Sponsoring Committee:  Professor Barbara Hesser, 
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UTILIZING MUSIC THERAPY AS A MODE OF TREATMENT
FOR THE PERFORMANCE STRESS OF
PROFESSIONAL MUSICIANS

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With sincere gratitude —

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And to the many musicians who have shared their treasures with me and who have had the courage to shine as beacons of light in the musical community. Thank you.
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See deep enough, and you see musically; 
the heart of nature being everywhere 
music, if you can only reach it.

- Thomas Carlyle
CHAPTER I
INTRODUCTION

Need for the Study

The incidence of performance stress in professional musicians is reaching epidemic proportions in our society today. According to a recent national survey conducted by the International Conference of Symphony and Opera Musicians (ICSOM), performance anxiety, and its concomitant stress symptoms, is the most prevalent medical problem among professional orchestra musicians (Fishbein, et al., 1988). Piperek (1981), in his psychophysiological investigation of twenty-four musicians from the Vienna Symphony Orchestra, also found a high incidence of performance stress among professional orchestra musicians. Data from Raeburn's (1987) study on occupational stress and coping in a sample of professional rock musicians suggests that these musicians are also a highly stressed group.

Stress is defined by Spielberger (1979) as a complex psychobiological process which is initiated by a situation or stimulus that is potentially
harmful or dangerous (stressor). If a stressor is interpreted as dangerous or threatening, a fear/anxiety reaction will be elicited. Fear and anxiety are both responses to stress as well as contributors to it. For example, a certain performance situation may place extreme demands upon a musician which causes stress. If the musician also perceives the performance situation (stressor) as threatening, he will experience state anxiety, which Spielberger describes as, "an emotional reaction that consists of subjective feelings of tension, apprehension, nervousness and worry, and heightened activity of the autonomic nervous system" (p. 17).

According to Holland (1985), the repercussions of performance stress in musicians can be observed in the chronic afflictions of muscles and tendons due to the "over-use" syndrome, a high incidence of coronary heart disease, and the debilitating burden of mental stress, stage fright and the unrelenting pressure to excel (p. 8). Performance stress negatively affects the way the musician feels about performing which, in turn, has a deleterious effect on performance quality.

Because of the high incidence of performance stress among professional musicians, there is a great need for appropriate interventions to treat
and ultimately to prevent this debilitating problem. The major focus of this study is to introduce the use of group music therapy as a treatment for the fear/anxiety subcomponent of musical performance stress and to develop an evaluation procedure to assess the effectiveness of the intervention.

Musical Origins of Performance Anxiety

A musician often becomes anxious when he is challenged beyond his musical capabilities and is unable to find the resources within himself to communicate appropriately the essence of the music to the audience. According to Reubart (1985), the musical origins of performance anxiety can be traced to two sources: inadequate levels of musical awareness, and physical/technical deficiencies. Reubart believes that some of the musical difficulties which create anxiety in the performer may be inherited. These include: low auditory awareness; low capacity for musical imagery; low rhythmic awareness; and low intellectual capacity (p. 29). According to the performance anxiety literature more than inherited factors and physical

1 The masculine form of personal pronouns is used throughout this dissertation. It is to be assumed that all statements, unless otherwise specified, apply as well to the feminine.
limitsations are responsible for the musician's debilitating stress/anxiety experience.

**Psychological Origins of Performance Anxiety**

In his descriptive study on the features of performance anxiety as experienced among professional solo musicians, Hutterer (1980) found that many anxious musicians had experienced early disturbances in musically specific interpersonal relations. Negative responses from significant others toward the musician's initial efforts are internalized and then projected upon the audience during concerts. Hutterer also found that the highly anxious musician experiences ambivalence and worry prior to, during and after performing due to overwhelming fears of being judged and rejected. This stress negatively affects the performer's musical expression. The highly anxious musician is more vulnerable to unfavorable criticism and experiences more unfavorable reactions in the event of failure than the low anxious musician.

Kendrick (1979) found that musicians with anxiety are more easily distracted by difficulties extraneous to the music than unstressed musicians. They often have low self-esteem and usually rely on outside validation of their musical efforts. According to Kendrick, high anxious musicians are
consequently more self-involved and self-deprecating than low-anxious musicians.

The psychoanalytic literature describes the underlying causes of performance anxiety as stemming from the re-activation of unconscious childhood conflicts involving the child's relationship with his parents, especially the mother (Gabbard, 1979). These conflicts include pathological narcissism, which is caused by the frustration of the child's early exhibitionistic and grandiose-self needs (Kernberg, 1975; Fenichel, 1945; Ferenczi, 1950; Freundlich, 1968); the shame dynamic, which is related to the feeling of "not being good enough," loss of control - the fear that the individual will make a mistake and be punished (Mayman, 1974), and the separation/individuation crisis, which involves the child's struggle to exist as an autonomous individual against the regressive pull of symbiosis (Mahler, 1975).

Related to the separation/individuation crisis is the experience of depersonalization, which is defined by Kaplan (1969) as

A split between a functioning and observing self, with pronounced spatial disorientation. The observing self perceives the functioning self as off at a distance, operating mechanically before an audience which is also perceived as quite distant (p. 65).

Kaplan believes that the anxious musician may
anticipate a negative reaction from the audience which he perceives as the "bad" mother as he attempts to separate from her and present himself as an autonomous being. To protect himself, he physically splits himself off from the "bad" individuating self at a safe distance.

**Previous Methods of Treating Performance Anxiety**

Previous research on the treatment of performance anxiety in professional musicians include anecdotal reports from the psychoanalytic literature (Gabbard, 1979) and experimental studies on the use of cognitive/behavioral techniques for anxiety reduction. The main focus of cognitive/behavioral therapy is to neutralize or eliminate the symptoms associated with the performer's undesirable behavior. The following techniques have been evaluated: relaxation training (Sweeney, 1982), systematic desensitization (Wardle, 1975; Appel, 1976); musical analysis (Appel, 1976), behavioral rehearsal and attentional training (Kendrick, 1980).

Although most cognitive/behavioral techniques proved to be somewhat effective in reducing the symptoms of performance anxiety in controlled laboratory settings, it is unknown whether the treatment effects would carry over into the
musicians' "real life" performance situations. Only one of the above-mentioned studies contained follow-up data. None of the studies were replicated. It is also questionable whether insights gleaned from the free association technique of psychoanalysis (which traditionally takes place in a "sheltered" environment) can readily be transferred by the musician to his actual performance situations.

All aspects of the musician's physical, psychological and spiritual being are reflected in his music (Diamond, 1982). It is suggested that a holistic group music therapy approach would allow for more possibilities of transfer between the treatment situation and "real life" and be more effective in dealing with musical performance anxiety.

**Group Music Therapy as a Holistic Treatment Approach**

The primary goal of the group music therapy intervention as used in this study is to help the anxious musician to focus on his actual process of music making, how the body, mind and emotions interact during musical preparation and performance. In this way, the musician can become aware of and understand the underlying dynamics of his anxiety. In addition, through the process of
"inner listening," the musician is able to systematically bring unconscious, repressed material related to his early performance experiences into consciousness. This can be achieved as the musician learns to focus inwardly and to observe (with detachment) the inner mental processes which occur during "reality rehearsal" performances, clinical improvisations (Priestley, 1975; Nordoff & Robbins, 1977) and music imaging exercises (See Appendix E). It is only when the musician is not identified with his limiting mental or emotional patterns, that he can begin to change them.

Furthermore, through the process of music therapy, the musician is encouraged to use his own music, as a symbol of his creative life urge, to transform his anxiety into a meaningful communication of self. According to May (1977), the aspects of the personality marked by anxiety often become sectors of significant growth when the individual deals with his anxiety constructively (p. 355). For a more detailed discussion of the use of music in transforming anxiety, see Appendix C.

The theoretical framework of the intervention is based on humanistic principles (Maslow, 1971; May, 1975), which emphasize the search for meaning
and values in the process of musical expression, the importance of the dynamic relationship between the musician and the audience, and the importance of self-determination and motivation in the therapeutic process.

Within the holistic and humanistic framework, the music therapist is interested in treating the whole person (Hesser, 1985; Adelman, 1985; Kenny, 1985), recognizing the inherent creativity in each individual, and helping clients to achieve self-actualization through their relationship with and understanding of their own music, which actually becomes symbolic of the evolving self (Nordoff & Robbins, 1977; Boxill, 1985; Hesser, 1985). May (1977), defines "self" as, "that capacity of the human organism to have conscious awareness of its activities, and through this awareness, to exercise a measure of freedom in directing these activities" (p. 68).

To foster self-development as a means of alleviating the fear/anxiety subcomponent of musical performance stress, the following treatment goals of the group music therapy intervention were developed: 1) to provide a consistent, non-threatening and supportive environment for emotional awareness and change to occur; 2) to encourage interaction, empathy and sharing among
group members; 3) to facilitate the exploration of group dynamics (Hesser, 1985); 4) to encourage spontaneity, self-expression (musicality) and reparation through creativity (Klein, 1937); 5) to awaken, through musical activities, grandiose-exhibitionistic energies which may have been repressed due to early trauma; 6) to facilitate "peak" musical experiences as a way of enhancing self-esteem, growth motivation and musicianship; 7) to refocus attention by activating the giving and receiving feedback loop which occurs between the musician and audience during performance; 8) to re-awaken the inner "music child" (Nordoff & Robbins, 1977), the individualized musicality inborn in each human being; and 9) to teach breath awareness and relaxation exercises as tools for coping with state anxiety.

The group music therapy approach, as used in this study, provides an energetic and relational analogue for the musician's real life situation. In this way, the group can actually model potential conflicts associated with the musician's performance anxiety. As part of the therapeutic intervention, musical performance, clinical improvisation, awareness techniques (Gendlin, 1978) and verbal processing are used as catalysts for communication, change and personality integration.
It is hypothesized that this approach, which is uniquely congruent to the musician's lifestyle, can address issues that have not been explored in the previously mentioned studies.

Basic Research Hypotheses and Design

To evaluate the validity of the group music therapy intervention as a treatment for musical performance stress, it was decided to conduct an exploratory experimental field study utilizing a Pretest-Posttest Control-Group design. The following hypotheses will be tested:

1. The anxious musician experiences fear, apprehension, and worry related to performance. Because of his anxiety, the musician is unable to feel confident as a performer.

2. The group music therapy intervention will be effective in reducing the musician's performance anxiety and increasing his confidence as a performer because it deals directly with the musician's feelings about his own music and his relationship with the audience, the actual source of his performance anxiety.

The music therapy intervention will serve as the independent variable, and the musician's anxiety related to performance, as measured by the Spielberger Trait Anxiety Inventory (1977), and his
feelings about performance, as measured by the Personal Report of Confidence as a Performer Scale (Appel, 1974), will serve as the dependent variables.

To test the effectiveness of the music therapy intervention, post test scores of experimental and no-treatment control subjects reflecting change in the above measures will be compared. The Adjective Checklist Scale will also be used to measure pre to post session change in experimental subjects' feeling states during the course of the intervention. The Spielberger State Anxiety Inventory will be used to measure subjects' state anxiety before and after each group session and before and after each performance test.

As this study is exploratory in nature, it will contain both quantitative and qualitative components. The qualitative data, which will include an evaluation of the efficacy of the treatment goals of the group music therapy intervention (see page 9-10), will not be analyzed as part of this presentation, although a preliminary interpretation and analysis can be found in Appendix C.
CHAPTER II

STUDY 1

The researcher's purpose in the first study was to determine if selected professional musicians with performance stress would become less anxious and more confident as performers after participating in group music therapy.

