel confident that he is able to do for himself. Brazelton (1992) states:

While we cannot change our own styles and outlook just to influence our children, we can learn ways to nurture a child’s initiative and boost his self-esteem. In any new task, encourage the child, but don’t shape it for him or press him. Praise him gently when he succeeds. Let him try out several different ways of doing the same thing….never forget the enormous power of frustration to fuel a small child as he searches for mastery and a sense of his own competence. (p. 364)

It is through an environment such as this, designed to be safe and free for exploration yet with the added emotional safety net of mother, that the infants
were enabled to securely develop at his own pace and within his own person.
Each of the babies in this study had his own personality and used his strengths of
relating in whatever way possible to communicate with the people around him.

The Mothers' Themes

Representing Self

Theme One: “I’ve learned to present myself differently in different situations.”
As time passed, I became aware that there were many aspects of the
mothers’ lives that they only disclosed bit by bit. These disclosures came toward
the end of our work together. Two of the mothers, Rhea and Dee, appeared to be
quite adept at devising different accounts of their lives in different circumstances.
Over the course of this study, different issues seemed paramount as the
participants presented themselves in different and conflicting ways. This appears
consistent with the findings of Gergen and Davis (2003) who, in a study of
midlife transition narratives of women, stated:

We explore the assumption that people are composed of multiple selves
and what it means for narrative research if people harbor many different
voices and different stories. If it is the case that people can become
different selves as they move through life and, as a consequence, tell
different stories of their lives, must they settle on any single one, even in a
particular situation? (p. 243)

These women appeared to be discovering themselves within the
therapeutic context. Consequently, their personal challenges in communicating
their histories became far more understandable – their lives were often painful and
difficult to share, especially to a virtual stranger. One of the benefits of the music
therapy process was that it laid the groundwork for each individual participant to grow in sharing trust and to share her story as it became more bearable and tolerable for her to accept.

I felt that Rhea seemed to need to be accepted. She wanted to demonstrate that she was mature enough to mother Matthew. During the first few sessions Rhea appeared to be performing. In analyzing the sessions, I came to feel that she sized me up as a person and first told me a history that presented her as being a sensitive, caring and connected mother. She talked about how she had a family bed (Thevenin, 1987), and she breastfed Matthew for six months. Rhea’s stories centered on her intent to appear to be the perfect mother, daughter and woman. It was not until the last two sessions that Rhea confided to me about how she felt responsible for her father leaving the family because she was, in her words, “a hard kid to handle.” She told me stories about how she did not drink, do drugs or act promiscuously. I later learned from the social worker that Rhea had difficulty with all the above.

Rhea’s mother had a difficult time with Rhea caring for Matthew in the home setting. It appeared that Rhea painted a picture of being much more capable of taking on the role of motherhood than she actually seemed to be.

Dee used the musical spaces to confide in me or give me history. She presented herself very differently to me than she did to the director of the program. I had the opportunity to observe her with different individuals in the program. She seemed more withdrawn and timid with me. It was difficult to
know Dee or to learn her many facets as she presented herself. After meeting
with the program director, I had more insight into why she presented herself in
different ways to different people. It seems that Dee was searching for security
and her own identity. Initially Dee told me that Angel was her only child. It was
not until she finally said “he is the only child I have been able to keep so far,” that
I had the first indication that she had more than one child. I came to discover that
Angel was her fifth child. She had three children, teenagers, who were being
raised in the Dominican Republic by her first husband’s mother. She also had a
little girl who was one-and-a-half years older than Angel and was being raised by
her second husband’s mother. Social Services had taken that child from Dee at
birth. Ultimately, that little girl appeared during the therapy session after Angel
was returned to Dee when the court gave her an opportunity to demonstrate her
ability to mother her last two children.

As mentioned earlier, Mona’s primary issue appeared to be that of low
self-esteem. She seemed cautious, quiet and guilt-ridden. Mona protected herself
with downcast eyes, low voice, presenting herself in an unsure manner. Possibly,
by presenting in this way, she felt that individuals in authority might make fewer
demands of her. She appeared to be a simple person who wanted the best for her
son and was working out her own issues. She was kind, loving and confident
when she was with Rafael. She used the more quiet intimate times in the music to
share her history as she could remember it, and her story and responses in the
sessions were consistent.
Trust

Theme Two: “As the weeks went by I began to trust Rebecca and used music therapy time to talk about my personal problems while my baby played on his own.”

In the mother, as with the infant, trust is primary before playfulness emerges. An adult who has a narcissistic injury is unable to trust (Austin and Dvorkin, 1993). The mother-infant music therapy session provided a creative place where the mothers felt supported by, or secure enough with, the therapist to bring forth the portions of their history that negatively impacted their egos. By reviewing this history in the safety of the therapy sessions, the mothers released painful feelings and, in the cases of Rhea and Dee, disclosed long-held secrets. Without trust, it is unlikely that this critical information would have been shared. Consequently, it appears that the music therapist became a guide and partner, validating and supporting these mothers in the process of expression outside the limitations imposed by their abusive pasts (Soshensky, 2001). It appeared to be the relationship between mother and therapist that helped in restructuring the ego to lend itself to trust (Austin, 2001a; Summer, 1998; Winnicott, 1971).

The mothers, just as the infants, needed time to develop a rapport with me before a foundation of trust could be established. Consequently, their discussions of the challenges in their lives also evolved over time. I realized that their individual confidences in me were layered and that, over time, each mother brought me on her concentric journey towards her own reality.
Over the course of this study, different issues seemed paramount as the participants presented themselves in different ways. This experience was painful for me at times because the outer concentric layers of their challenges as they portrayed them were often obscure, difficult for me to understand. Upon reflection, it seemed to me that through the multiple layers of each person’s life she was sharing only pieces at a time until she could trust me to tell me a more complete story. I was pleased to discover that as our time together progressed, we circled closer to each mother’s actual story. I became aware of this through collaboration with the program social workers, case managers and program coordinator.

Although Rhea seemed strong enough to trust almost immediately, this almost immediate trust appeared to be more of a facade that she placed between herself and me, maybe as a means of protection. She did not know me and could not trust that I was safe until proven so.

In time, however, Rhea did use the music therapy session to talk about relationships in her life. She spoke of agreements made with her mother. She had difficulty with trust related to the male figures in her life. Apparently, her ability to trust men was damaged when her father deserted the family. In the beginning she did not share her own feelings of guilt over her father’s abandonment of the family. Later she revealed that she thought she was the cause of her father leaving and carried that burden alone until she shared this in music therapy. She was about five years old at the time. In general, this is the age of fantasy and
focus on the self. Therefore, as most five-year-olds would have, she believed that it was her fault that her father left the family. Rhea seemed to compensate for this loss in her early childhood by having a great need to be accepted and loved by a man in adulthood. Rhea stated that she believed it is easier to trust women. I believe this is because her mother had been a constant figure in her life.

In the earliest sessions with Dee and Angel, Dee appeared resistant to the therapy itself. When we were into about the fourth session, and Angel was taken from her after her relapse, she finally opened up to me emotionally. She sought my assistance as she was preparing to go to court to reclaim custody of Angel. Initially, it seemed that her feelings toward me were not genuine, because she seemed to be using me to write a letter on her behalf. After that episode, however, she attended every session that was agreed upon while Angel was in foster care. During these sessions, she slowly began to share with me incidents from her traumatic history. The following is an excerpt from a transcript when Dee was concerned about losing Angel to foster care:

Dee: I went from foster home to foster home from the time I was three. I did not know my own father. I thought one of my foster fathers was my natural father and I thought I loved him but he abused me. I do not want the same thing to happen to Angel. He is the only child I have been able to keep so far... (Transcript VII of XI)

Dee had not been able before this to admit that she had other children she could not care for and that she was fearful of having her infant taken away from her if people knew her story. Over a brief period of just two sessions, Dee told most of her childhood history that brought her to the point she was at when we first met.
It took Mona a long time to begin to trust within the sessions. She wanted everything for her son, but her self-esteem appeared shattered from her abusive past. I found that trust of adults, peers and authorities was the most challenging issue for her. Yet, she was able to confide in me regarding Rafael’s development. When she was able to trust me she gave her history as she remembered it. Often she would tell me that, because of the severity of the beatings she had experienced, she could not remember some details of her past. Apparently, she must have had head trauma and some long-term memory loss – or possibly the abuse was so severe that psychologically and emotionally her mind was still repressing those portions of the memories she was not yet strong enough to process. Her son, Rafael, and the music gave her a focal point so that she could then slip in pieces of her past and her concerns for her own and her son’s future without feeling that she was the center of attention. She needed that sense of partial seclusion to feel safe enough to share these painful fears and recollections:

Mona: I thought I had hurt Rafael by my actions – you know, using. He was so little and I did not want to mess up his brain. Do you think he is smart? He likes music.

Mona was guilt ridden by her use of cocaine and fearful of the possibility of having injured or debilitated her son, as well as fearful of being deported due to her immigrant status. All of these issues played into her diminished self-esteem.
The Bridge of Trust: Process and a Developing Dyadic Model

The trust in me as therapist that evolved from each mother over the course of the music therapy sessions indicated that the sessions were helping not just the infant, and the relationship between the mother and child, they were also helping the mothers renew their sense of trust and their ability or strength to face the painful stories that are part of their past.

The inspiration for “The Bridge of Trust” came from the infants and children I have worked with in the past and the dyads in this study. It seemed that I had a developmental process as a frame of reference that I used in my work. This study helped me to analyze the process that I saw unfolding with the dyads, give it a metaphorical name, and helped me to visually see it. Thus, “the bridge,” an arch, came to be. The following is a diagram that visually represents the process of building trust in a therapeutic relationship and the arch that it forms to assist individuals to bridge across development and growth and establish therapeutic alliances.
Figure 1 – The Bridge of Trust

THE BRIDGE OF TRUST

Phase I  Phase II  Phase III  Phase IV  Phase V
Building Developing Exploration Developmental Integration of Rapport Connection Process Knowledge
Rapport Through the Nurturing Environment

The initial phase, building rapport through the nurturing environment involves the therapist understanding the reason for the client's being in therapy. In the setting in which the present study took place, usually the mothers and infants are referred due to a crisis in the interactional pattern of mother or infant. For example, a dyad may be referred because the mother is having post-partum depression and the baby is at risk for injury or maybe showing signs of infant depression, or the baby is severely colicky and the mother is experiencing sleep deprivation or high anxiety to the point of hurting her infant. Other reasons for referral include the court system mandating mothers and infants have assistance via a therapeutic approach/medium. Mothers are threatened that their infants will be placed in foster care if their parenting does not improve. This sets up a judgment that the parenting by these mothers is bad. The signs of difficulty are observed and assessed by professionals before an infant is removed from the
home. Social service agencies prefer being involved with a family so that the infant is kept within the family unit rather than placing the infant in foster care (Surbeck, 2000). Also, in populations in which mothers are addicts, a mother and infant are often referred because the mother has relapsed. The mother is usually mandated to attend all programming that might assist in refraining from abusing substances.

The second phase is that of *developing connection* where rapport has been established and trust begins to form. This is a phase that may take a long time in a population similar to the one in this study due to the traumatic injuries the mothers have experienced. However the consistency of the therapist is important. It is through this consistency that the therapist can build rapport. The sequence of development begins by creating a safe place. That is the fundamental premise to the work. The therapist works to nurture the mother so that she can nurture herself and her infant through the environment. Once the feeling of safety is established, connection is fostered, rapport continues to strengthen and trust evolves.

Phase three is that of *exploration*. The mother and infant use the environment to explore the instruments, the music and each other. Within this exploration the mothers learn to play with their infants if they do not know how, or if they have not freed themselves to be playful. It is an interactive, sensory, space where mother, infant and therapist can communicate. Within the communication the mother shares her history and gives pertinent information
regarding her infant. Through exploration a developmental process occurs where
the mother learns about herself, sharing information as she wishes with the
therapist, and the baby is exposed to various experiences, thus enhancing his/her
development.

In phase four the developmental process continues as the mother increases
her awareness of herself and learns about her infant. It is through the interactions
they have within the music and with the therapist that learning happens. Mother
and baby gain knowledge, learn new interactional patterns, are exposed to new
experiences, learn coping skills, and practice healthy patterns in relating. This
promotes further development.

Phase five is when integration of knowledge occurs. It is a time in which
the mothers may resolve a personal conflict or experience resolution within their
family unit. This increases binding and attunement with self, infant and family.
The ultimate goals in working with mothers and infant are: connection to self,
connection to infant, connection to family, connection to community and
connection to culture. It is in the fifth phase that integration, binding and
attunement assist in making all these connections. Ultimately the mother will be
connected to the whole, while the infant is connected to mother, and through her
to self, to family, to community, to culture and interconnected to the whole. The
infant cannot exist separate from the mother or a mother figure. The mother is
that infant's self, and ego development begins there. This bridge is consonant
with Winnicott's (1986b) theory of holding, Stern's (1995) theory of affective

Metathemes

The meta-analysis of this study provided an understanding that was deeper than the initial thematic analysis. Metathemes may serve to bridge the gap between the themes of participants and broader professional and social issues. They also provide a means of reflecting on the research process itself (Ely et al., 1997, p.151). Through my roles as therapist and researcher and the actual framework of the therapeutic process undertaken in this study, I learned much from working with these dyads. These layers of understanding will unfold in the presentation of metathemes in the following sections.

Therapeutic Insights

Metatheme One: In the dyadic music therapy process there was a braiding between babies and mothers so that the babies’ appearance and behavior gave insights to possible issues that needed facing by the mothers.

Babies are emotional beings right from birth. Research has shown that babies respond to emotional expressions, like a big smile on your face, within the first few weeks of life (Cicchetti & Cohen, 1996; Fox & Gelles, 1984). Many researchers now think that within three months babies can react to and express five "basic" emotions: joy, interest, anger, sadness, and disgust (Fischer & Als, 2004; Als & Mcanulty, 2000). The emotion of fear is also considered one of the
emotions basic to all children and begins to show up at around 7 to 8 months (Lewis, et al., 2000).

Most contemporary researchers think babies are born with these emotional abilities to help them form strong bonds with their caregivers, thus helping them survive. It was not long ago that an infant’s smile was considered relatively meaningless. Research has also shown that infants are expressive beings and do express themselves within a relationship. Although their emotions are not fully developed, infants are already beginning to show hints of an emotional life (Izzard, Fantauzzo, Castle, Haynes, Rayias & Putnam, 1995).

In the beginning of the music therapy program, all three babies were concerned about their mothers’ whereabouts. They watched their mothers with unblinking focus. The emotional states that they reflected varied.

Sometimes I observed sadness:

Mona arrived to a session appearing worried. Rafael had a sullen look on his face. Mona had heard some bad news about one of her friends in the program. Rafael hung onto his mother as both mother and baby looked sad. When Mona attempted to put him down he began to cry. (Session III)

On occasions, I observed separation anxiety:

Dee appeared very tired. She went into the nursery to get something to drink. I sensed that Angel needed to keep his mother in sight, and while she was gone I sang about mother going to get a drink and sang “Mama” several times until she returned. He appeared like a statue of an infant frozen in time waiting for his mother. (Session VIII)
And at other times I observed joy:

Rhea and Matthew were beaming with joy during this particular session. Rhea had decided to go back to school to get her GED and her goal was to open a day-care for unwed mothers. Matthew was especially bouncy and joyous, responding, apparently, to his mother's happiness. (Session X)

In addition, when they were having family problems, before the family issue was expressed to their social worker, the mothers often talked to me about their troubles. It appeared that the music supported their ability to feel safe enough to confide in me:

The background music I call doodling gave Mona the opportunity to express some of the feelings she was going through while she was holding Rafael. Mona stated: "My husband is a good man, he loves Rafael, but he drinks. When he drinks he becomes a person I do not know. I am afraid." Mona focused on the piano, not making eye contact but saying what she needed to say in a quiet, sullen voice. (Session VII)

At times the mothers expressed feelings that were directly related to their initial traumas. They told me their histories in more detail as they felt safe in the music therapy experience. When I checked with the social workers, they would only know some of the mother's stories but not all, and especially not that the mothers blamed themselves for the abuse they had endured as children. Rhea's depth of trauma was expressed during one of Matthew's drum-playing sessions:

My new boyfriend treats Matthew like his own. I want him to be connected to a man because my father is not around. It is my fault that my father left. I was a rotten kid and he could not stand it any more. (Session X)

In the previous chapter I have already described how Angel, who was initially vibrant, seemed to become depressed. In a clinical note following a session I wrote:
Angel was very quiet. In the first two sessions he was babbling and cooing. He looked a little gray, had a bump on his forehead that was a greenish purple color. When I took his shoes and socks off later in the session to play the drum, his feet looked wrinkled and dry with red splotches on them. When I held his hands to reach the piano I noticed that they were wrinkled and dry as well. He looked like a little old man. I was concerned that he was dehydrated... Most of all, he appeared so sad...(Session IV)

Angel needed his mother; he was too young to become healthily autonomous and unable to be independent of his mother (Klien, 1932; Mahler, 1969; Winnicot, 1949, 1964, 1971).

Dee stated during a session after Angel was returned to her care:

I never want to abuse my child the way that I was abused. I never wanted to use corporal punishment. I want my child to grow up safe and without fear.

The babies were mirrors to the mothers and they reflected the anger, depression, denial, fear and sadness. The infants physically manifested the mothers’ experience. When a mother relapsed it was first noted not in the urine specimen but in the infant’s emotional or physical health a month or so before the relapse. They also empowered the mothers in many ways as they reflected joyful, excited and happy emotions that at times helped the mother to lift from a more depressed emotion (Beebe, 1986, Downey & Coyne, 1990).

Value of the Dyadic Model

Metatheme Two: The overall research process illustrates the values of working with mother-infant dyads within a developmental framework.
Several researchers have developed systems approaches to working with dyads (Bell & Ainsworth, 1972; Clarke-Stewart, 1973; Bateson, 1979; Beebe 1982; Beebe, Jaffe, Feldstein, Mays, & Alson, 1985; Bernier & Rosenthal, 1991; Papousek & Papousek, 1989). The most recent writings on this topic were done by Beebe and Lachmann (2002). They used infant research as a new port of entry into psychoanalysis, not from the couch, not from pathology, but through their own eyes in ingenious studies of normal babies and what they did when relating to their mother. Lachmann developed a picture of early development that was radically different from the psychoanalytic view. Both Beebe and Lachmann were impressed by the role that dyadic interaction played in the early organization of experience. The infants they studied were involved in reciprocal, split-second, mutually adjusting systems with their caregivers. At the same time, the infants had capacities to regulate their own states.