The Method

Selection of Sample

Two months prior to the first group meeting, flyers announcing the proposed study were distributed to the music departments of two universities and one music conservatory in New York City. These institutions were chosen as representatives of the wide spectrum of performing musicians, ranging from those pursuing careers in pop and jazz music, to those who were performing in the classical and electronic music fields. Twenty-seven musicians responded to the flyer. Criteria for selection of subjects was based on a minimum score of 12 (which represents a moderate level of anxiety) on the Personal Report of Confidence as a Performer Scale (PRCP) (Appel, 1974), which measures specific
anxiety responses during solo musical performance. Subjects' performance anxiety was also evaluated through personal interviews with the researcher and from their responses to a 32-item Musical Background Questionnaire (See Appendix K). The questionnaire traced the performer's musical development from childhood to the present, covering such subjects as family relationships, musical education, performing experiences, attitudes toward music and performance, performance anxiety and coping mechanisms, as well as the musician's personal goals for therapeutic change during the music therapy group process.

The purpose for the interviews and background questionnaires with respect to selection criteria was to assist the researcher in choosing subjects who could commit themselves to participating for the full 12 week program, as well as to eliminate volunteers who had previous history of psychiatric disorders. Seven volunteers were rejected as subjects because they did not satisfy the above criteria. Twenty musicians ranging in age from 18-42 years (M=28) were selected for inclusion in the study. Subjects were randomly assigned to treatment group (n=10) and waiting-list control group (WLC; n=10). The WLC group was included to determine the extent of improvement from
"spontaneous remission" (Goldstein, 1962), attention from researcher, nonspecific therapeutic factors and the promise of treatment. For a fuller description of the demographics of experimental subjects, see Appendix A.

Apparatus

The music therapy group was conducted in a large performance classroom at New York University. Subjects had access to a grand piano, an assortment of instruments for improvisation including drums, cymbals, xylophones, bells, a set of Paiste gongs, as well as their primary instruments. The group met once a week for 1-1/2 hours over a period of 12 consecutive weeks.

Intervention

The music therapy group is a process-oriented intervention which focuses on the "here-and-now" experience of the individual, using clinical improvisation, performance, awareness techniques and verbal processing as catalysts for communication, change and personality integration. It was adapted for use in this study from Hesser's (1985) music therapy group training model for music therapy students.

The sessions were structured into four
components: a warm-up which included relaxation and breathing exercises; followed by an unstructured group improvisation; verbal processing of the group improvisation; leading to individual and/or group music therapy interventions. These interventions included techniques such as improvisational role-playing, clinical improvisation, instrumental and vocal self-statements, "reality rehearsal" performances and guided imagery exercises.

Therapists

The music therapy group was co-led by the Director of the Music Therapy program at New York University and the researcher. Both co-leaders were certified music therapists with 12 and 4 years of clinical experience, respectively.

Research Hypotheses

To determine the effect of group music therapy as a mode of treatment for the performance stress of experimental group subjects, the following hypotheses were tested: 1) Experimental subjects would become significantly more confident as performers after music therapy intervention; 2) Subjects' trait and state anxiety scores would decrease significantly; and 3) Subjects' adjective checklist choices would become significantly more
positive, i.e., from competitive to cooperative; uncreative to creative.

Measures

Pre and post experimental measures (taken from both treatment and control subjects):

Personal Report of Confidence as a Performer (PRCP). This scale consists of 30 keyed true and false statements indicating experienced anxiety in solo musical performance. The reliability of the PRCP was found by Appel to be .94 by the split-half method of the Spearman-Brown correction.

Spielberger Trait Anxiety Inventory (STAI), Form Y. The trait anxiety measurement of the STAI gives an objective self report of an individual's trait anxiety, which is used to describe individual differences in anxiety-proneness. It has an overall test-retest reliability of .92 and high construct validity (Spielberger, 1983).

Pre and post weekly measures (taken from treatment subjects only):

Spielberger State Anxiety Inventory (SSAI), Form Y. The state anxiety measurement of the STAI gives an objective self report of an individual's state anxiety, which is defined as unpleasant emotional reactions to specific stress situations. It has an overall test-retest reliability of .90
and high construct validity (Spielberger, 1983).

Adjective Checklist (ACL) (Gough & Heilbrun, 1983). This self-report measure consists of an alphabetized list of 300 adjectives commonly used to describe a person's attributes, to which subjects typically respond by marking those adjectives considered to be self-descriptive. Twenty-three adjectives were chosen by the researcher for their relevance to the performance stress syndrome.

The ACL scales have strong internal consistency (median values of .76 and .75 for males and females, respectively) and quite strong stability (one-year test-retest correlations for females showed a median value of .71). Construct validity of the ACL is modest and discriminant validity is weak overall.

Procedure

Along with written tests, performance tests were conducted with subjects during the second session, sixth session (mid-point) and twelfth session. Stephen Foster's Slumber Song was assigned to the subjects at the end of the first session. This piece was chosen for its simplicity, beauty and potential to evoke deep feelings, i.e., being a lullaby, the mother's love for her
Subjects were asked to learn the piece and to perform it for the group the following week. The same piece was to be performed by subject mid-group as well as during the final group session.

The performance test was used diagnostically by therapists to obtain information from subjects regarding their "lived" experience of musical performance. This included subjects' experience of being in a "test" situation; attitudes towards preparation and interpretation of performance piece; musicianship; body/mind integration while performing; communicative ability; creativity; coping skills.

The researcher was interested in assessing the changes in subjects' state anxiety before and after each performance, as well as the changes in state anxiety from one performance to the next. Qualitative changes related to performance were also analyzed with respect to subjects' attitudes and musicianship.

Results

Study Attrition

The experimental group started out with ten subjects. By the end of the second session, three subjects had withdrawn from the study. To find out whether there were personality differences between
the subjects who dropped out of the study and those who remained, t-tests (two-tailed) were done comparing differences in STAI and PRCP pre test scores between the three drop-outs and the remaining seven experimental subjects. No significant differences were found between the two groups.

Table 1
Comparison of Pre test Scores of Drop-outs and Remaining Subjects on Measures of STAI and PRCP

<table>
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<td></td>
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<tr>
<td>Experimental</td>
<td>47.4</td>
<td>11.7</td>
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<tr>
<td>Drop-outs</td>
<td>55.6</td>
<td>9.4</td>
<td>-1.04</td>
<td>8</td>
<td>.328</td>
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<tr>
<td>PRCP</td>
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<td>3.7</td>
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<td>8</td>
<td>.461</td>
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<td>Drop-outs</td>
<td>17</td>
<td>2.6</td>
<td>-.77</td>
<td>8</td>
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Pre and Post Experiment

To evaluate the effect of the group music therapy intervention, the treatment group subjects were compared with the waiting-list control subjects with regard to their pre and post experiment measures. Two one-way between-group analyses of covariance (ANCOVAs) were performed on the pre and post test measures of the PRCP and STAI. Means and standard deviations appear in Table 2.
Table 2

Means and Standard Deviations of Personality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Experimental (n=7)</th>
<th>Control (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>PRCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>15.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Post</td>
<td>6.0</td>
<td>3.5</td>
</tr>
<tr>
<td>STAI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>47.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Post</td>
<td>41.4</td>
<td>12.5</td>
</tr>
</tbody>
</table>

On the Personal Report of Confidence as a Performer Scale (PRCP), treatment group subjects experienced a significant increase in their confidence as performers post treatment as compared to the waiting-list control subjects, $F(1,13) = 10.8, p < .009$. This supports the hypothesis that the experimental subjects' confidence as performers increased after group music therapy intervention.

On the Spielberger Trait Anxiety Inventory (STAI), experimental subjects experienced a significant decrease in their trait anxiety as compared to waiting-list control subjects, $F(1,13) = 7.4, p < .013$. This supports the hypothesis that group music therapy lowered experimental subjects' trait anxiety.
Weekly Test Results

Having seen a difference in the post treatment personality measures between the experimental and control group subjects, an inspection of the weekly test results provided an opportunity to evaluate the kinds of changes taking place within the experimental group.

A t-test was used to compare pre and post treatment measurements of state anxiety from all treatment group sessions (N=65). As formally hypothesized, there was a significant difference, $t(64)= .81, p < .036$ (one-tailed). Post session anxiety averages ($M=38.1, S.D.=8.91$) were lower than pre session anxiety ($M=41.7, S.D.=12.4$). This supports the hypothesis that subjects' state anxiety decreased after music therapy intervention.

The adjective checklist responses from before and after each treatment session were entered into a principal components analysis and the results were rotated to help interpret components. Five components emerged from the analysis which together accounted for 71.7% of the variance. These were named: successfulness; relatedness; task orientation; emotionality; and tenderness. Scales were created for each component.

T-tests were used to compare the pre and post treatment scale scores aggregated from all
sessions. Two-tailed probabilities will be reported because the comparisons are post hoc.

Group members felt significantly less successful after each session, $t(64) = -2.33$, $p < .021$; less related, but not significantly so $t(64) = -1.94$, $p < .055$; and more emotional, but not significantly so $t(64) = -1.75$, $p < .083$. There were no pre/post treatment differences for task orientation and tenderness. This last finding fails to support the hypothesis that subjects' adjective checklist choices would become more positive after music therapy intervention.

Results of Performance Test

In taking a closer look at changes experienced by experimental group subjects due to music therapy intervention, pre and post performance test measures (SSAI) were evaluated along with subjects' corresponding anecdotal reports.

First performance (second session). Subjects reported a state anxiety (SSAI) mean of 43, pre-performance, which increased to a mean of 47 ($S.D. = 4.7$), post-performance. Subjects were extremely self-involved prior to, during and after performance. Most had not prepared the piece adequately and were only concerned about "getting through it." One subject reported experiencing
heart palpitations due to nervousness and had to postpone her performance until the following week. All subjects criticized their performances harshly.

Second performance (sixth session). Subjects' pre-performance SSAI scores were higher than their pre-scores on the first performance test (M=47). Subjects were less anxious post-performance (M=44, S.D.=7.8). At the sixth session, subjects were still extremely anxious with regard to performing before an audience, although they all seemed to know the piece better. Most subjects expressed difficulty in connecting with the emotional content of the piece. One subject shared that she liked the piece because it represented feelings of being supported and nurtured, but she was unable to accept these feelings in herself and thus could not communicate them through the music. During this performance test, specific problem areas emerged for each subject which became the therapeutic focus for subsequent sessions.

Final performance (twelfth session). Subjects had a mean of 38 on their pre-performance SSAI scores, which decreased slightly to a mean of 36 (S.D.=6.9), post-performance. This shows an almost 10 point over-all reduction in subjects' state anxiety at treatment termination. During this
performance test, subjects reported feeling more confident, took greater liberties in interpreting the piece, made eye contact with and attempted to communicate the music to the audience. Several subjects reported feeling a more intimate connection with other group members and with the audience during the performance. Prior to the end of this session, several subjects suggested that the group create their final improvisation on the theme of *Slumber Song*.

Discussion

In summary, the results of this exploratory study suggest that the group music therapy treatment approach was effective in reducing the fear/anxiety subcomponent of musical performance stress as compared to a waiting-list control condition. Experimental subjects became significantly more confident as performers (PRCP) after treatment and both state (SSAI) and trait (STAI) anxiety were reduced in a statistically significant fashion.

In comparison to results of previous treatments of performance anxiety, the music therapy intervention's reduction of state anxiety was greater than Kendrick's (1979) attentional training and behavior rehearsal treatment groups. Changes in PRCP due to music therapy intervention
were on the same order of magnitude as Appel's (1974) systematic desensitization treatment and greater than her musical analysis treatment.