In developmental research, despite the increasing emphasis on systems views, more attention was given to the influence of the parent than to the influence of the child. Not until the early 1970's did infant research begin actively to endorse a fully bi-directional view of each partner's contribution to the organization of the dyad (Ainsworth & Bell, 1971, 1972; Lewis, Alessandri, & Sullivan, 1990; Lewis, 2000). In developmental psychology, three interacting units constitute the system: the parent as a self-organizing, self-regulating unit; the child as a self-organizing, self-regulating unit, and the parent-child dyad as an interactive field with a unique organization of its own. None of these three units
can be fully described without reference to the other two. (Beebe & Lachmann, 2002, pp. 21-22, 25)

In the present study, Rhea and Matthew developed together within the process of therapy as Rhea appeared to evolve from using Matthew as a toy, puppet, or performer to realizing that her son was his own person and she could allow him to initiate on his own. His emerging independence is documented in chapter V in Rhea and Matthew’s musical journey. Matthew, during the last music therapy sessions, no longer took his mother’s lead but actually initiated independently by choosing the instrument he wanted to play rather than the one that his mother was handing him (p. 86).

Dee went through many stages in regards to the dyadic work. Initially she was upset about being in therapy and wanted me to work with Angel while she sat off to the side. As I coaxed her to join us in the process she did so reluctantly. After Angel was taken from her by social services, however, she returned to music therapy on her own. This was the turning point for Dee in her development towards dyadic music therapy with her son. She later relished playing with and being with Angel and saw the development of him as a person. This development stands out most clearly between the ninth to the eleventh sessions (pp. 106-109).

Rafael and Mona’s need for each other was paramount. Rafael provided Mona with the ability to share herself authentically because she was genuine when she related to Rafael. Rafael’s ability to doodle within the music gave Mona the space to share herself, while also providing her the safety of being able
to focus on Rafael. An example of this is documented in Chapter IV under “Musical Doodling” (p. 64), and Chapter V under “River of Melody and Babbling Brook” (p. 123) and “I’m OK, its Ok, The Piano” (p. 124).

The “Musical Womb” Technique

Working with dyads using the technique of the “musical womb” appeared, in the course of this study, to be very effective. The drum was often the center of a baby’s attention. For example, on one occasion Matthew crawled quickly into the large frame drum. He patted his lap as he bounced saying “Mama, Mama, Mama.” Rhea followed him, getting down on her hands and knees and saying “Matthew, what are you doing?” Matthew was grinning and bouncing. A song emerged while Rhea played with Matthew in the drum.

Angel was seated next to the drum. He allowed himself to drop over on his side so that he was lying parallel to the drum then he rolled himself over to face the drum. Dee and I watched as he was maneuvering himself closer and closer to the drum. At this point I picked up the guitar to sing about him rolling while Dee kneeled behind the drum and looked over the drum at Angel. Dee was taking cues from Angel, who realized that he wanted to get into the drum. She began to pat the drumhead in rhythm to my guitar playing and singing:

Rebecca: (Singing)
Angel is rolling, rolling, rolling,
Angel is rolling, rolling to the drum.

Dee: (Looking intently at Angel and patting the drum) Saying:
“Ven hijo ven.” “Come son come.”
Angel: (Had the look of determination on his face as he rolled)

Rafael crawled like wild fire from the guitar and over small rhythm instruments to the bass drum. He stood up by holding onto its side. Mona quickly ran over to stabilize the drum so that he did not topple over as it rolled. He stood there hanging on, put one leg in, turned himself around like an acrobat and turned himself into the drum. At first bending over, and then sliding his bottom on the head and sitting. He made such a noise that it sounded like thunder. Mona in her cautious, protective manner, apologized for his abrupt behavior. I helped her realize that it was another opportunity for play and the creation of yet another song – the thunder song.

Hesser (1995), wrote about the process of music therapy saying:

Clinical improvisation, one of many approaches to using music in therapy, is here-and-now experience where the music of the session is improvised based on the person or persons present in the session. Each individual and group will respond to this task differently. Many percussive and melodic instruments from around the world are made available to the clients and can be played successfully without previous training. These instruments tap the innate potential of all people to make and respond to music. Singing and sounding, instrument playing, dancing and moving are all interwoven into the unique expression of the group. (p. 47)

The babies led the mothers into musical improvisation within a contained space. It was the babies’ use of the percussive instrument, the drum, which provided the creative, playful, self-discovery and relatedness for the infant and his mother. It is in this invitation to play that the infants discovered themselves and what they can do. Winnicott (1971) stated, “it is in playing and only in playing that the individual child or adult is able to be creative and to use the whole
personality, and it is only in being creative that the individual discovers the self” (p. 54).

Kenny (1989) in *The Field of Play* talks about musical space:

The musical space is a contained space. It is an intimate and private field created in the relationship between therapist and client. It is a sacred space, a safe space, which becomes identified as “home base,” a territory that is well known and secure. In early childhood development, it is similar to the space created between mother and child. Trauma necessitates the recovery of such a space for growth and change. It is a time when a person must reorganize and reintegrate him/herself, after trauma, a break in natural and healthy development. Initial entry into this space is gained when participants are motivated to make the first sound, a creative gesture, a risk, a self-motivated action from an intention to engage. In a sense, the space is “sealed off” or contained, when both participants have joined each other in these first sounds. They get to know each other in the territory. In this field of musical being and acting, the emerging process of delicate new beginnings in development is enacted in musical form. (p. 79)

Using the musical womb strategy supports and implements the theoretical concept of working with dyads. Systems theory looks at relationships as reciprocal, split-second and mutually adjusting systems. These symbiotic, rhythmically synchronized, interactional experiences with the caregiver give the infant the basis for security in his person and the ability to self-regulate (Beebe, 2002, p. 25). It is this premise that seemed to be very productive in my work with mothers and infants. The drum provided the environment for the interaction to occur, and the womb-like environment fostered security for the dyads.

The findings on the musical womb technique in this study are analogous to Austin’s (2003) work with “vocal holding,” described earlier in Chapter II.
Her work resonates with mother-infant dyadic work in part because of the vocal play that is encouraged. In personal conversations with Austin (2001-2003) she and I often spoke of the similarities in working with adults traumatized as children and working with mother-infant dyads. The need for creating a secure environment where clients feel safe is primary. Thus they can be re-born in the musical experience. For Austin, the process occurs through her vocal holding technique. For the mother-infant dyads in this study it occurred through the “musical womb” technique.

**Issues around Effective Therapy**

Metatheme Three: For therapy to be effective over the long-term it must be entered into willingly and continued as long as it appears needed.

As mentioned in Chapter V, two of the three participant mothers were either strongly advised or mandated to attend music therapy. Rhea’s mother had sought out a parenting class for Rhea. Rhea attended the rehabilitation program after being threatened by her mother that she and her baby would become homeless if she did not, and this program included parenting classes for young mothers.

Dee, at Angel’s birth, was told that she had to attend the program for addicted women and that she had to begin upon discharge from the hospital. Angel was two days old when she began the program. I met her and Angel two and a half months later. Upon meeting her, it was clear that she was very angry that she had to attend yet another program. Later, when Dee went to court, the
judge mandated her to attend music therapy or not receive Angel back. At this point, however, she and I had made connection and her attitude towards the therapy had changed. After the second mandate she was more consistent and seemed to be a willing participant.

Once Mona learned of the music therapy component offered by the program she asked specifically to attend. She initially began with the group for families involved in domestic violence and later began the program for addicted women and families. Although I met her early on, she actually did not start the music therapy program until Rafael was nine months old. However, she was the one participant who requested to be a part of the program.

As mentioned above, the two mothers who were mandated to attend music therapy or suffer the loss of their infants were the ones who had the most difficult time in the therapeutic process. The earliest indications of the need for long-term therapy were evident within the first few sessions, as the mother’s expressed themselves non-verbally by their actions and/or avoidance of the therapy. These two mothers entered the therapeutic process with resistance and unwillingness. The following are two post-session notes of my observations of the mothers as they entered the therapeutic environment.

Dee arrived into the therapy room, plopped Angel in his car seat in the middle of the carpet and heavily walked over to the couch approximately five yards from where she left Angel. She sat on the couch, crossed her arms, threw her left leg over her right knee and proceeded to swing her leg in a fidgeting motion. Dee appeared defiant, angry, closed and unwilling to enter a relationship with her son or me. (Session I of XII)
Rhea bounced in, singing, playing with Matthew, not making eye contact, completely focused on Matthew as if to avoid any connection with me as a therapist (sessions I, II, III, IV & V of XII). This behavior continued for five subsequent sessions.

The mothers had a difficult time making connection with the therapist. It took several weeks, almost half of the music therapy sessions in this study, before any progress was noted. The issues that caused the problem with connecting therapeutically were multi-layered. However, a longer investment in the therapeutic relationship, as well as a different approach to enrolling the mothers in the program may have assisted the mothers as they developed personally along with their infants.

Researchers who are studying the effects of enrolling and retaining clients in a drug abuse program have stated the importance of long-term supportive therapy within an interdisciplinary team environment (Dakof, Quille, Tejeda, Alberga, Bandstra, & Szapocznik, 2003; Grella & Greenwell, 2004). It is said that for every year a person is ill it takes one month to heal (Anderson, 1998; Rector-Page, 1992). Maybe this healing includes emotional healing as well as physical healing. For the youngest participant, Rhea, a year might have been fine if the support services were consistent once she completed the program. Dee, however, who was abandoned at three years of age and who at that age was already being sexually abused, may have needed to be in an intense, supportive program for two years or more. It is hard to speculate what might have changed the course of history for these two mothers and their infants in this study. However, the outcome does indicate the need for strong early intervention
programs, not only for the infants but for the whole family (Baxter, Butler, Brinker, Frazier, & Wedgeworth 1995), as well as consistent long-term therapy. As mentioned in the review of related literature, very few longitudinal studies address cognitive and social-interactive development of drug-exposed infants. Even fewer have been conducted for mother-infant dyads (Bandstra, Vogel, Morrow, Xue & Anthony, 2004). One reason cited for the lack of investigation is the chaotic, transient lives of these mothers. Unless there is a connection with staff within a program and support within the community to provide long-term solutions, these mothers may well continue to end up in the judicial system (Chasnoff, Griffith, Freier, & Murray, 1992; Christian-Parilla, 2000; Dakof, Quille, Tejeda, Alberga, Bandstra & Szapocznik, 2003; Grella & Greenwall, 2004).