On the basis of descriptive data taken from a qualitative research component not reported in this presentation (see Appendix C), eight key factors which contributed to the performance stress syndrome in experimental subjects were found: inner critic; ambivalent association with primary instrument; lack of commitment to musical performance; lack of preparation for performance; under-developed will and lack of focus in musical performance; inability to share one's music with the audience; lack of strong self-concept; and ambivalent relationship with the audience. In reviewing these data, it appeared that experimental subjects were generally overly self-involved due to certain psychological factors and could not fully communicate their music to the audience.

Analysis of the subjects' adjective checklist responses before and after each music therapy session during the 12-week study showed a tendency in subjects towards denial of "negative" feelings, especially during the first 7 weeks of the group process. Subjects repeatedly reported feeling anxious upon coming into the group (as measured by the Spielberger State Anxiety Inventory) with
positive affective states (as reported by the adjective checklist) and left the group feeling less anxious, with an increase in negative affective states.

Often in the case of chronic anxiety, an individual will develop a "false self" (Winnicott, 1974), which becomes a defense against the underlying feelings which occur during high anxiety situations. Threatening feelings are thus dissociated from consciousness and the individual "pretends" that he is in control of himself. In order to keep threatening feelings or thoughts out of awareness, the musician becomes overly self-involved and cannot be totally present in his musical expression.

In reviewing the qualitative data with respect to subjects' description of change experienced as a result of the music therapy intervention, it appears that the music therapy group gave subjects an opportunity to let down their guard against undesirable feelings and to be more relaxed and less judgmental. In this way, they could channel more of their energy into musical expression. As they began to feel more integrated in their musical activities during the music therapy group process, most subjects also reported feeling more confident and less anxious in their real life performance.
situations. An objective measure of change in subjects' musicality due to the music therapy intervention was not measured as part of the research methodology of this study.

After contemplating the results of the foregoing exploratory study, the researcher decided to replicate the study using a similar methodology with the addition of an objective measure to rate change in subjects' musicality (performance quality), stress symptoms and observable signs of self-involvement related to musical performance. The relationship between self-involvement, performance stress and musicality will be explored to ascertain if and how music therapy actually reduces subjects' extreme self-involvement and increases their musicality.
CHAPTER III

STUDY 2

The Problem

The researcher's purpose for this study was to determine if, after group music therapy intervention, selected professional musicians with performance stress would not only become less self-involved and less stressed, as in Study 1, but also more musical. Thus Study 2 served not only as an effort to verify by replication that the group music therapy intervention could assist musicians in feeling less stressed and more confident as performers, but also examined whether there resulted from this an actual improvement in performance quality as perceived by others.

In replicating Study 1, both the Spielberger Trait Anxiety Inventory (STAI) and the Personal Report of Confidence as a Performer Scale (PRCP) were used as self-report measures. Since extreme self-involvement is one of the key characteristics of pathological narcissism as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1980), it was hypothesized that narcissism could be a complicating factor in the performance stress syndrome. Thus, to assess the
degree of narcissism experienced by subjects and to evaluate any change in narcissism levels due to the music therapy intervention, an additional self-report measure of narcissism as a personality trait, the Narcissistic Personality Inventory (NPI) (Raskin & Hall, 1981) was added to the methodology of this study.

Pathological Narcissism as a Contributing Factor to the Performance Stress Syndrome

Anxious musicians are often described as being overly self-involved and narcissistic (Kendrick, 1979; Ferenczi, 1950; Freundlich, 1968; Waite, 1977). Kernberg (1975) refers to normal narcissism as "integration of good and bad self-images into a realistic self-concept that incorporates rather than dissociates the various component self-representations which is the requisite for the libidinal investment of a normal self" (p. 15).

In pathological narcissism, good and bad self images are split rather than integrated. The narcissistic individual identifies with the good object and denies any relationship with the bad (Klein, 1937). Pathological narcissism manifests itself in extremes: "egocentrism and low self-esteem; omnipotence and helplessness; over-control and weak identity" (Krueger, 1976). For a fuller discussion of the underlying issues related to the
narcissistic personality disturbance, see Appendix H.

Two Categories for the Analysis of Data

An important focus in this study has been the relationship between the musician and the audience. According to Diamond (1986), "A musician's orientation is one of outward directed communication. He performs for others." (p. ix). This factor has not been taken into account in other studies on performance anxiety. A primary goal of the music therapy intervention in this study is to activate the giving and receiving feedback loop which exists between the musician and the audience. It is hypothesized that as the musician becomes more aware of his purpose of communicating the music to the audience, he will become less self-involved, less stressed and more musical. Ultimately, the audience of the therapized musician will receive the benefits of the music therapy intervention.

The analyses of data of this study (which will include both self-report personality measures and observer-rated video measures) will be divided into two groups: one which is directly relevant to the performer only, and the other which is directly relevant to both the performer and the audience.
Table 3

Distribution of Research Tools Among Experimental, Attentional Control and Waiting-List Control Groups

<table>
<thead>
<tr>
<th>Performer-Relevant Measures</th>
<th>EG</th>
<th>ACG</th>
<th>WLCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRCP</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>STAI</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>NPI</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Video measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSI</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>PSS</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>GSI</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSS</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Audience-Relevant Measures  |    |     |      |
| Video measures              |    |     |      |
| PM                          | x  | x   |      |
| GM                          | x  |     |      |

Note: EG = Experimental Group; ACG = Attentional Control Group; WLCG = Waiting-List Control Group; PRCP = Personal Report of Confidence as a Performer Scale; STAI = Spielberger Trait Anxiety Inventory; NPI = Narcissistic Personality Inventory; PSI = Performance Self-Involvement; PSS = Performance Stress Symptoms; GSI = Group Self-Involvement; GSS = Group Stress Symptoms; PM = Performance Musicality; GM = Group Musicality

The Method

The apparatus, therapists and intervention used in this study were the same as those used in Study 1.

Selection of Sample

As the control group subjects from Study 1 were promised treatment following the completion of
the first study, these musicians became the experimental subjects in Study 2. Additional subjects were needed to participate in the control groups. Two months prior to the starting date of the first music therapy session, an advertisement was placed in the Local 802 (musician's union) newspaper, Allegro, announcing a study to be conducted in connection with the Music Therapy Program at New York University on the use of music therapy as a treatment for performance stress in professional musicians. Thirty musicians responded. The musicians came from a variety of musical disciplines - about 70% of the respondents were classical musicians; 10% were jazz musicians; 10% were rock/new wave musicians; and 10% other. The age range of the respondents was between 24 and 65 with a median age of 35 years. The musicians had different levels of performance experience and played a variety of instruments, including voice.

The criteria for selection of subjects was identical to that used in Study 1. Eight volunteers were rejected as subjects because they did not satisfy selection criteria. Twenty-two musicians were selected to participate in the research study.

The subjects were randomly assigned to two control groups: waiting-list control group (n=10),
to control for the possibility that the musicians' stress might be reduced naturally over time without any intervention; and an "attentional" control group (n=10) to control for the Hawthorne Effect, which points to the fact that control subjects often improve even without treatment because they were aware that they were participating in an experiment and receiving special attention (Tuckman, 1978).

The attentional control group in this study represented a systematic intervention and interaction on the part of the researcher with the subjects which was not related to the treatment or intervention variables being evaluated. The attentional subjects met with the researcher/author weekly during the course of the study to complete a battery of psychological tests and to discuss musical topics. Both groups of control subjects were promised music therapy treatment at a later date.

The rationale for using the two control groups was to study the effect of varying amounts of attention given to the subjects who were not actually engaged in the music therapy process and if and how this attention was related to changes in post test scores.
Procedures for Testing Hypotheses

To determine whether experimental subjects would become significantly more musical aesthetically pleasing and technically proficient), less self-involved and less stressed as compared to attentional control subjects after treatment, both experimental and attentional subjects were asked to prepare a piece (5-10 minutes in length) to share with their respective group members and other interested listeners during the second week of the experiment. Relatives, friends and students were invited to participate as audience members to provide a more authentic performance environment. The subjects performed again for a similar audience during the thirteenth week of the experiment. The videotapes of these performances were rated by two independent raters (a psychologist, who was also an amateur musician, and a professional musician) on scales for observable signs of self-involvement, stress symptoms and musicality. See Appendix I for details on the development of video rating scales. The two performances were presented in counterbalanced order with raters blind as to group membership and performance order.

Experimental subjects' observable signs of self-involvement, stress symptoms and musicality
were also rated by the raters during the third and
eighth sessions to study the changes which took
place in each subject during the music therapy
group process which occurred between the two
performances.

To determine whether there were significant
correlations between experimental subjects'
observer-rated scores on self-involvement, stress
symptoms and musicality, as well as between the
standardized personality measures and the video
rating measures, Pearson correlation coefficients
were performed pairing each of the measures with
each other.

To determine whether the experimental
subjects' trait anxiety would decrease significant­
ly; confidence as a performer would increase
significantly; and narcissism as a personality
trait would move significantly toward the norm
after music therapy treatment, as compared to both
waiting-list and attentional control subjects, the
following standardized tests were given:

The Spielberger Trait Anxiety Inventory
(STAI). The trait anxiety measure gives an
objective self-report on an individual's overall
anxiety proneness. See Study 1, page 17.

The Personal Report of Confidence as a
Performer Scale (PRCP) (Appel, 1974). The PRCP
includes 30 keyed true and false statements as evidence of experienced performance anxiety in solo performance situations. See Study 1, page 17.

The Narcissistic Personality Inventory (NPI) (Raskin & Hall, 1981). The NPI is a 54-item forced-choice questionnaire designed to measure individual differences in narcissism as a personality trait. The mean for normal narcissism (in college students) as measured by the NPI is 20.8. Scores above the mean represent a movement toward pathological narcissism (extreme self-involvement). Scores below the mean represent a movement toward low self-esteem. The NPI has considerable evidence of construct validity as described by Emmons (1984).

Because of the small sample size of the experimental group, effect sizes calibrating the magnitude of change from pre test to post test will be calculated to supplement the statistical significance of the findings using Cohen's (1988) statistical power analysis.

Results

Study Attrition

The experimental, attentional and waiting-list control groups started out with 12, 10 and 10 subjects, respectively. At treatment termination,
4 subjects had left the attentional group and 2 subjects had dropped out of the waiting-list control group. By the end of the third music therapy session, 4 subjects had dropped out of the experimental group. Two-tailed t tests were done to compare differences in pre test scores (PRCP, STAI and NPI) of the drop-outs and remaining experimental subjects. No significant differences were found between the two groups on the above measures.

Table 4
Comparison of Pre Test Scores Between Drop-Outs and Remaining Experimental Subjects

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td>8</td>
<td>48.6</td>
<td>10.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop-outs</td>
<td>4</td>
<td>54.5</td>
<td>9.5</td>
<td>-.93</td>
<td>10</td>
<td>.377</td>
</tr>
<tr>
<td>PRCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td>8</td>
<td>14.5</td>
<td>4.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop-outs</td>
<td>4</td>
<td>15.7</td>
<td>3.5</td>
<td>.05</td>
<td>10</td>
<td>.962</td>
</tr>
<tr>
<td>NPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td>8</td>
<td>24.3</td>
<td>9.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop-outs</td>
<td>4</td>
<td>25</td>
<td>9.9</td>
<td>-.11</td>
<td>10</td>
<td>.918</td>
</tr>
</tbody>
</table>

Demographics of Experimental Group Subjects

The experimental group was composed of four men and four women between the ages of 29 and 40 with a median age of about 34. A more detailed description of the demographics of experimental subjects can be found in Appendix B.
Group Comparability

To insure that any possible post-intervention results were not due to pre-intervention differences in groups, a pre-intervention comparison of groups was made. A one-way between-group analyses of variance (ANOVA) yielded no significant differences among groups (p > .05) for pre-test scores of video rating scales (PM, PSI and PSS), and personality measures (PRCP, NPI and STAI). See Appendix J.