Towards the end of the therapy in this study each of the mothers was showing signs of becoming a more attuned parent. Though much progress seemed to be made throughout the contracted sessions, it seems that these successes during the limited number of therapy sessions did not withstand the test of time in two of the three cases. A long-term therapeutic outcome for the mothers was not apparent, as is detailed in the postscripts at the end of the chapter on their musical journeys. The yearly check-ins with the mothers and the staff in the program helped me to see how crucial it is to have follow-up with these families and to provide long-term therapy and support.
Discussion

Playing implies trust and is an integral component of the connection between mother and infant. Even when the sessions were challenging and difficult, there was a great deal of joy manifested by the babies’ curiosity, their physical expressions of excitement and the elements of exploration in their sounds and touch. There was movement on the part of the babies from the mother to the music. Then the babies and mothers moved to a shared experience within the music. This related to a collaborative culture within the play. The babies developed from dependence to independence and then shared experiences. Winnicott (1971) stated: There is a direct development from transitional phenomena to playing, and from playing to shared playing, and from this to cultural experiences (p. 51).

Following these sessions in which pertinent information was shared I discussed the sessions with the dyad’s social worker or case manager. This created teamwork on behalf of the mothers, assisting them in receiving more services or preventing, at least for the short term, a more serious situation from occurring that could be detrimental to the mothers’ and babies’ health (Fraiberg, 1980; Baxter et al., 1995).

I also was made aware of the need for follow-up services and the need for early intervention not only for the infant but also for the mothers, fathers, and families. The old saying, “one rotten apple can ruin the barrel,” may also hold true for families plagued with abuse issues. As has been explored by other
researchers (Sameroff & Emde, 1989; Smith, Coles, Poulsen, & Cole; Reber, 1996; Shabazz, 1996; Bradbard, 2000) many families have fallen apart because of this very issue. As seen within this study, grandparents or parents of cocaine-addicted children are raising their grandchildren and some are raising their great grandchildren. The findings in this study are consistent with those documented by Young & Gardner (2002), Brook et al., (2003) & Nair et al., (2003). Studies have been done that have positive prognosis for infants who have been cocaine exposed in utero. In a few longitudinal studies the infants exposed were able to reach appropriate developmental milestones when they were involved in supportive therapy (Askin & Diehl, 2001, Azuma & Chasnoff, 1993, Griffith, 1988).

This study indicates ways in which both mother and infant searched for their "self" – "identity." The baby searches the mother for that "self" and the mother searches and sometimes looks to the infant for her "self" (Austin, 1991). The mother responded to her baby in various ways – cooing, laughing, and playing. Other times the mother was non-responsive, yet the baby kept searching and prodding her for any response – babbling, cooing, watching, and reaching. At times the mother withheld her response. All the mothers and babies were musical. Each felt a rhythmic pulse and toned melodically. They were able to be "in tune" with each other from time to time as presented in the musical vignettes. At those times, they engaged with each other and rhythmically reciprocated. The mothers did not hide feelings of fear and anger. Two out of the three appeared to
intuit the needs of their infants whereas one seemed disconnected from herself and barely connected with her infant. The physical form was "the dance" of which Stern (1989) and Winnicott (1965a) wrote. It is a physical representation of the musical form. All these characteristics were observed in the musical relationship between these mothers and infants.

The premise that music is a productive tool to use with mothers and infants was borne out in the findings of this study. Music therapy provided freedom, playfulness, expression, relating within the music and a host of other attributes that contribute to healthy human development. The non-verbal aspect also made it a compatible tool in working with mothers and their infants.
CHAPTER VII
SUMMARY, IMPLICATIONS, AND CLOSING REFLECTIONS

This chapter is divided into four sections. The first is a summary of the study. The second section is devoted to the implications for policy and practice that emerged from the findings, and the third section presents suggestions for further research. The final section is devoted to my reflections on the research process using qualitative methods.

Summary

My purpose in this study was to document the experiences of three mothers in a substance-abuse rehabilitation program and their infants as they were engaged over time in the music therapy process. Four sub-questions emerged during the course of the study: 1) how did the relations between mothers and their infants evolve over time? 2) In what ways did the mothers’ relations with the therapist change during the course of the music therapy process? 3) How did the music evolve within the process of the therapy sessions with the mothers and infants? 4) In what ways did the mothers’ history of substance abuse manifest itself?

This study was conducted within a naturalistic qualitative paradigm. The naturalistic paradigm is congruent with music therapy research because in the
course of their work music therapists look closely at the words, actions and music of the clients in the context of the therapeutic environment. The study, which developed a dyadic model of music therapy with mothers and their infants, was designed within a theoretical framework based on the work of Winnicott (1960), Stern (1995) and Rogers (1960). This theoretical foundation posits that the provision of a base of security within the mother-infant relationship is of utmost importance in supporting infants as they grow towards independence.

The study was conducted at a drug-rehabilitation program for Hispanic women and their infants in a large metropolitan city center. Three dyads of substance abusing women between the ages of 16 and 45 were seen together with their infants who ranged in age from two weeks to nine months. The research was designed to document work with the mothers and infants through a series of 12 weekly music therapy sessions. The data for the study consisted of my therapeutic notes, audio recordings and researcher’s log, which were the bases for analysis. My approach to music therapy is humanistic, psychotherapeutic and at times psychodynamically oriented.

Chapter IV is devoted to strategies and techniques that were used or emerged in the course of study. My overall approach to music therapy is improvisational. Foremost among the strategies and techniques used with the mother-infant dyads was that referred to as of the “musical womb,” which incorporates instruments and the positioning of the mother and infant. The infant or young child is encouraged to settle inside the primary instrument used for this
method—a large bass drum with bedding inside. This physical arrangement is consistent with my goal to design an overall feeling that simulates a secure and "womblike" environment. Once a baby was positioned, I asked the mother to kneel in front of the open end of the drum and encouraged her to hum, sing or speak to her baby. This created a tunnel of sound that bounced off the drumhead and enveloped the baby. I knelt next to the mother, encouraging her, or knelt on the opposite side, rocking the drum back and forth to create the rocking motion of the womb. I rhythmically matched a mother as she spoke, humming or singing while patting the head of the drum lightly, thus creating the effect of a heartbeat.

Among other techniques that proved to be effective were: river of melody, climbing the ladder to interaction, rhythmic synchronicity, rhythmic reciprocity, rhythmic holding, the musical surprise, repetition, the musical question. In climbing the ladder to interaction the element of suspense was used within the music – either using diatonic movement or chromatic movement. The movement of a semi-tone upward engaged the infant and mother and provided a hook for interaction. Although rhythmic synchronicity and rhythmic reciprocity may sound similar, they differ in that synchronicity can occur at any time without an intimate relationship, whereas reciprocity needs a mutual relationship in which both individuals involved are respectful of each other. There was much use of repetition, questioning within the melody, and interacting through the awareness of all that was occurring in the environment. Everything that was used — instruments, voice, and external noises — created integration of the interactions
between mother, infant and therapist. The improvisatory nature of the sessions provided a context within which these techniques and strategies were used as circumstances indicated.

Chapter V is dedicated to the musical journeys of each of the dyads. The three participant dyads were Rhea and Matthew, Dee and Angel and Mona and Rafael. At the beginning of the therapy sessions Rhea was 16 years old and Matthew was 9 months; Dee was 26 years old and Angel was two-and-a-half months; and Mona was 43 and Rafael was 9 months. Rhea was unmarried at the time and both Dee and Mona were married. The chapter provides insights into the mothers’ histories relevant to the study.

Each dyad is introduced in turn and the mothers’ stories are presented in the form of first-person narratives composed from interview data and the transcripts of the mothers’ accounts shared in the course of therapy sessions. Additional data are presented in various literary forms: a playlet, a three-person poem and a drama. Each dyad’s music therapy process is then presented through the musical journeys.

At the beginning of therapy the participants varied in their interactions and the building of rapport and trust. Rhea was self-assured, energetic and playful. Matthew was watchful of his mother and she was the focus of his world. Dee was angry and Angel was tenuous, appearing somewhat anxious regarding her whereabouts. Mona appeared insecure, unable to make eye contact, yet extremely attentive to Rafael. Rafael appeared happy, secure in his mother and
developmentally age appropriate. At the end of therapy each mother and infant had made dramatic changes. Rhea was calmer, allowing Matthew to be more independent; she did not have such a great need to conduct the session and was able to improvise with Matthew. Matthew became autonomous, able to let his mother know what he wanted. Dee was much more playful, her anger appeared to have diminished, she was able to “be with” Angel rather than setting herself apart from him. Angel appeared much more secure, no longer anxious regarding his mother’s whereabouts but continued to be cautious of his surroundings, bordering on fearful. Mona had developed a strong rapport with me as her and Rafael’s therapist. She was able to make eye contact, talk about difficult issues and had gained an understanding of her natural “good mothering” abilities. Rafael was a very independent, secure, curious, autonomous, one-year-old. He had always been secure in his relationship with his mother. However, there seemed to be an even deeper sense of connection through the music and his mother.

Five years after the sessions had been completed I sought final follow-up information from my contact at the center. Both Rhea and Dee had been pulled back into addiction. Rhea had married her boyfriend and had had another child, a girl, with him. At the time of the follow-up she was incarcerated and her mother was raising her two children. Her husband had visitation rights and I was informed that Matthew was doing well. Dee had a restraining order placed against her; she had been incarcerated several times for dealing and prostitution. Family members adopted all her children and Dee was mandated not to attempt to make
contact with her children. Angel remained a somber, serious child, who was intelligent but borderline depressed. Mona and Rafael had continued on a successful path. Mona was working full-time as a secretary. Her husband had finished the spousal abuse program and was reported to be a model husband and father. Rafael was in first grade and at the top of his class academically.

Chapter VI is devoted to the thematic analysis. The themes are divided into three sections: the babies’ themes, the mothers’ themes and metathemes with discussion. The babies themes were: “When I am in this place I can have fun and play with the instruments as much as I want to” and “We have come here several times, and my mother seems more happy now to let me explore on my own.” The mothers’ themes were: “I’ve learned to present myself differently in different situations,” and “As the weeks went by I began to trust Rebecca and used music therapy time to talk about my personal problems while my baby played on his own.”

There were three metathemes that presented aspects of the data that appeared to have larger professional and social ramifications. Metatheme One stated: In the dyadic music therapy process there was a braiding between babies and mothers so that the babies’ appearance and behavior gave insights to possible issues that needed facing by the mothers. Metatheme Two: The overall research processes illustrate the values of working with mother-infant dyads within a developmental framework. Metatheme Three: For therapy to be effective over the long-term it must be entered into willingly and continued as long as it appears
needed. Although there were only three dyads, the findings were consistent with those of other related research. The themes and metathemes highlight that the babies moved from insecurity and minimal interaction to security, independence and autonomy. They developed in a healthy fashion according to developmental guidelines. One exception to the developmental pattern was Angel, whose demeanor, described as “borderline depressed,” appeared to reflect his mother’s return to substance abuse. These findings are consistent with those of Austin (2003), Cicchetti & Cohen (1996), and Chasnoff, et al. (1990, 1992). The fact that over time two of the three mothers were drawn back into a life of substance abuse is consistent with the statistics on recidivism of Dakof, et al. (2003).

Implications for Policy and Practice

The findings reported in this study are based on work in a naturalistic setting with three mother-infant dyads in music therapy. It is not my intentions to attempt to draw generalizations, but rather to present a mirror within which other professionals may view their own work and consider the implications of these findings for policy and practice in the following two areas: work in music therapy and work with persons who are abusing substances.

Implications for Music Therapy

In developmental research, despite the increasing emphasis on systems views, more attention has been given to the influence of the parent than to the
influence of the child (Beebe & Lachmann, 2002, p. 25). Winnicott (1949, 1960) looked at the mothers and infants as one unit within the first year. He also, however, separated the two as their relationships evolved over time. Although this dyadic view of mother-infant work began with Winnicott and his colleagues, in general, throughout the research community, the mother and the infant remained two separate entities within the clinical process.

Working with substance abusing mothers and their infants in a dyadic model appears to be particularly useful in the following three areas: the growth of relatedness between mother and infant, natural infant development, and the mother's personal growth and development of ego strength.

The work described in this study supports the perspective that a mother and infant are one within the first nine months of life. They are a unit within which each person is constantly influencing the other, even when separate from one another, and appear to be energetically connected. This influence seems to continue on throughout several phases of development. This finding is consistent with several recent studies and supports the recommendation that dyadic work be considered more commonly as a productive therapeutic approach.

As stated in Chapter II (p. 25), Austin (2003) listed nine points that address techniques as interventions in the clinical process. These points are reflected in mother-infant music therapy work. Based on the present study the need to establish rapport, develop connection, explore, be aware of the developmental process and how it moves forward within the therapeutic process
and the ability to integrate the knowledge is consonant with Austin's nine points. The similarities are reflective of the development of the therapeutic relationship to assist individuals in reaching their maximum potential, whatever that might be.

Another age group of individuals who can benefit from this type of work includes older children with physical, medical and emotional illnesses. In addition, although the work would probably not be dyadic, it would be consistent with the theoretical framework of the present study to work with individuals who have been emotionally injured as children and return in therapy sessions to their childhood to address those early traumatic experiences. Some of these adults may be in their later years and others may be younger.

The Musical Womb

Before any work can begin there must be a place to provide it. This place needs to be safe where the mother and infant feel cared for and not threatened. Based on past experiences working in hospitals where the environment was filled with lights, machinery and cold white walls, I find that the environment for therapy is as essential as the therapy itself. In Chapter IV, Music Therapy Techniques, I described this environment in the technique I refer to as the “musical womb” in which I use a drum to re-create a womb-like environment. Also, in the Method Chapter, I explained the need for setting up the room in a circular fashion with the instruments creating a nest within which the mother and infant could interact. The findings relating to the success of this technique
indicates that it, and such related techniques as Austin’s (2003) vocal holding, might prove effective in a variety of settings when working with dyads. I have also used variations on techniques in which special attention is given to setting up a nurturing environment for different ages, including geriatric patients, who appeared to be having difficulties with developmental issues traced back to infancy and early childhood.

Effective Therapy for Mothers

Working with mothers and infants is a hopeful type of work. It is important to work at the beginning before ingrained, unhealthy patterns persist in the mother-infant relationship. Ideally it would be best to work with adolescents, girls and boys, prior to their becoming sexually active or with couples who are thinking about having a family.

As a child, each mother in this study had been abused and/or lacked healthy mother-role models. None had been educated in child development and parenting skills. Their communications appeared raw and reactive. Thus it would seem important for a mother to have her own personal therapy session while engaging in music therapy with her infant. This would allow her to focus on her relations with her child in music therapy rather than her own personal needs.

Rogers (1995) wrote about the dilemmas in therapeutic practice, stating that many music therapists are working with abused clients without knowing it. The personality traits of the women in this study clearly identified these women
as abused emotionally, sexually and physically. Two out of the three informed me of their histories of abuse while the third who experienced abandonment was dealing with aggression and conflict in the family unit. Historical data is essential when working with children and adults who have been abused. Yet, although this is crucial for practice, depending on the age of the child or adult’s abuse and the relationship to the abuser, this history may not be easily attained. Knowledge and evidence of the abuse may be repressed, unconscious or unrecognized, both by the client as well as the clinicians in their care (Furniss, 1991; Rogers, 1992). The abuse may be locked in the pre-verbal consciousness and is manifested in psychological impairment and distress: eating disorders, drug and alcohol abuse, depression, poor self esteem, social isolation, mistrust, helplessness, difficulties in forming relationships, and guilt (Rogers, 1995). All of these aspects indicate the probable need for long-term personal therapy for mothers in addition to dyadic music therapy.

Further Development of Education for Music Therapists

Improvisational Models

The improvisatory nature of working with mothers and infants is extremely important to address. A seasoned music therapist, if continuing to learn and grow as a clinician, needs to be able to improvise in order to be truly client-centered. Nordoff and Robbins (1971) initiated this approach in their work with handicapped children. The philosophy of the Nordoff-Robbins approach is that in
every person there is a music child. The core of every person is healthy and whole. When an individual is able to reach this healthy core through creative expression it provides a forum for re-creation of the ego. Many music therapists in practice over the past thirty years have been influenced by the Nordoff-Robbins philosophy.

If a therapist is going to be prepared to work in an improvisatory style, maintaining the client as the center of that freedom, the therapist will need to work very spontaneously. This seems to imply that in the education of music therapists attention be given to advanced work. Classes and workshops on improvisational models are offered in a number of institutions. However, more education programs are needed to explore various approaches. In addition, it seems that more work with dyads in the education of music therapists could well lead to the development of additional strategies and techniques of the type of techniques that this document addresses (Pavlicevic, 2000; Aigen, 1998; Forinash, 1993; Bruscia, 1987b; Nordoff & Robbins, 1971, 1977).

Working within a Team Approach

Music therapists, being client-centered and addressing the non-verbal expression of emotion as well as assisting in the development of person and ego, would appear to be important members of a therapeutic team. In the therapeutic situation, in general, a heightened awareness of the contribution music therapists can make to a team is needed. In addition, there is a need for music therapists to
communicate with therapists in other fields and other helping professions. Working in isolation is detrimental to all of our disciplines. It is better to have a broader picture that includes a variety of perspectives to implement a more holistic approach to treatment (Amir, 1996). In the course of the present research project, I met regularly with a staff member at the site to our mutual advantage.

I have worked in teams of therapists and medical professionals for most of my twenty-three-year career. Even when working in private practice I develop a team of professionals with whom I collaborate regarding the patient/client I am serving. These professionals are there because usually by the time a person is referred they are in a system that is requesting music therapy services. Within that system there are professionals working with the referred person. I take the time to connect with these individuals to gain a better understanding of how I can help the person. I would encourage music therapists to build teams in order to learn as therapists and to better serve the populations with which they work. As noted within this study, I was aware of submerged emotional issues that led to a relapse that a mother was experiencing before it was evident in the urine sample. For reasons such as this it is important to have teams of professionals to address issues before they further traumatize or injure the individuals who are receiving services.