Reliabilities

Interrater reliabilities for observer-judged dependent measures appear in Table 5. Almost perfect agreement among raters was indicated on all variables with the exception of Group Stress Symptoms (GSS), where a lower reliability (r[6] = .65) was found. It is believed that in some cases it may have been difficult for the raters to assess individual subjects' stress symptoms accurately because the video camera was focused on the whole group during the music therapy sessions, and not on specific individuals.
Table 5

Interrater Reliabilities - Pearson Product-moment Correlation Coefficient

<table>
<thead>
<tr>
<th>Variable</th>
<th>PCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI</td>
<td>.95</td>
</tr>
<tr>
<td>GSS</td>
<td>.65</td>
</tr>
<tr>
<td>GM</td>
<td>.99</td>
</tr>
<tr>
<td>PM</td>
<td>.99</td>
</tr>
<tr>
<td>PSI</td>
<td>.96</td>
</tr>
<tr>
<td>PSS</td>
<td>.99</td>
</tr>
</tbody>
</table>

**Performer Relevant Treatment Effects**

**Observer-Rated Video Measures**

To study the effect of the music therapy intervention, the differences between pre and post measures of the video rating scales for the experimental group and the attentional group were compared. Two between group analyses of variance (ANOVAS) using pre-test measures as co-variates were performed (See Appendix J). Means and standard deviations appear in Table 6.

At treatment termination, experimental subjects were found to be significantly less self-involved, $F(1,12) = 47.6$, $p < .001$, and significantly less stressed, $F(1,12) = 52.7$, $p < .001$, during performance as compared to the attentional group subjects. This supports the hypothesis that experimental subjects would become significantly less self-involved and less stressed during performance as compared to the attentional group.
subjects after music therapy intervention. When effect sizes (Cohen, 1988) were calculated, the above statistically significant results had associated effect sizes that were all greater than .74. According to Cohen, a large effect size in social science research is on the order of .14. This indicates that there is an extremely large effect associated with the music therapy intervention.

When compared with their own pre-scores on measures of group self-involvement, group stress symptoms and group musicality, experimental subjects' post scores indicated that they had become significantly less self-involved, less stressed, and more musical while participating in the music therapy group, beyond the p < .05 level. The associated effect size of the intervention was greater than .72.

Table 6
Means and Standard Deviations of Video Outcome Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Experimental (n=8)</th>
<th>Attentional (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>PSI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>20.4</td>
<td>5.7</td>
</tr>
<tr>
<td>Post</td>
<td>9.0</td>
<td>3.1</td>
</tr>
<tr>
<td>PSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>19.6</td>
<td>5.7</td>
</tr>
<tr>
<td>Post</td>
<td>9.6</td>
<td>2.7</td>
</tr>
</tbody>
</table>
Table 7

Two-tailed t Test Results of Pre-Posttest Changes in Experimental Subjects' Group Musicality, Self-Involvement and Stress Symptoms

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>GM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>33.0</td>
<td>10.0</td>
<td>4.2</td>
<td>7</td>
<td>&lt;.008</td>
<td>.72</td>
</tr>
<tr>
<td>Post</td>
<td>18.1</td>
<td>6.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| GSI     |    |     |     |    |       |             |
| Pre     | 24.3 | 3.5  | 12.3 | 7  | .001  | .95         |
| Post    | 9.5  | 2.7  |     |    |       |             |

| GSS     |    |     |     |    |       |             |
| Pre     | 19.4 | 5.1  | 10.9 | 7  | <.001 | .94         |
| Post    | 8.9  | 2.9  |     |    |       |             |

Standardized Test Measures

To evaluate the effect of music therapy on subjects' PRCP and STAI scores, two between-group analyses of variance (ANOVAS) comparing the experimental, no-treatment and attentional control groups were performed, using pre-test measures as co-variates (See Appendix J). Means and standard deviations appear in Table 8.

On the Personal Report of Confidence as a Performer Scale (PRCP), experimental subjects became significantly more confident as performers as compared to both the attentional and waiting-list control subjects. The difference in PRCP
scores between the waiting-list control group and the attentional group was not statistically significant. This supports the hypothesis that the experimental subjects' confidence as performers would increase significantly after music therapy intervention. Between the experimental group and both control groups, the associated effect sizes were both greater than .42.

On the Spielberger Trait Anxiety Inventory (STAI), there were no significant differences among the three groups. There was a slight decrease in the STAI scores of the experimental subjects post treatment, but this did not reach statistical significance. This fails to support the hypothesis that experimental subjects' trait anxiety would decrease significantly after music therapy intervention.

Table 8
Means and Standard Deviations of Personality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Exp. (n=8)</th>
<th>Control (n=10)</th>
<th>ACG (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>PRCP</td>
<td>14.5</td>
<td>8.4</td>
<td>16.5</td>
</tr>
<tr>
<td>Pre</td>
<td>8.6</td>
<td>7.7</td>
<td>15.9</td>
</tr>
<tr>
<td>Post</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI</td>
<td>48.6</td>
<td>10.7</td>
<td>50.4</td>
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<tr>
<td>Pre</td>
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<td>49.9</td>
</tr>
<tr>
<td>Post</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: M=mean; SD=Standard Deviation; PRCP=Personal Report of Confidence as a Performer (25 represents the least confidence; 1 represents the most confidence); STAI=Spielberger Trait Anxiety Inventory (normal mean for working adults=36)
To evaluate the effect of music therapy on subjects' NPI scores, the difference scores between time 1 to time 2 were calculated for high NPI and low NPI subjects (the mid-point, or normal personality mean was 20.8). An average difference score was then calculated for the experimental group and for the two control groups. A one-way analysis of variance was used to compare the means of the three groups to see if there were significant differences in the change scores. Post hoc comparisons were made using the Scheffe test. See Appendix J.

Changes in the experimental subjects' NPI scores were found to be significantly different from the attentional subjects, but not significantly different from the waiting-list subjects. The mean change towards normalcy for the experimental group was 2.63; the mean change for the attentional group was -.6; and the mean change for the waiting-list group was .67. This supports the hypothesis that experimental subjects' NPI scores would change significantly in their movement towards the norm after music therapy intervention as compared to the attentional subjects, but fails to support the hypothesis that experimental subjects would change significantly as compared to waiting-list subjects. The associated effect size was .16.
Performer and Audience Relevant Treatment Effects

It was decided that the Performance Musicality (PM) measure of the video rating scales had an impact both on the experience of the audience as well as the musician. To evaluate the effect of music therapy on the observer-rated changes in musicality of experimental subjects as compared to attentional group subjects, one between-group analyses of variance (ANOVA) using pre-test measures as co-variates was performed (See Appendix J.) Means and standard deviations appear in Table 6.

Experimental subjects were rated significantly higher in musicality, $F(1,12) = 30.7, p<.001$, by observers (post-treatment) than the attentional subjects with an associated effect size that was greater than .74.

Correlations

According to the theoretical rationale of this study, it was hypothesized that there would be significant correlations between experimental subjects' video-rated levels of self-involvement, stress symptoms and musicality. Table 12 provides the Pearson product-moment coefficient for both pre and post treatment measures. See Appendix J.

Significant positive correlations were found between Group Musicality (GM) and Group Stress
Symptoms (GSS) at time 1 ($r[6] = .73; p = .019$) and Performance Musicality (PM) and Performance Self-Involvement (PSI) at both time 1 and time 2 ($r[6] = .66; p = .037$), ($r[6] = .69; p = .029$), respectively. This supports the hypotheses that stress symptoms are significantly related to musicality (i.e. when stress symptoms are high, musicality is low); and that self-involvement is also significantly related to musicality (i.e. when self-involvement is high, musicality is low). All of the remaining correlations showed positive, but non significant relationships between stress symptoms, self-involvement and musicality, suggesting that with the reduction of stress symptoms and self-involvement, subjects' musicality increases.

Personality measures were also correlated with each other and with the video measures so that greater insight into the rationale for change experienced by subjects could be gained.

The Personal Report of Confidence as a Performer Scale (PRCP) had a significant positive correlation with the Spielberger Trait Anxiety Inventory (STAI) ($r[6] = .71; p < .02$) indicating that the lower the subjects' confidence as performers, the higher their trait anxiety. The Narcissistic Personality Inventory (NPI) and the
STAI had a small negative, but not significant correlation, suggesting that the higher the anxiety, the lower the NPI score. The NPI, which was expected to measure levels of self-involvement, had a small negative, but not significant correlation with both self-involvement video rating scales (GSI and PSI). This suggests that the NPI and the self-involvement video scales were not measuring the same dimensions of self-involvement.

**Individual Trait Differences As Indicators of "Therapability"**

Having found significant changes in both experimental subjects' levels of confidence as performers (PRCP) and their levels of musicality, it was decided to study which personality constellations would most benefit from the group music therapy intervention. To determine how subjects' initial personality characteristics were associated with subsequent change due to the music therapy intervention, subjects' PRCP change scores versus subjects' initial STAI and NPI scores were plotted. By graphic inspection, it was found that subjects who had the highest trait anxiety (STAI) initially were the ones who experienced the greatest change in PRCP. Subjects who were the lowest in narcissism (NPI) initially also experienced the greatest change in PRCP. See
Appendix J, Figures 1 and 2.

It was then decided to perform a discriminant analyses to see if it was possible to discriminate between high and low changers based on a median split of their change scores. The Standardized Canonical Discriminant Function Co-efficient for the NPI was .96. The STAI Co-efficient was -.48. One hundred percent of the cases were classified accurately. This indicates that both the NPI and the STAI can be used to discriminate between high and low changers, with the NPI having a greater impact on prediction than the STAI.

When it was found that there were specific characteristics that were indicative of who was going to change after music therapy intervention, it was decided to see if there were any personality changes that accounted for the PRCP changes. The PRCP change scores were compared with the NPI and STAI change scores to see if there was any relationship between changes in the two personality measures in relationship to the dependent measure. There was a significant positive correlation between the change scores of the PRCP and the STAI change scores ($r[6] = .86; p = .003$). This indicates that a change in subjects' PRCP scores was accompanied by change in their trait anxiety (STAI), even though the change in STAI was not
found to be significant in itself. There were small non-significant positive correlations between the NPI change scores and the PRCP \( r[6] = .24; p = .132 \) and STAI change scores \( r[6] = .11; p = .31 \), suggesting that a movement towards normalcy in NPI could be responsible for a decrease in subjects' trait anxiety and an increase in their confidence as performers.

As previously reported, high changers in PRCP initially had low NPI scores. However, the change in NPI is not proportional to the change in PRCP. The norm for college students on the NPI is 20.08, which represents healthy narcissism (self-esteem). As the NPI scores increase away from the norm, an individual moves towards pathological narcissism (inflated self-esteem). As NPI scores decrease away from the norm an individual moves toward pathologically low self-esteem. According to the NPI results in this study, subjects with high NPI scores became less narcissistic and subjects with low NPI scores became more narcissistic after group music therapy intervention. The NPI is a critical factor in looking at subjects' levels of change in this study.
Having found that subjects' initial personality characteristics were predictive of changes in PRCP, the researcher was then interested in seeing if this could be confirmed using the video scores as dependent measures. Using discriminant analyses, the following relationships were found:

Self-involvement scales. The variable that predicts changes in subjects' self-involvement was the NPl score. Subjects with high NPI scores, the only significant predictor, change the least in their self-involvement ratings. Discriminant analysis predicted 87.5% of the cases accurately.

Stress symptoms scales. The NPI score is also the only significant predictor of who is going to change in the stress symptoms ratings. Discriminant analysis predicted 87.5% of the cases accurately. Subjects high in NPI change the least in their stress symptoms ratings.

Musicality scales. The STAI and the PRCP scores were both significant predictors of change in subjects' musicality. The Standardized Canonical Discriminant Function Co-efficients of the STAI and the PRCP were -1.12 and 1.62, respectively. Discriminant analyses predicted
87.5% of the cases accurately. Subjects who become more musical are the ones who have higher PRCP scores and moderate trait anxiety (STAI) to begin with. Subjects with very high trait anxiety initially are less likely to become more musical than those with moderately high trait anxiety. The less confident as performers (PRCP) subjects are to begin with, the more chance they have of becoming more musical after music therapy treatment.
increasing experimental subjects' confidence as performers (PRCP), as compared to both no-treatment and attentional control groups, and slightly lowering (non-significantly) subjects' trait anxiety (STAI), as compared to both no-treatment and attentional groups. Experimental subjects changed significantly towards the norm in their NPI scores as compared to attentional subjects; and 3) significant positive correlations were found between subjects' levels of self-involvement, stress symptoms and musicality. There was also a significant positive correlation between the PRCP and the STAI.

According to the performer/audience-relevant treatment measures, the experimental subjects became significantly more musical than the attentional control subjects on observer-rated measures of musicality during performance.

Because of the significance of the experimental subjects' change in PRCP as well as their significant changes in self-involvement, stress symptoms and musicality, it was decided to identify who, based on their initial characteristics, was most likely to experience the benefits of this therapy. It was found that subjects with the highest trait anxiety (STAI) and the lowest narcissism (NPI) experienced the greatest change in
PRCP. A discriminant analysis was performed using both the NPI and STAI which enabled accurate classification of all subjects into either high or low changers. Change score correlations on all measures were conducted in order to see if personality changes were responsible for the change in PRCP scores. A significant positive correlation was found between the PRCP and STAI change scores and small non-significant positive correlations were found between the NPI and PRCP and STAI change scores, suggesting that as NPI scores change in the direction of the norm, there is more of a chance that PRCP scores will increase and STAI scores will decrease.

In studying the relationship between subjects' initial characteristics and their subsequent change in video-rated measures, it was found through discriminant analysis that 87.5% of the cases of high and low changers in self-involvement and stress symptoms could be predicted accurately using the initial NPI scores; and musicality could be predicted accurately in 87.5% of the cases using initial PRCP and STAI scores.
Discussion

Validity of Music Therapy Intervention

The results of the study suggest that music therapy is effective in reducing musical performance anxiety as indicated by the significant change in subjects PRCP and NPI scores, as well as by the significant change in observer-rated video measures. Despite the small sample size, these results appear to hold up given the absolute magnitude of the effect sizes associated with the music therapy intervention. According to Cohen (1988), a large effect size in social science research is on the order of .14. The mean effect size of the group music therapy intervention on the above measures was .70, indicating that results from this study are far greater than those typically expected.

The effect of the music therapy intervention is also strengthened by the replication of findings of Study 1 by Study 2. Levels of change experienced by experimental subjects in STAI and PRCP moved in the same direction in both studies.

With respect to the Hawthorne Effect, it is evident that the changes in PRCP and NPI were not just an effect of the attention and support received by subjects from therapists and peers in
the group context. Experimental subjects, as compared to the attentional control subjects, became significantly more musical as a result of the music therapy treatment; the attentional subjects, who met weekly as a group with one of the therapists during the same time period, did not. This points to the external validity of the music therapy intervention. If the goal of the professional musician is to freely communicate music to an audience, the observer-rated video results indicate that experimental subjects were more able to achieve that after music therapy intervention.

The effectiveness of the group music therapy intervention is supported by subjects' qualitative data (See Appendix D). Subjects reported experiencing increased awareness, a stronger sense of identity, greater ability to communicate, increased feelings of community and body/mind integration as a result of the music therapy intervention. Most subjects also reported that the insights gained during the music therapy group process were having a positive impact on their "real life" performance situations. The researcher inferred from subjects' reports that their qualitative changes reflected the influence of the holistic and humanistic principles which permeated
the entire therapeutic process - awareness of the interrelationship of the body, mind and spirit, self-responsibility, self-expression and communication, and relatedness with others.

Discussion of Change in Observer-rated Video Measures

In order to understand how subjects' musicality, self-involvement and stress symptoms changed as a result of the music therapy intervention, the following analysis was made.

As mentioned before, there were significant positive correlations between both self-involvement and musicality, and stress symptoms and musicality. A reduction in subjects' self-involvement and stress symptoms appears to be related to an increase in their musicality. In reviewing the qualitative data, it was found that subjects' extreme self-involvement was actually a coping mechanism for their anxiety, either as a form of defensive denial, or as a safety valve when emotions became overwhelming. The stress symptoms were also related to suppression of feelings underlying subjects' anxiety.

It appears that the major conflict at the root of subjects' performance anxiety was related to self expression. Subjects seemed to become overly self-involved and anxious whenever they had an
opportunity to express themselves as autonomous beings. In many of the subjects, the inner "music child" (Nordoff & Robbins, 1974), the spontaneous, joyful, expressive capacity of the individual, lay dormant because of early unresolved music-related trauma and its associated emotional repression.

A primary goal of the music therapy intervention was to reawaken the life flow of the "music child" through guided imagery, play, humor and clinical improvisation, which is defined by Priestley (1975), as the spontaneous use of music and sound to release energy bound up in repressing images or memories in the unconscious because of fear of their disturbing emotional content. It is suggested that as the musician began to bond with his inner "music child" while participating in the above-mentioned processes, the psychological boundaries which limited his creative expression became more fluid and permeable. The musician was then more able to face the good/bad polarities within himself, (which were often the root cause of his anxiety) and could choose to resolve them metaphorically through the creative process of musical expression.

A core concept of music therapy as used in this study is the inherent power of the individual to repair what was damaged in the self through the
creative process (Klein, 1937). Through the process of reparation, subjects first acknowledged their self-destructive feeling states stemming from unresolved traumas. Through their willingness to enter into threatening feeling states as deeply as possible during the process of clinical improvisation and "reality rehearsal" performances, and trusting in the integrity of the reparative energies of the inner "music child", most subjects were able to experience their own music as a healing modality, which inspired deepening awareness, self-empowerment, resolution of conflict and wholeness.

Clinical improvisation also offered the anxious musician an opportunity to release rigid, perfectionistic attitudes related to performance. It required a more direct personal relationship with his primary instrument which led to intensified listening and expression. While improvising, subjects reported becoming more sensitive to inner psychic processes and were able to explore inner reality (feelings and images) symbolically through sound and musical forms.

It is suggested that clinical improvisation was an important factor in reducing the underlying musical causes of subjects' performance anxiety as described by Reubart (1985), as well as increasing
subjects' musicality as indicated in the observer-rated video measures. According to Ristad (1982), improvisation facilitates the development of musical imagination, sensitivity to rhythm, inner listening skills, musical memory and auditory/haptic coordination.

From the results of this study, it is evident that extreme self-involvement (as a reaction to weaknesses in the self-structure) is an integral part of the stress/anxiety syndrome. The music therapist helped to musician to become aware of the unloved, unresolved areas of the psyche and encouraged him to use his own music to meet his inner needs and to make strong musical affirmations of self. According to Winnicott (1971), the willingness to express one's self when in a threatening situation helps to heal the original trauma. Once the trauma is acknowledged and mourned, the need to be overly self-involved as a defensive measure diminishes. Additionally, as the subjects became more self-reliant and assertive in their musical-self expression, it appeared that they required less outside validation (from group members, therapists, teachers, music critics, etc.) of their self-worth as creative individuals.

In addition to the benefits of clinical improvisation in dealing with underlying core
issues of performance anxiety, subjects' sense of self was further strengthened through participation in "reality rehearsal" performances and through the activation of the giving and receiving feedback loop during musical performance. During reality rehearsal performances, subjects were able to reframe negative performance behaviors in a positive context, thereby becoming more confident and creative. As they began to feel more comfortable in the performance situation, subjects were also encouraged to focus, not on themselves, but on giving their music with love to the audience. It is suggested that this refocusing process further reduced self-involvement and increased self-esteem. Subjects also became more aware of the body/mind connection through breath and relaxation exercises, and thus more able to understand and deal with stress symptoms.

In summary, during the process of group music therapy, subjects began to become aware of and integrate the split-off feelings underlying their performance anxiety. As they became less judgmental, more accepting, and more musically expressive, they learned to take the focus off themselves while performing and to give their music un-self-consciously to the audience. For a more detailed description of the music therapy
Discussion of Change in Personality Measures

In both studies, reduction in subjects' trait anxiety was minimal in comparison to the reduction in their PRCP scores. This seems to suggest that a short-term group approach is beneficial in increasing subjects' musicality and confidence as performers. For a greater reduction in trait anxiety to occur, subjects would probably need more individual work within the group and more time to integrate and utilize what was learned during the 14-week intervention. It is suggested that the consistent emphasis on self-expression through improvisation and performance and the non-judgmental, supportive group environment offering positive feedback and a feeling of community was mainly responsible for the significant changes in subjects' musicality and PRCP scores.

The graphic inspection revealed that those subjects with the lowest NPI scores (low self-esteem) initially, changed the most after music therapy intervention. This finding suggests that group music therapy is effective in increasing self-esteem (healthy narcissism) in highly anxious, non-narcissistic musicians. Although subjects with high initial NPI scores did move significantly
Comparing the Music Therapy Intervention to Other Treatments for Performance Anxiety

In comparing the effectiveness of music therapy to that of the previously-mentioned treatment modalities, it is suggested that music therapy provided a more comprehensive approach to dealing with performance anxiety. In this study, music therapy's unique contribution was a holistic, humanistic approach which helped the anxious musician to use his own musical process as a means of overcoming performance anxiety. The main focus of the treatment was not on teaching new skills for coping with performance anxiety, but on fostering self-awareness, self-acceptance, self-expression and sharing with others. By narrowly focusing on the symptoms of performance anxiety, as was practiced in the other treatment modalities, the musician is bypassing the self-transformational aspects of his chosen profession - the opportunity to transcend limitations of the ego through creative expression and service to others.

Recommendations

Limitations of the Study

Reference is made to the attrition rate in both Studies 1 and 2. Although there is no empirical evidence which could help to explain why
certain individuals dropped out of the studies, it would seem, based on the results of the t-tests, that the subjects with the highest levels of trait anxiety were more apt to drop out than those with moderate levels of anxiety. It is hypothesized that the group context itself, which required a certain degree of self-disclosure and sharing from the very first session, may have been too great a stressor for certain extremely anxious subjects.

In reviewing the group process of the music therapy intervention of Study 2, it is obvious that the short-term music therapy intervention is just the first stage in a long process of psycho/aesthetic change for subjects. By the end of the 14th week, the group had become cohesive, the sense of trust among group members and therapists was deepening, and each subject's individual core issues were being explored. Because of the time limit of the group, however, subjects were not able to move to the next stage of treatment which would have involved more psychodynamic work, more trust and a deeper commitment to the therapeutic process. Seeds of growth were planted during this initial period, but at the termination of this study, it was too soon to determine how the seeds would grow. For these reasons, the subjects were offered the opportunity to continue the treatment
with one of the therapists, outside of the university setting for a minimal fee.

It is suggested that a future study be designed to explore the group process of the music therapy intervention and levels of change experienced by anxious musicians over the period of one year. This might provide a deeper level of understanding of the creative process involved in resolving relevant psychodynamic issues through the process of music therapy. This could also help to further validate the music therapy theory.

Because the therapeutic approach of the group music therapy intervention was multi-modal, it is difficult to state empirically which components of the therapy were most effective in reducing musical performance anxiety. A future study might include self-report measures which assess the efficacy of each component of the intervention on a week to week basis.