Often an individual is referred to music therapy when that client is difficult to reach or appears at a standstill in the therapeutic process. The non-verbal nature of music therapy provides a very different approach where emotions
can be expressed without words then processed verbally if needed. Music therapy is a growing field, and it is important to provide learning experiences regarding professional ways in which a music therapist can share pertinent client information in a concise manner within a therapeutic team. It is of utmost importance to present the clients as whole individuals. The therapist can help the team to see a different perspective through music therapy. This form of education might best be provided in an experiential context, such as a mentoring or intern situation (Austin and Dvorkin, 2001b; Forinash, 2001, Aigen, 2003).

**Implications for Working with Mothers Who Abuse Substances**

The life stories provided by the mothers who participated in this study indicate that the needs of each mother and her family must be assessed individually with every effort made to access appropriate support services to address identified needs. This was, in fact, implemented at the center where this study took place. Appropriate referral to parenting-education classes can be one of the considerations. Although progress in appropriate parenting will be difficult for the active drug user, programs that have incorporated goals for improved parenting into the recovery process have been useful in strengthening family functioning (Chasnoff et al., 1992; VanBremen & Chasnoff, 1994). Service providers who facilitate access to a wide range of family supports can be instrumental in enabling parents with a history of drug abuse to both diminish their drug use and to effectively nurture and provide for their children.
A 1962 Supreme Court decision unequivocally defined chemical dependence as an illness rather than willful misconduct or criminal behavior (Robinson v. California, 1962). However, moralistic and punitive attitudes toward women abusers have resulted in policies that stress punishment rather than treatment. As a result, the criminal justice system and child protective services have become the major, overworked channels for dealing with families affected by substance abuse. Foster care and other out-of-home placements, especially for very young children, have increased dramatically (Goerge, Wulczyn, & Harden, 1994; DHHS, 1992), while funding for mental health services, treatment, and preventive measures continues to decline. For this reason, it is essential to develop programs that can provide appropriate intervention for young children and their mothers. Knis (2003), an occupational therapist, studied a long-term rehabilitation program with a parenting component for parents who were substance dependent. She observed the need for longer term parenting courses because short-term drug programs in which she had worked were geared towards the individuals and their drug problems. Family responsibilities were often seen as a secondary treatment issue and a distraction to the person’s initial stages of recovery (p. 2). Knis stated that there is a need for consistency in the programming as well as in helping parents learn how to communicate with their children during play and in other situations. The findings of Knis (2003, 2004) and of the present study are consistent with research data that support the benefits in early intervention using music as a primary modality due to its non-verbal
qualities and the aspect of play within the therapeutic environment (Grella &

It was clear from my study in general (See pp. 163-169) that there is a
need for this population, in particular, that the therapy to be long-term, be part of
a comprehensive substance abuse rehabilitation program that addresses the whole
person, and that it have consistent follow-up. These implications are consistent
with other studies in this field. Massachusetts, (1997), Messinger, (2004), and the
National Institute on Drug Abuse, (2000), all advocate for family-friendly
treatment programs to reduce recidivism and assist families to establish support
networks.

Integrating Music Therapy into Treatment Programs

Currently some treatment programs with individuals who suffer from
substance abuse do have music therapists working within them (AMTA Source
Book, 2004). However, the music therapy component is the first to be cut when
budgets are revised and funding is not available. In a few states there are
alternative funding sources that support music and other arts therapy professions
(Simpson & Burns, 2004). Implications in the above sections for music therapy
and for working with mothers who abuse substances are similar, as it seems that
they are interconnected with education and funding. As mentioned earlier (pp.
179-183), music therapists can become an advocate for their clients and also for
their own profession within a treatment team. This can strengthen integration of
music therapy in treatment programs. Individuals who seek further education and who become activists for the field often find ways in which to fund new and existing programs in order to service the needs of the population with which they are working (Simpson & Burns, 2004).

Suggestions for Further Research

More studies working with dyads in a variety of situations and contexts are needed. These include working with fathers, grandparents, and other significant caregivers. As well, it seems important to do dyadic music therapy work so as to learn more regarding our clients' ability to self-regulate their emotional states in order to live balanced, productive lives. Research on work that involves other disciplines collaborating with music therapists in various settings – neonatal intensive care units, home care, through agencies and shelters – can also assist in developing stronger networks, teams and support systems for the professionals working with dyads (Young & Gardner, 2002; Fischer & Als, 2004).

Music therapy research is being done in rehabilitation programs for individuals with neurological impairment (Tomaino, 2002). However, in the area of substance abuse rehabilitation, with a focus on families, there is still a paucity of research. In-depth, longitudinal studies need to be done with mother-infant dyads, parent dyads, group-work with siblings and with the family units.
Individual music therapy and psychotherapy are needed for many substance-abusing parents. Researching the benefits of parents addressing personal issues so that they can better listen to and understand their children may in time offer families more opportunities for healthy relatedness and personal gratification in their family unit (NIDA, 2002; Paton, 2001; Stern, 1995).

Often, when there are issues with a child or the parents in a family unit, siblings are either left out, end up having their own personal conflicts, and/or begin to act out in the family unit so as to be noticed. It is important to research the effects of living with a brother, sister, mother or father who has a special need or an addiction. This type of research may be done in a group format with other siblings – possibly in a support group format or within a family group. Ultimately, this type of clinical research will provide a foundation for better communication within family units, assisting family members to change their lifestyle and/or communication styles to benefit the family and provide a forum for continued growth within the family unit (Messinger et al., 2004; Erskine, 1997).

**Personal Research Interests**

There were a number of questions that have arisen in the course of my practice or during the present study that I would like to pursue further. It is important to note that infants develop preferences through their senses. They prefer the sound of their mothers’ voices, mothers’ smells and even mothers’ musical preferences. Studies have been done in which an infant could distinguish his mother’s voice within the first fifteen hours of birth and preferred it to those of
strangers (DeCasper and Fifer, 1980). One of the developmental learning aspects I noted within the work with the mothers and infants in the present study was the fact that the infants continued to prefer their mothers' voices to those of strangers (Graven, 2000). The mothers learned to use their voices whether speaking or singing (Newham, 1994). They seemed to understand that although they were critical of their own voices, stating that they were not musical, they used their voices for the sake of their infants. I encouraged each mother to use her voice, as I told her that her infant thinks that her voice is the most perfect sound he has ever heard. This understanding was crucial to the development of the mother and infant and the connections they made within the music therapy setting. I am interested in researching mothers and infants in neonatal intensive care (NICU)—specifically focusing on the mother’s and father’s connection to their infant in NICU when the situation remains very critical and the parents do not know if the infant will survive (Als & Mcanulty, 2004).

Upon closer examination, the mothers in this specific program culturally identified with music and rhythm. They did not, however, see it as a tool to communicate with their infants. The music therapy session was an avenue through which to educate the mothers in how they and their child could benefit from the musical interaction thus increasing development and opening communication. The infants and families connected to their culture through music heard in the womb. Apparently individuals who are adopted from another culture when they are babies still prefer their cultural music (Hughes, 1997). This
would require studying adopted infants or infants who will be adopted after birth. The insights that might be attained could give the adoptive family the advantage of understanding the tie to culture and encouraging the families to learn the language of the infant they are adopting in order to raise the infant bilingually and maintain that infant’s cultural ties (Surbeck, 2000; Zenker, 2000; Newham, 1998).

Currently I am working with children with cerebral palsy. An area of interest is a specific program called “Conductive Education” (CE) (Roth, 2004). The philosophy of CE originated with Dr. Andras Peto, a Hungarian physician and educator who founded CE after World War II. He realized the brains’ plasticity for adaptation and new learning. Neuroplasticity consists of the ability of the nervous system to adapt its structural organization to new situations emerging from developmental and environmental situations as well as from injuries (Baker, 2003f). CE is a multi-disciplinary system of education focusing on a child’s development within emotional, cognitive and motor function (Roth, 2004). Children with mild to severe cerebral palsy are worked with from the moment they wake up to the time they go to bed within a multi-disciplinary approach. The use of music, movement, and educational strategies lead to total independence in walking, feeding and all activities of daily living as well as vocational training later in life. The area of research that I am interested in is the ability to apply music therapy strategies and techniques within CE. Music appears to be used at all times within CE programming. My current research questions are: How can parent-child dyads be integrated into this work? What
type of music therapy profile would enhance the work? And, what music therapy strategies would most involve the children in self-actualization and self-activation? (Kozma, 2002; Darrah et al., 2004).

In my private practice I have had children with autism. Now, seven to ten years later, these children are adolescents and young adults. I have listened to frustrations of many parents regarding their inability to access appropriate services for their adolescent or young adult. These services include therapy as well as vocational training. The services through the schools begin to diminish during middle school and continue to diminish through to adulthood. Many of the families would like to have a life-giving learning environment for their older children to continue to master skills in relatedness, vocational training and activities of daily living. I would like to be involved with other professionals – specifically autism specialists, occupational therapists and biomedical practitioners – to research the needs of this growing population of adults with autism (Robarts, 1998).

The final area of interest falls into the developmental spectrum of older adulthood and geriatrics. I worked for eight years in geriatric psychiatry – six years in New York and two years in Texas. As well, I worked with older adults and geriatrics in hospice on and off for twenty years. In light of this experience I would like to research multidisciplinary team approaches within geriatric psychiatry that include family participants – such as adult children of the geriatric patient and the patient within a session.
I worked on units that were unique in that they had a broad range of complimentary staff – music therapists, art therapists, dance therapists, neuropsychologists, psychiatrists, nurses, clinical nurse specialists, social workers, occupational, physical and speech therapists as well as residents and interns. I am interested in multi-disciplinary team communication. All teams develop their own culture, some are better at communicating their view of the patient than others, all of us within a team see the patient in a different way and patients express themselves differently within each discipline. My interest is in researching and writing a book on interdisciplinary team communication for the benefit of the patient (Geisler, 2002).