Although each session was videotaped and subjects were told that the videotapes were available to them to be reviewed after each session, only a few subjects were interested and only toward the end of the study. It is suggested that the use of videotapes could become an integral part of the therapeutic approach. Viewing the tapes during an actual session could be effective
in helping musicians to see themselves more objectively and to become more aware of the unconscious self-defeating behaviors related to their performance.

With respect to group composition (selection of subjects), it is suggested that specific groups of musicians be studied separately in the music therapy context so that individual differences among sub-populations of musicians (for example, between anxious musicians who play wind instruments vs. string instruments; musicians high in NPI vs. musicians low in NPI) could be determined. This can lead to a more in-depth understanding of the problem of performance anxiety in the musical community.

A future study might include the effect of music therapy with "normal" musicians. Perhaps this would indicate the underlying constituents of the positive performance experience. The personality profiles of these musicians could also set baselines of "normalcy" to be used as comparisons to the personality profiles of stressed musicians. This information could further substantiate the effectiveness of the music therapy intervention.

It would be helpful to validate the results of this study in a future study by running all the
measures on the control groups, to see if and how the music therapy intervention could be controlled for. To correlate standardized test measures with the observer-rated video measures, it is suggested that the STAI, NPI and PRCP be given to subjects pre and post session, as well as have the observers rate subjects during each group session with respect to self-involvement, stress symptoms and musicality. This would provide more data with which to understand the relationship between subjects' personality change and their observable behavioral change.

Further recommendations for future studies might include recruiting a larger number of subjects for the experimental group and rating subjects' performances outside of the music therapy group.

**Implications for the Music Therapy Community**

The magnitude of the findings in this study suggest that this use of group music therapy as a treatment for the fear/anxiety subcomponent of musical performance stress is worthy of further investigation. It is therefore suggested that this study be replicated using other music therapists to control for the personality factors of the therapists and to further validate the effective—
ness of the intervention. It is also recommended that similar studies be conducted using the group music therapy approach to treat performance stress in other performing artists including dancers, actors and visual artists. It is suggested that anxious dancers, actors etc. might have similar problems with self-expression that could be dealt with effectively in a group music therapy context.

Additionally, the use of the group music therapy intervention may prove to be equally effective in treating various other anxiety disorders. Empirical research along these lines would grant the field of music therapy more credibility so that more diverse groups of individuals can be benefitted by the holistic, humanistic approach of music therapy.

**Implications for the Musical Community**

Because the problem of performance anxiety among professional musicians is so prevalent in our society today (Fishbein et al., 1987), it is suggested that group music therapy become an integral part of the curriculum of the institutions which train musicians. Through participating in the music therapy group, music students can not only become aware of and resolve the underlying causes of their performance anxiety,
but can also develop a healthy relationship with their own music and with fellow music students and teachers. In this way, the student musicians are able to prevent more serious problems such as debilitating stage fright and the over-use syndrome (Frye, 1985). It is important for students to learn to cope with and resolve their anxiety prior to their journey into the "real world" of professional performance.

Since music therapy deals with mind, body and spirit, it can teach the musician to use his own music as a therapeutic tool to keep himself in an optimum state of emotional, mental and physical health. The unconscious, stressed musician channels his anxiety into his music which can be damaging to the body, as can be seen in the over-use syndrome. Anxiety and the concomitant misuse of the body must be acknowledged and understood before the musician actually damages himself and begins to fear and even resent his music. If he is continually anxious during his performance experiences, the possibility of illness, whether of a physical, emotional or spiritual nature, is greatly enhanced.

Most importantly, music therapy for musicians, when integrated into the performance community, can help musicians, young and old alike, to awaken
their highest purpose for performing, that which has the potential to keep them at the optimum levels of health and well-being. Havas (1979) offers her thought on this matter,

... the idea of giving, of transmitting something greater than oneself, is the essence of artistic creativity and should be nurtured (in musicians) from the very beginning (p. 98).

Finally, the researcher concludes that the music therapy group is a natural context for anxious musicians to work through their fears and creative blocks related to performance. The music therapy group seems to counteract the "normal" societal context of musical performance which apparently adds to the anxiety of the already vulnerable musician.
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Musical Background Information on Study 1 Subjects

1. D. was a 25 year old pianist and composer who had been performing his original music (jazz fusion, pop) in clubs around the metropolitan area for the past three years. His presenting problem in the group was his fear of performing solo and making mistakes. He reported that he had always "kept a distance" in his relationships with music teachers and with his audiences. This gave him a feeling of safety, but did not allow him to fully communicate his message through his music. D. experienced the following stress symptoms related to performance: upset stomach, feeling fearful, and feeling inferior to others.

D. reported that his parents had been supportive of his musical development, however, he remembered a "traumatic" incident where his parents had asked him to stop playing the piano (when he was 11 years old) when their guests had arrived. D. reported that he had felt humiliated and insulted by the incident and that around that time he had lost his enthusiasm for playing music publicly.

D. stated that the therapeutic value of music "turns pain into beauty; makes me feel like I'm not
alone." His therapeutic goal for the music therapy group was to learn to relax and enjoy performing more and to feel really comfortable sharing with others.

2. G. was an 18 year old jazz/rock bassist and fine arts student who had performed publicly in "surf" bands since she was 17 years old. Her original instrument was the recorder, followed by the piano, and then electric guitar. Her presenting problem to the group was her extreme bodily tension related to musical performance and her need to get through personal blocks, "and just play." She reported that her mother had been supportive of her playing, but only as a hobby. She reported being traumatized at age 12 when a new music teacher had compared her to her brother, naming him the "musical" one. From this point on she had felt herself to be uncreative and unmusical. G. experienced the following stress symptoms related to performance: allergies, heaviness in arms and legs, feeling inferior, overeating, feeling fearful, and thoughts of ending her life.

D. reported that her main goal for playing music was to gain personal fulfillment and to show off her work. She finds performing, "fun, as long as there is no spotlight on me." As a way of
coping with her stress, D. prays for strength not to "screw up." D.'s therapeutic goal for the group was, "to be able to get over the hang up that I'm not creative", to be able to trust herself and to improvise freely.

3. M. was a 34 year old opera singer (alto) who has been performing professionally for many years. As a child, she was asked to perform regularly in church by her father, a Lutheran minister. Her original instrument was the piano, followed by the trombone, followed by the french horn. She reported that as a child she loved singing and thought she was "hot stuff". Now she feels she is never good enough. As she was growing up, she constantly compared herself (musically) to her brothers and sisters. She reported being highly competitive. M. was rejected for the first time (musically) at her college graduation where she was denied a recommendation to a conservatory by her primary teacher. M. experienced the following stress symptoms related to performance: tightness in jaw, feeling nervous/tense, difficulty falling and staying asleep, loss of sexual functioning, grinding of teeth, allergies, difficulty concentrating and binge/purge patterns.

M. reported that her basic need for performing was to express emotions that had no other outlet.
She also felt that she needed to please others and be appreciated by them. She reported finding it easier as a performer to play a character (as in opera) as opposed to just being herself. Her therapeutic goal for the group was to focus on her reason for becoming a musician; to be "at one" with her self and her instrument; and to be able to focus on what she wants to give in her music rather than competitiveness with others.

4. T. was an 18 year old jazz saxophonist and performance major who had some professional performance experience. She reported that her earliest memory of music was one of listening to the radio in the basement with her father and feeling dismayed. Her presenting problem to the group was her feeling of being "out of control" due to nervousness which caused her to hate performing. She reported that her nervousness was due to her lack of trust that God would not answer her prayers. She feared that she would sound awful while performing, that she might play a lot of notes without meaning and that the audience would hate her. She experienced the following stress symptoms related to performance: extreme fear, thoughts hard to get rid of, difficulty making decisions, loss of interest in things, feeling inferior and bodily tension.
T. reported that she performs because it is necessary for her growth; she performs to overcome fear of performance. She also reported being very self-conscious and feeling the need to be perfect and pleasing to the audience; she was apologetic that she was not. T.'s therapeutic goal for the music therapy group was to become aware of when she experiences stress, to overcome inhibitions and to become more flexible in her body while playing music.

5. D.C. was a 29 year old singer/songwriter who performed sporadically around the metropolitan area with his new wave/rock band. His first memory of music was as a small child listening to Brenda Lee's "I'm Sorry" in a diner with his mother. He reported feeling safe and secure. His parents had encouraged his musical development, "as long as he didn't make too much noise." He reported being traumatized in the fifth grade by a teacher that he really loved. He was ridiculed by her in front of his classmates for playing the kazoo in class. He reported feeling embarrassed, betrayed and humiliated and lost face in front of his peers.

His presenting problem to the group was his performance anxiety which he believed was due his confusion of "not wanting to be made a spectacle of, while at the same time desiring attention." He
also feared being judged harshly, being threatened physically, and boring the audience while performing. D.C. reported the following physical symptoms related to performance: tightness in jaw, stress tension, overeating, twitches, tics, spasms, grinding teeth and soar throat.

D.C. reported that his motivation for performing was to communicate and reach people. He wanted to, "physically manifest his music in a real and powerful way". His therapeutic goal for the group was to feel more at ease about performing and to gain more self-confidence.

6. D.G. was a 40 year old classical clarinetist who had been performing publicly as a freelance musician for over 20 years. He reported that his mother had been supportive of his musical development until she died when he was 14. His father had been supportive financially only. His older brother would not tolerate D.G. 's practicing as he was growing up, and he competed with D.G. musically. He was traumatized at age 18 by a teacher who had singled him out among other students as not having made sufficient progress in his musical studies.

D.G. reported that his motivation for playing music was, at first, an escape, then as "a way to express a part of me that wasn't finding
fulfillment in my home life." It was also a way for him to "show himself to others". Although D.G. reported feeling anxious and tense while performing, he did not report any stress symptoms related to performance.

According to D.G., his purpose for performing was to share the expression of his love of life. He felt that music brought together people from all over the world. His therapeutic goal for the group was to discover new things about himself, and to channel his nervous energy positively. D.G. was in psychotherapy briefly prior to his participation in the music therapy group, and was an est graduate.

7. C. was a 27 year old flutist and music therapy student with some performance background. Her first memory of music was a negative experience; her father banging angrily on the piano. She reported that her mother had been supportive of her musical studies; her father was neutral. She felt she had been cheated out of many years of musical enjoyment because of impatient and harsh flute teachers. She reported having blocks about practicing, and sabotaged her own playing by not preparing well enough. She feared being judged and watched by others. C. reported the following stress symptoms related to performance: overeating, worrying, heart racing, difficulty concentrating,
and outbursts of anger.

D. reported that her purpose for performing was to be noticed. Her therapeutic goal for the music therapy group was to free herself from inhibitions related to self expression and to overcome her nervousness related to playing music.
APPENDIX B

Musical Background Information on Study 2 Subjects

1. G. was a 38 year old operatic tenor who had been performing publicly as a singer/dancer/actor since he was a small child. His presenting problem in the group was his inability to use the upper register of his voice because of extreme tension which surfaced around the time of the death, to years earlier, of his grandmother, who he believed had been his only source of support and nurturance. He also experienced the following stress symptoms related to performance: voice quavering, shakiness, nervousness, tightness in stomach, nausea, difficulty falling asleep and feeling inferior to others.

G. reported that his parents had not been supportive of his musical career and were abusive to the point that he had to be placed in foster care. He stated that the therapeutic value of music was essential for him, "to keep from going crazy", during the extremely stressful periods of his life. Previous forms of therapy included individual, psycho-drama and encounter groups. His therapeutic goal for the music therapy group was to learn to become more relaxed so that he could get
back the use of his upper register and return to a regular performance schedule.

2. S. was a 30 year old classical violist who did freelance work (orchestral, chamber music, musical theater) around the metropolitan area. He has been performing since the age of 14. He reported that his parents had been supportive of his music, "to the point of coercion" and were primarily interested in the "product" of his music making. His presenting problem was his extreme anxiety, which he believed was caused by his "inner critic", which seemed to sabotage many of his professional musical endeavors. He also experienced the following stress symptoms related to performance: dry mouth, tightness in jaw, sweaty palms, nervousness, shakiness, grinding of teeth, tightness in stomach, nauseau, extreme fear, difficulty concentrating and feelings of inferiority.

He reported that his main goal in playing music was to reveal himself to others, to communicate beauty to the audience. He experienced an ambivalent relationship with his music, however, a sense of joy on the one hand, and the pain of past failures on the other. He believed that his anxiety caused him to play way below his ability on his instrument and he hoped that through
his participation in the music therapy group that he would understand the cause of his anxiety and be able to deal with it more constructively. He also expected that the group would help him to know himself better. He had previously been in therapy for a brief time, but did not find it helpful.

3. C. was a 29 year old "new wave" song stylist who also played the guitar. She reported that her early experiences of playing music had been frustrating to her; as a child she was "forced" by her parents to study the piano for 5 years, when she really wanted to play the guitar. She also reported that her parents had not encouraged her musical development. She began studying the guitar at the age of 24 and made her professional debut as a song stylist at age 26.

C. felt that her purpose as a musician was to communicate what she could not put into words, mainly her anger and frustration. She reported having difficulty expressing feelings of love and happiness in her music. Her presenting problem to the group was her debilitating feeling of inferiority and anxiety prior to performing and extreme feelings of negativity after performing. She also experienced the following stress symptoms related to performance: voice quavering, dry mouth, tightness in jaw, shakiness, grinding of
teeth, heart racing, tightness in stomach and nervousness.

Her therapeutic goal for the group was to understand the dynamics behind her fear of becoming a successful musician, and to learn to interact better with other musicians.

4. J. was a 29 year old classical flutist who was completing her doctoral degree in music performance at a local conservatory. She also was a free-lance musician and played frequently in orchestras and chamber groups around the city. J. had received some encouragement regarding her musical development from her parents and from her grandmother, who was a Julliard-trained pianist. Her presenting problem was her performance-related insecurity and self-consciousness. While performing, she often experienced fears that she would fall apart, lose control and have to stop playing in the middle of a piece. She also experienced the following stress symptoms relating to performance: hot flushes, nervousness, shakiness, heart racing, abuse of alcohol or drugs, difficulty concentrating and feeling fearful and inferior to others.

J. reported having been traumatized by her flute teacher when she was about to present her first solo recital. The teacher, who had been
supportive of J's musical development for 3 1/2 years during college, abruptly pulled back her support in helping J. to prepare for her recital and also refused to give her recommendations to continue her musical studies in graduate school. J. felt that this rejection from her teacher had seriously affected her feeling of self-worth as a musician.

J. reported that her musical goal was to express herself, as well as to work harmoniously with other musicians in musical performance. Her therapeutic goal was to learn what caused her nervousness and to be able to control her "nerves" while performing and taking auditions. Several years ago she had been in psychotherapy for a brief time, but did not find it helpful.

5. L. was a 40 year old singer/songwriter who also played guitar. She just recently started performing professionally after putting aside her career as a fine artist. Her presenting problem was her severe "inner critic" which seemed to prohibit her enjoyment of performing. She also found it difficult to be "forceful" and to project herself in her music. L. also experienced the following stress symptoms related to performance: voice quavering, dry mouth, tightness in jaw,
nervousness, tightness in stomach, nausea, trouble getting her breath, feeling fearful and inferior to others, difficulty falling asleep and staying asleep, and headaches.

L. reported that while in her teens, she was traumatized by her father's severe criticism of her singing when she performed a few tunes with a band while her family was traveling in Israel. She also reported that her parents had not been supportive of her musical development. While she was growing up, she had dreamt of becoming a singer, but had given up her dream because of parental pressure. Her purpose for wanting to play music was to express herself. She reported that music helped her to be in touch with positive forces within herself and within the world. Her stated purpose for being in the music therapy group was to learn how to deal with her performance stress and to learn how other musicians experienced and dealt with their stress.

6. H. was a 40 year old classical pianist and music therapy student who had some professional performing experience. Her presenting problem was her experience of being emotionally disconnected from her music while performing, which she believed was related to her extreme fear of making mistakes. She also experienced the following stress symptoms
related to performance: voice quavering, nervousness, blushing, lower back pain, feeling fearful and inferior to others, and headaches.

H. reported that she had loved playing the piano and performing as a child, but when she reached adolescence, she preferred to relate to music more privately, choosing not to perform. She reported that her parents had been concerned only with how "good" she played and forced her to perform for friends and relatives. On one occasion, she reacted to her father's severe criticism of her music by choosing to terminate her piano lessons and put aside her desire to play music. This had been a traumatic experience for H.

H. resumed her piano lessons later in life when her daughter had started studying the piano. At this point she had become more autonomous, but still felt ambivalent about her playing. H. reported that her goal as a musician was to share her love of music with others and to express herself. Her therapeutic goal for the group was to find a way to allow herself to feel joy instead of anxiety when playing alone or with others. H. had been in psychotherapy for a year prior to her participation in the music therapy study.
7. G.S. was a 31 year old rock bassist who was a member of two rock bands and performed sporadically in clubs around the city. He reported that as a child his parents had decided, against his wishes, that he should study piano and violin. His mother had been a semi-professional classical pianist, and wanted him to pursue a career as a classical musician. He experienced many failures as a young musician, had non-empathic violin teachers and developed an ambivalent relationship towards music. G.S.'s presenting problem was inability to focus on his music while performing. He believed this was caused by his intense fear of making mistakes, or forgetting the music. He also experienced the following stress symptoms related to performance: voice quavering, nervousness, shakiness, difficulty in making decisions, difficulty staying asleep, lower back pain, tightness in stomach, extreme fear of events or places, feeling fearful and inferior to others and difficulty concentrating.

G.S. reported that his musical goal was to have fun and to be a part of a harmonious group. He wanted to play dance music and make people happy. Playing music for him was uplifting and made him feel like he had a purpose in life. His therapeutic goal for the group was to learn how to focus and to enjoy performing more, not to be
afraid of making mistakes, and to gain more self-confidence. G.S. had previously been in psychotherapy for a brief time but did not find it helpful.

8. J.C. was a 37 year old singer/songwriter who also played guitar. He performed his own compositions, both solo and with bands in the metropolitan area, as well as in other parts of the country. His presenting problem was the emotional and physical stress which he experienced prior to performance, which he believed affected his musical expression. He also experienced the following stress symptoms related to performance: dry mouth, soreness of muscles, eczema, nervousness, grinding of teeth, trouble getting his breath, and difficulty concentrating.

J.C. reported having been the only musician in his entire extended family, although his sister had studied piano as a child. His parents had been supportive, but were pessimistic about his being able to "make it" in the music industry. He reported being traumatized when he was dropped from a pop band that he had been playing with 5 years earlier. This had created feelings in him of being rejected and incompetent during that time.

J.C.'s musical goal was to share himself (his music) with others. He had sung in a church choir
as a young boy, and felt he had a spiritual connection with music. As an adolescent and young man, he performed rock, folk and blues music in different musical settings. He reported that music helped him to relax and to expand outward. He liked to perform music that was light-hearted and had difficulty expressing feeling of grief and anger.

J.C.'s therapeutic goal for the group was to unmask parts of himself that were hiding his "real" self; to gain insights on how to excel as a musician; and to learn to relax more. He had no previous experience of individual psychotherapy but had participated in several self-development groups, i.e., EST.
Two instruments were developed by the researcher to obtain information from subjects regarding their "lived" experience of performance stress/anxiety as well as their "lived" experience of group music therapy:

1. Post-group questionnaires. These contained a number of open-ended questions regarding subjects' goal for each session, their experience of group improvisation and individual interventions (if any) and what they learned about themselves during the group process.

2. Weekly logs. These contained a number of open-ended questions which related to subjects' performance experiences outside of the group. Non-musical experiences which may have affected subjects' state anxiety were to be reported in the logs as well as subjects' goals for each session and reports on if and how insights gleaned from the music therapy group process were being integrated into their daily lives.

The bulk of the qualitative data came from the subjects' verbal dialogue, which was transcribed from weekly session videotapes. Giorgi's (1975)
phenomenological method was adapted by the researcher for use in analyzing the raw data taken from the videotapes as well as from post-group questionnaires and weekly logs. In this method, the task of the researcher is to let the world of the describer, or the situations as it exists for the subject, reveal itself through the description in an unbiased way (p. 74). The five stages of the qualitative analysis were as follows:

1. The researcher viewed each of the 12 music therapy session videotapes and transcribed all the verbal dialogue of each group onto a word processor. She also read through all of the weekly logs and post-group questionnaires of each subject.

2. The researcher then read through the verbal dialogue (taken from the videotapes), the post-group questionnaires and logs, slowly, looking for individual descriptions of subjects' performance stress and performance issues; subjects' awareness of thoughts, feelings and bodily sensations associated with performance stress; subjects' overall experience of group music therapy; and subjects' report of change due to music therapy intervention.

3. The researcher then categorized individual descriptions of each group member under the above categories. Redundancies were eliminated and the
meaning of each category was clarified or elaborated by relating them to each other and to the sense of the whole group process.

4. The researcher then reflected upon the given categories (with data still in the subjects' original language) and extracted the essential information of each category from the given data.

5. The researcher then attempted to interpret the meaning of the above categories in the light of relevant psychological and music therapy theories.

The underlying constituents of performance stress as extracted from the qualitative data are described below. The constituents are ranked according to the frequency of qualifying statements made by the subjects.

1. Inner critic. According to subjects, the inner critic represented negative self-talk which seemed to have originated from harsh judgments of parents, teachers and peers in response to past performance situations. The subjects reported that the inner critic became more active in situations where they felt their expression of self would be evaluated in some way.

   The first step in transforming the "inner critic" was for subjects to become aware of the voices that had instilled the harsh judgment upon their music. This was done in-the-moment in the
music therapy group context. By unearthing these voices, the subjects were then able to become aware of the emotions which were connected to the voices. Subjects found that on a deeper level, the self reacted to these voices with feelings of anger, sadness, helplessness, guilt and fear. It was actually these emotions which blocked the full expression of the music and prevented the musician from experiencing fulfillment in his performance. As the musician became aware of the negative inner voices and the feelings underlying them, he was then able to make choices, based on his own realistic assessment of his musical performance, as to which voices were helpful and which voices needed to be relinquished. The musician received support and encouragement in making these choices from the group members and therapists.

2. Ambivalent association with primary instrument. Most subjects felt pressured to play "perfectly" while performing on their primary instruments. They felt they would be personally judged while playing their primary instruments and were fearful of making mistakes. They did not worry so much, however, while improvising on instruments other than their primary ones. In this musical situation, they felt they would not be judged. They could relax and enjoy themselves.
The relationship between the musician and his music often reflects his primary relationship with his mother (Benenzon, 1982; Salk, 1955; Diamond, 1986). If the musician did not work through early separation/individuation issues, his instrument often becomes a substitute for the "loved/hated" object (mother) and his ambivalence for mother is projected onto his instrument. His severe judgmental attitude towards his primary instrument becomes symbolic of his inner relationship with his expressive self. Unconsciously he feels that if he plays badly or makes mistakes, he will not receive his mother's love. He is still dependent on her approval and acknowledgment and is frightened that if he is not perfect, he will be rejected. His music becomes a measure of his self worth. This creates anxiety for the musician every time he is about to perform for an audience, which also is representative of mother (Gabbard, 1979). Often the musician projects this anxiety, in the form of anger and frustration, onto his instrument, his vehicle for self expression.