Sound qualitative studies in music therapy are beginning to emerge in the literature. It seems as the profession continues to grow and mature, so too must the research in a wide spectrum of the populations in which music therapists work.

**Reflections on Method**

The naturalistic paradigm is congruent with music therapy research because music therapists are looking closely at a client’s words, actions and music within the context of the therapeutic environment. Qualitative methods are challenging because it is helpful if the researcher has some background in cultural anthropology and the meaning of a social-cultural systems. In this study I needed to understand different cultures at one time: the culture of addiction, Latin
American culture, the culture of mothers and infants in rehabilitation, as well as the social-welfare system culture. The time it took to collect the data was extensive, involving “prolonged engagement in the field” (Ely et al., 1997, p. 51). It was equally challenging to craft the narratives to tell the stories of the participants since those stories were given in Spanish and in small pieces at a time. In retrospect, I understand that the translation of the language was also an opportunity for analysis. Piecing the information together was part of the puzzle being constructed. There was a deepening of understanding that assisted me as a researcher to learn from the mothers and the infants and to honor the naturalistic paradigm. Finally, one of the great dangers within this paradigm is the possibility of “going native” (Denzin & Lincoln, 1994, p. 7) and being unable to complete the study or being compromised in the study. This is but one issue that I faced in the course of this research project.

The emergent nature of qualitative methods is best stated by Ely et al., (1997):

One of the most fascinating – and sometimes frightening – aspects of qualitative research is its emergent nature. Nowhere is this more evident than during the interwoven processes of writing and recursive analysis. Qualitative analysis requires that the researcher go back again and again over the accumulated log material in a process that for many has a cyclical feel. (p. 175)

Therapy is a process that invites a person to growth through self-knowledge and experience. It is not done in isolation. It is done through a “relationship with.” That relationship may be with “self,” but usually it involves another individual, the therapist, who serves as a facilitator, mirror. The therapeutic relationship with
mothers and infants is a special one. This relationship invites growth from the
deepest core of both mother and infant. It also invites growth from the therapist.
It is the responsibility of those who are therapists to learn from their work in order
to enhance the therapeutic process. The therapist who researches her/his own
work must become an open vessel so that understanding can come from the
research process.

As a therapist I looked back on my own practice and saw situations where
I might have been more open to the fact that the participants might be presenting
themselves in a variety of different personas. If I had been more open, or aware,
it may have assisted me in deepening the therapeutic process and being less
judgmental of the mothers.

Working as a researching therapist is a learning process, with phases
similar to those in the developing model for working with mothers and infants in
music. Moustakas (1990) talks about how a researcher intuitively and reflectively
sees in all the depictions the qualities or characteristic meanings that make the
experience what it is. It is during the “creative synthesis,” or what I call the
integration of the experience, which occurs toward the end of the research
process, that a researcher recognizes the universal nature of what the findings are
and what they mean and at the same time grows in self-understanding (p. 90).

I have been a therapist much longer than I have been a qualitative
researcher, yet both of these roles converged to create the document you are
reading. As a therapist, I deal with the ongoing concerns in the moment of the
therapeutic environment with the mothers and infants. When I examine the therapeutic interaction, I become a researcher. A therapist can function in both roles without the one interfering with the duties of the other. As therapist-researcher, I need to be honest about my motives, and give attention to therapy when functioning as therapist and to research when acting as a researcher.

Bruscia (1995) states, “qualitative research is enhanced when the researcher is the subject’s therapist or when the researcher actively engages and interacts with the subject” (p.75). Aigen (1996) questioned the timing during the research process. Can research be conducted while the client is in treatment or only after he has terminated? This study helped me to understand how the process of therapy and research are dynamic and fluid, each weaving in and out of the other and informing the therapist/researcher at all times. The time taken to tease out various roles, both personal and professional, was an important issue for me to address. By clearly defining each role, I clarified my actions and responses within the therapeutic and research relationships.

For the therapist, the keeping of detailed descriptive notes after each session is fundamental to understanding the process. These same notes may also serve as a research tool because they, together with additional log notes, become the primary source of data. The issue that is important to address is the possibility of skewing data to fit already formed assumptions.

As a result of being a therapist researching my own work, I was able to discern that I had the beginnings of a possible new model of therapy. This study
enlightened me regarding the evolution of my clinical practice and the integration of techniques, theory, and practice in music therapy with mothers and infants that culminated in the awareness that a model was evolving.

I began my career in neonatal intensive care with premature infants, with children with physical disabilities, babies and children who had been burned and were in a pediatric hospital. I have been doing dyadic work with mothers and infants when possible in pediatric critical care facilities since the early 1980s. Since then I have also worked, and continue to work, with multi-generational populations in various settings. The developmental process of studying my own work educated me to the fact that I had engrained strategies and techniques for doing therapy that had evolved from these years of practice. I had interpreted other techniques I had learned and then encapsulated and transformed these to create a technique from my persona. The result was a possible model for working with mother/infant dyads based on a theoretical understanding of the development of relationships. The process in this developing model moves from the supporting context of the "musical womb" outward, from healthy relatedness between mother and infant to an increasing sense of self for both. A major finding within this study was that music therapy with mother/infant dyads is potentially a new model and can be further developed by continuing with future practice and research.
Out of clutter, find simplicity.
From discord find harmony.
In the middle of difficulties lie opportunities.

Albert Einstein
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APPENDIX A

SAMPLE RECRUITMENT FLYER

Revised on July 8, 1997

RECRUITMENT FLYER
First Time Mothers And Infants Up To One Year

Rebecca Loveszy is a music therapist and a doctoral student who is interested in studying the specific contributions that music therapy can make to early communication and attachment in infants (0-1 year) and their mothers. She will provide 12 music therapy sessions. The following question will guide the study: How can music therapy address mother-infant communication and attachment within the first year of life in infant mental health? The research aims are to delineate how the music is used, to discover what type of music emerges in the process and address the patterns of communication between mother and infants. In documenting music therapy sessions with mothers and infants the hope is to find some answers to these questions.

WHAT IS MUSIC THERAPY?

Music therapy is the prescribed use of music and/or music activities provided by a trained professional to restore, maintain and/or improve an individual’s physical, emotional, social, cognitive and psychological well-being.

HOW DOES MUSIC THERAPY WORK?

Music therapy does not claim to cure nor prolong life in the medical sense, but rather seeks to improve the quality of an individual’s life by developing the potential that she or he has. Oftentimes, music therapy is an effective intervention for creating a trusting and non-threatening environment helpful to the individual’s personal development. The music therapist uses music as a tool to develop an individual’s cognitive, social, emotional, behavioral, physical and communicative skills. Music has inherent qualities which reflect the full range of human emotions through non-verbal means. For this reason it is an excellent tool in working with infants who are at the pre-verbal stage.

If you or anyone you know would like to participate in this study and may benefit from this service please contact Rebecca at (718) 816-7675.
APPENDIX B

SAMPLE CONSENT FOR AUDIO-TAPING

Revised on July 8, 1997

CONSENT

I __________________ agree to participate with my infant __________________
(Mother’s full name) (Infant’s full name)

in a music therapy study. I understand that I will be given 12 music therapy
sessions. I can choose to discontinue the study at anytime without losing
services since my participation is voluntary.

I understand that my infant and I will be videotaped during every session. I
agree to be videotaped with my infant as long as I participate in the study. I
also understand that I may review the tapes and request that all or any portion
of the tapes be destroyed. I have been informed that the video tapes will be
used only for research and educational purposes and that my infant and I will
be protected by confidentiality.

I have been informed that this study is being conducted as a part of Ms.
Loveszy’s doctoral work at New York University’s School of Education,
Department of Music and Performing Arts.

Rebecca Loveszy, MA, RMT
135 Corson Avenue
Staten Island, New York 10301
(718) 816-7675

Mother’s Signature

Place and Date
APPENDIX C

EXAMPLE OF VERBAL TRANSCRIPT

1. Fear etc. I will be speaking more of the cultural severing and the lack of self-esteem it causes in the mothers and in the children.

4. R: (SD) Speaking for the baby - Ay, yai, yai, yai, mami, mami, mami, mami, Yo quiero usarlo mami, mami, mami!

7. (ET) I want to use it!

8. M: (SD) Es que él lo quiere ahora en la boca y lo va a tocar luego

9. (ET) He wants it in his mouth now and he will play it later

11. R: (SD) Ah, dice - mmm - pero sabe tan bueno (Speaking for the baby)

12. (ET) Ah, he says - mmm - but it tastes so good!

14. M: (SD) Que es?

15. (ET) What is it?

17. R: (SD) Es de plastico, no es de madera.

18. (ET) It is plastic, not made out of wood.

20. Shaking the egg shaker.

22. R: (SD) Necesitamos uno de madera.

23. (ET) We need one made out of wood.

25. R: (SD) Ooh, mami

26. Mother laughing. Rebecca laughing

29. M: (SD) Eh, si a él le encanta meterse todo a la boca

30. (ET) Eh, he loves to put everything in his mouth.

32. At this point, I knew that B.'s back molars were coming in and he needed to put everything in his mouth to help him get through the teething.

35. Excerpt 11

37. This was the end of the session. Mother and I were talking about the time element and if it would be good to meet at the same time next week. I also told her of the structure of the session and the need for a good-bye song and the contract between she and I. B. was playing on the mat with the different instruments laid out. Other people were walking in because there were sessions to follow. I had to ask people to wait. I ended the session with an upbeat syncopated melody on the guitar.
APPENDIX D
EXAMPLE OF MUSIC TRANSCRIPT

Excerpt from Drumming (5/7)

Excerpt

Theme XI

Insert credentials to become clarifying.
APPENDIX E

SAMPLE ANALYTIC MEMO

1

Rebecca Loveszy: Tuesday, September 14, 1998. The ungodly hour of 2:30 AM!

Researcher's Memo: I keep thinking about the stance of my dissertation. This
section is extremely important to me because it will lay out why I chose the topic. I
chose it and why I feel it is so important to the field of music therapy. I am also
asking myself in each session I have had with the mothers and babies if I am being
trustworthy and not just fulfilling my own needs. I can take these issues into
therapy but they keep re-emerging as I do the work and especially after I met with
my doctoral support group of music therapists. I felt that I needed to begin
working on my stance so as to mold it and as I complete the clinical work and
continue to transcribe I will have much more clarity. As always, it hit me in
regards to the several layers that began many many years prior to this dissertation
topic. It seemed that I kept going further back - not only my history affected me in
choosing this dissertation topic but also my parents' history. I say parents because
they were so influential in my becoming a music therapist.

I had to ask myself - why mothers and babies at risk for normal development?
Why on earth women who abused drugs? The first was a little easier to answer but
the second really hit me when I figured it out.

The first question I was able to answer because of my clinical work in hospitals
Even before I became a mother I was always struck by the fact that babies in
neonatal intensive care were so vulnerable - they were often laying flat on their
backs with tubes and needles attached and a breathing apparatus helping them to
breathe. It is so unnatural for a baby to be in a prone position when they are
newborn. Usually babies are swaddled and kept close to their mothers so that the
babies hear the familiar voices and rhythms that they heard in the womb. I also
saw the developmental delays that many of the children had as they were growing
because the same children that were in the NICU were followed through an
outpatient clinic. Especially saw this when I was working with medically fragile
babies in a playgroup through an integrated developmental preschool. So, through
working in hospitals was where my interest began way before I was married and
had children. One of my first jobs as a music therapist was in psychiatry with
suicidal teenagers. This work was very painful for me - I had been a teenager who
would have been considered a "goody two shoes" but it was because I had so. I did
not have my wild rebellion until college - even then I could not go very far -
especially when I was practicing 5-7 hours a day. I often think back to this first
experience and wonder why these children were trying to take their lives? I always
came back to - if there was a prevention program for children and their parents
who are having a challenging time communicating and feeling connected - maybe
these teens would not want to take their lives so desperately. This manner of
thinking also presents problems because I question my motives - do I want to save
the world according my frame of reference? Maybe this will not help? Haven't
their been major problems since the beginning of time? Why will my approach to
life be the best? Now, what is my approach? Most of these questions I cannot
answer but I can answer my approach which is emerging from the data that I
collected thus far. My approach is simple and yet very difficult to achieve for
many parents because it requires abandoning pre-conceived notions and not
listening to the "experts". It requires time and patience - it is so much easier to set
up a child in a play pen with a bunch of toys and go about your business. I feel
like I am rambling - but this is really for me to be able to figure out my stance. It
always seems that with one thought and question another thought and question
begin. This is why qualitative research is so challenging. It never ends! It is so
much easier to count numbers rather than have to process not only your patients
issues but also your own. So, what is my approach? It is that of musical holding. I
hold a mother and baby while they communicate with each other. I set up
instruments and the piano so that mother and baby always have eye contact and I
have eye contact with them as well – whether we are at the piano or on the floor
with the drums rhythm instruments and guitar – that contact is maintained for the
duration of the session. Musically I follow both the mother and the baby and
weave in their melodies with the melodies that I create around them. I surround
them in a cocoon of sound, I liken it to how it must have felt to be in the womb — a
constant rhythm either vocally or through the instruments I use. Throughout the
session I am creating – whether the baby vocalizes or just stares into her mothers
eyes making faces. I am constantly following – holding and caring for both mother
and baby. Sometimes the music is suspended with anticipation and excitement,
sometimes I use a minor mode with an enthusiastic rhythm that invites celebration,
other times it is contemplative when a mother is telling me her history that led to
her abuse of drugs. At all times I am holding that mother and baby – waiting to see
if my words – if my words and tones that leads me to be a Nigerian type therapist? As I
searched to answer this it really hit me. My mother was a child performer. At age 8
she accompanied my uncle who was 7 on the National radio of Mexico. They were
on each weekend singing Mexican folk music until they were teenagers. My uncle
was a phenomenal singer and my mother a pianist. When I was five years old I
used to sit on the floor beside my mother when she would practice. I remember
enjoying watching her pedal and hearing the Chopin waltzes, Beethoven Piano
Concerto’s and the countless Mozart pieces she loved to play. I begged to learn
how to play. My connection to my mother was through the piano. I did not realize
how connected I was to her through music. The other day when I was transcribing
one of my latest sessions with a mother who has a premature son – it hit me. My
mother died when I was eleven – I remember having a hardship license to drive a
car at the age of 15 since the distances were so far in Texas – I used to faithfully
take myself to my piano lesson. Yet, I had terrible teachers until I reached
university. When my mother died I was passionate about music. Using every
opportunity to sing in school and church choirs, madrigals and taking piano and
voice. My father was too busy to take me to all of the practices so I took myself.
Now as I work with mothers and babies – I realize that music connected me and in
my sessions I am offering music to mothers to hold and mother them so as to
enable them to mother their babies. This is a really long and drawn out
explanation but their seems to be no other way to write it. I am wardy. Now, my
philosophy in regards to being a parent and a mother three times over just began
this in my practice. I am deeply attached to my children – I say deeply because I can
leave for work and they remain happy. My parenting style is that of holding and
being present to them when I am around. For this reason I am writing at 2 in the
morning instead of during the day – there is no other time for me. Since my
children were born they were always close by. I nurtured them on demand, slept
with them, carried them for the first 9 months of their lives and played with them
all day. They all love to sing and they create songs throughout the day. I do not
consider myself an expert on parenting because I see parenting as a developmental
experience – there are times when you feel like you are going to pull your hair out.
But, it seems that the family unity that I have experienced is because the rhythms
in my family are in synch. We (my husband and I) stay in contact with our
children throughout the day. Often times we stop what we are doing to hold one of
them on our laps and to give extra attention - listening fully and interacting. This
seems to keep us all in harmony. Now, not all families have this because they are
ruled by the clock and external commitments. We have intentionally set-up a
flexible schedule with work in order to achieve the balance. Why am I going into
this long and drawn out explanation. The last session I had with one of the
mothers with a premie was told by someone (I do not know who) that she should
not hold her newborn very much because he will get spoiled. I said, “On the
 contrary - he needs to be held because he was in the hospital connected to tubes
for three months. Though he is three months old he was supposed to be born only
a week ago - this puts him in the category of a week old newborn. He needs to
hear your heartbeat and feel your skin. It is important for you to hold him. You
can even hold him while you are doing housework. He will grow and develop
much better if you keep him close to you. That way he can focus on growing
rather than worrying about where you are and have separation anxiety at such a
young age. He needs you. You are the most important person in his life. This will
help you too - you will see how much energy you have because you stay connected
to him. Talk and sing to him throughout the day, you will see what an easy baby
he will be!” I ended up with three very content children. I had friends who would
say - oh just wait - when your third comes this one will be your baby that you’ll
wonder where he or she came from. This did not happen - I do have to say that my
daughter was the only one who we had to work on a lot at the beginning of her life
because she was a C-section and separated from me at birth - also, my father died
when I was three months pregnant with her and I finished the masters program
when she was only three months old. The oldest and youngest boys were not
separated from me at all. It strikes me how “the system” takes our children over
and many of us give them up to the system. Native communities in Bali and other
places in the world take care of the mother for the first nine months of their babies
life. The mother’s job in these communities is to care for her infant and all the
women take over any of the household necessities - North America encourages
separation from the moment the baby is born. I am on my soap box. It appalls me
that “the babys room” is down the hall from the parents. All of these issues are
my own bias. I am well aware of this. It just strikes me how child “unfriendly” our
Society is. Thank goodness there are experts such as Dr. Welch who established
“The Mothering Center” in Connecticut and wrote “Holding Time”, Dr. Brandon
who has always encouraged mothers to be with their babies and promotes Baby
Friendly Hospitals. I am also thankful to Dr. Cunningham who is my doctoral
dissertation committee member who has a 45 year track record for working in
pediatrics and helping to establish the medical missionary program in Togo Africa.
It is refreshing to have colleagues that I respect and who support me as a mother
and a professional working with children. I do not know if I truly answered the
first question but in order to finish answering the “at risk” category to this
dissertation - especially the mother who abused drugs, I have very little
experience in substance abuse - it is an area much such as suicide that I could not relate
to and it is also a very important piece to my puzzle of why I chose this
population. It was not out of the blue. I searched for this site and created the
clinical space to do the work with these mothers. I finally put all the pieces
APPENDIX F

LIST OF NARRATIVES AND MUSIC FROM MUSICAL JOURNEYS

Rhea & Matthew’s Playlet and Music

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<td>Rhythmic Reciprocity</td>
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<td>The River of Melody and The Babbling Brook</td>
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<tr>
<td>I’m OK and It’s OK – The Piano</td>
<td>124</td>
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APPENDIX G

BIBLIOGRAPHY OF RELATED LITERATURE