The music therapist helped the musician to take the focus off his fears of making mistakes and being rejected, to creating a new bond with his instrument in the spirit of compassion and unconditional self-acceptance. The musician was
encouraged to enter into the process of getting to
know his instrument as if it were a new friend -
loving it, accepting it, for better or for worse.
This helped him to detach from his ambivalent
relationship with his instrument (mother), and to
become more autonomous in the process. As his own
musical identity began to develop, separate from
mother, his relationship with his instrument became
more "mature", infused with a sense of courage and
love as opposed to helplessness and frustration.
3. Lack of commitment to musical performance.
Fear of being judged was a common experience of all
subjects. Subjects reported that in order to deal
with this fear, a part of themselves detaches from
the performance experience, so that the whole self
is not put on the line, "subject to attack".Subjects reported anticipating failure as opposed
to success in the performance situation. They felt
they had to protect themselves in case they made a
mistake or did something "inappropriate" while
playing music.

The above behavior, in its extreme state, has
been defined by Kaplan (1969) as depersonalization,
"a split between a functioning and an observing
self, with pronounced spatial disorientation. The
observing self perceives the functioning self as
off at a distance, operating mechanically before an
audience which is also perceived as quite distant." (p. 65).

The subjects' above-mentioned behavior may have also represented Winnicott's description of the "false self". Because the subject feared rejection and abandonment from the audience, and at the same time wanted their love and approval, he would split off or dissociate from the fear and its underlying emotions of sadness, anger, frustration, and would pretend through the "false self" that he was secure and willing to please the audience. Because the subject was not allowing himself to be totally present in his musical experience, he was unable to communicate the music with the emotional intensity needed to really engage the giving and receiving feedback loop with the audience. In the end, this caused even more frustration, as a part of the subject's psyche was "frozen" during the performance, and remained frozen, unable to be melted by the creative fire of the particular piece of music he was performing.

The music therapist encouraged the anxious musician to become aware of the feelings underlying his anxiety response. When working with an actual performance piece, the musician was asked to let the music carry the emotions that may have been suppressed. Frequently these were feelings of
sadness, longing and anger. Most group members chose pieces which actually embodied the emotions that they had the most difficulty accepting in themselves. The music therapist helped the musician to use the music itself to draw forth the emotion in conflict or its polarity, in order to resolve past traumas and to facilitate inner balance in the performer. The problem with depersonalization was that the musician was disconnected from the emotional content of the music (and from himself). He was, in fact, identified with his negative self-image, which in effect was a cover-up for deeper emotional issues.

4. Lack of preparation (with regard to performance piece, Slumber Song). Some subjects did not prepare adequately to perform the piece for the group. A few subjects explained that by not preparing well enough, they would then have an excuse in case they made mistakes, or "screwed up" the piece. In this way, the audience would not have such high expectations of them.

This kind of thinking shows a rather negative association with performance, anticipating failure as opposed to success. It also may reflect subjects' initial resistance to the therapy process. This behavior also shows the subject's lack of commitment to performing music, a lack of
self-respect and a disbelief that if one prepares well, one will do well. The above-mentioned subject was also falsely projecting his own critical expectations onto the audience and was not able to be concerned about his role of communicating the music.

The music therapist helped to inspire a deeper sense of purpose in the performing musician. She encouraged the musician to focus on the meaning inherent in the music and to bracket out ego-identification and self-involvement. Through active techniques which had the potential to induce "peak" experiences, music therapy helped the re-awaken the original sense of joy in sharing music that many subjects had lost due to mixed messages (good/bad judgment) from parents, teachers, and societal pressures.

5. Underdeveloped will and lack of focus in musical performance. A common component of performance stress as reported by subjects was the feeling of being out of control due to nervousness during a performance. Subjects experienced shaking (in their voices, hands, knees and ankles), shortness of breath and heart palpitations as performance stress symptoms. Because these bodily symptoms led to a feeling of being out of control, subjects would try to control them by forcing the
mind to suppress the nervous reaction. This in turn would take the focus off the music, as attention was needed to keep the bodily sensations in check. The breath would lock, the body would become rigid and musical expression became stifled. This would create a feeling of anger and hopelessness in subjects. Subjects realized that they were conditioned to respond to the negative stress syndrome while performing, rather than to the pull of the music itself.

One of the most detrimental ways of dealing with anxiety is attempting to control the feeling state of being out of control. When one is feeling out of control, it is important to come back to center and to become the observer of the different dynamics (both inner and outer) which are occurring. This technique is called focusing (Gendlin, 1978). During an actual performance, it is quite difficult to do this. The music therapist gave the performer the opportunity to allow himself to feel out of control in a "reality rehearsal" performance situation and to study the dynamics of this state. The yogic technique of breath awareness (Rama, 1978) was taught to the musician so that the breath would become the home base that he could return to when feelings or thoughts began to overwhelm him. Focusing on and learning to...
control the breath calms the autonomic nervous system and allows the physical symptoms to subside. The musician could then return his focus to the music, and use his will to affirm his purpose and activate and channel his creative energy (nervousness/excitement) into the music.

6. Inability to share one's music with the audience. Most subjects reported that expressing emotions such as loneliness, anger, joy, and love were difficult for them to do musically. One subject said that connecting intimately with a small audience was more difficult than singing to an anonymous audience, "out there." During the group improvisations subjects found that communicating through singing directly to another group member was more difficult than just playing instruments together. They often reacted nervously when they were mirrored musically by the therapists and by other group members. One subject felt that the audience might get "squeamish" if she got too close to them while performing. All subjects reported having fears of playing solo in front of an audience or being the leader of an ensemble or improvisation group.

Mayman (1974) writes about the shame dynamic, a sense of feeling naked and unable to hide one's shame (underlying repressed memories of the
excitement and exhilaration of early childhood nudity) as being part of the stage fright syndrome. The performer is torn between the desire to expose himself to prove he is a fully equipped sexual creature and the fear that onlookers will find his equipment laughable (p. 386). The shame dynamic not only applies to the child's sexual feelings, but to any intense emotions which he feels may not be acceptable to or acknowledged by significant others.

Gabbard (1975) writes that separation anxiety, a child's fear of asserting himself as a separate individual against the regressive pulls of symbiosis (Mahler, 1975), is an important dynamic in the stage fright syndrome (see p. 10 of this paper). In her clinical experience, Shields (1980) has found that many musicians have conflicts around the mother-child symbiotic formation. From a psychoanalytic perspective, it would seem that most subjects in this study were still psychologically bound to their introjected "mother" and were dependent on her for the fulfillment of primitive needs such as nurturing, belongingness, approval etc. According to Mahler's theory, if they released their narcissistic bond with mother, these subjects would probably experience much tension and fear, as they would then come face to face with
realizing their purpose in life, taking care of their own mothering needs and standing up for themselves as separate individuals. Also, the anxious musician might fear that if he attempts to separate from mother, she would withdraw the love and support she had offered in the past and he would be left alone in the world, without a safety net.

When dealing with the issue of separation/individuation, the music therapist first helps the musician to become aware of his underlying dependency on significant others for acknowledgement, approval and love, and how this affects his performance experience. She then encourages him to take some time to think about what music he really enjoys playing. Often this is not the music he is focusing on at the time. Many musicians have been molded into musical "clones" by teachers and significant others. Because of their dependency on significant others (parents, teachers) they are often too fearful of expressing their own musical opinions and desires.

New choices of music might include songs from childhood, other genres of music, improvisation - or it could be the musician's current repertoire. Sometimes the musician needs only to be freed from the harsh judgment he places on himself while
playing music, so that he can allow himself to enjoy his playing and to be nurtured by the musical experience. In the music therapy context, the musician is actually bonding with his own music, with his own self. The music becomes the transitional object (Tyson, 1979) as the musician gradually begins to separate from mother and develops his own musical/self identity.

One way of strengthening the musician's sense of self is through the process of vocal improvisation. Khan (1954) describes the voice as the mirror of the soul. In the music therapy group, the musician was encouraged to let go of the judgments he placed upon his vocal expression, to go within and allow a vocal self-statement to emerge, and to share this with the group. He was asked not to think, but to feel the music emanating from his source, his hara (belly) and to allow it to just be in its own unique sound form and pulse. Through contacting the musical "self", the musician is reconnected with his own inner music (Nordoff & Robbins, 1974; Priestley, 1975). It is only from the space of one's inner music that true motivation for creativity and growth can be activated.

During "reality rehearsal" performances, the musician was encouraged to make contact with the "audience" and to become aware of the thoughts,
feelings and bodily sensations that emerge during the performance process which block this contact. If painful feelings emerged, it was suggested that the energy of these feelings (perhaps stemming from a past trauma) be accepted fully by the musician and then channelled into the music to enhance the musical expression.

According to object relations theory (Winnicott, 1974; Kernberg, 1982), individuals who have a weak sense of self often create a "narcissistic shell" around themselves which prevents them from making emotional contact with others. During the group improvisations, as well as in individual work, the music therapist reflected back to the musician, both instrumentally and verbally, certain self-revealing communications that he had made, in order to help him to be able to see and hear himself as he existed authentically in the here-and-now. Mirroring helped the musician to become aware of his self and to own it. In this way, he had also to deal with the fact that someone was really listening to him, really being with him. This was sometimes threatening for several subjects. Mirroring during the music therapy process helped to diminish the sense of unreality that the overly self-involved musician felt about himself and strengthened his sense of
personal identity.

7. Lack of strong self-concept. Many subjects reported that they found it difficult to separate their own thoughts and feelings from the critical judgment of others. Their moods seemed to change based on how others viewed them. One subject reported that she felt like a vacuum that was filled with the opinions, beliefs and judgments of teachers, peers and parents. Two subjects had fears of boring people with their music. Some subjects became aware of their need for approval when playing music. During the group improvisations, subjects became aware of their patterns of conformity within the group structure as well as their inclinations to act out or rebel against the group norms. Some subjects had difficulty playing music for their own enjoyment and experienced music as drudgery, "just a job."

Again, this data reflects subjects' weak sense of identity and low self-esteem. This particular personality structure might suggest a form of a narcissistic personality disorder (Emmons, 1987). Because the musician has a weak sense of self, he is constantly seeking recognition and approval from others. Because the narcissistic musician is often fearful of the imagined intensity of his emotions, they are often repressed. The repression causes a
lack of enthusiasm for life and weakens self-motivation. During the first few group improvisations, subjects evidenced extreme shifts in mood from conformity to hostility in their musical expression. There was a lack of true musical relationship among group members. The subjects were self-involved and found it difficult to put their music forward.

Because subjects were often cut-off from their emotional selves, the technical aspects of the music became over-valued. There was a striving for perfection and no allowance for making mistakes. These musicians tended to be left-brain dominant (Diamond, 1985). This imbalance fosters an assertive, aggressive behavior which does not allow much time for repose, reflection, reverie and emotional expression (right brain attributes). The musician's ability to play and his sense of wholeness were forced into the background of consciousness.

Through breath awareness, relaxation exercises and musical improvisation in a supportive "playful" atmosphere, subjects were encouraged to unwind their self-judgment and aggressive behavior, to soften their competitive attitudes and to cultivate gentleness and self-acceptance. Being in a group situation with other musicians with similar problems seemed to reduce feelings of aloneness and
vulnerability, as the musician began to allow some parts of himself which he had been hiding to emerge into the group process. Group members began to interact musically and verbally, and deeper levels of sharing unfolded as the group progressed. Self-involvement decreased as a sense of community was experienced among group members.

8. Ambivalent relationship with audience. Most subjects had inaccurate perceptions of audience attitudes and needs. They projected inner fears and wishes onto the audience and often worried about what the audience might be thinking of them. Some of the fears experienced by subjects were that the audience would: be overly critical, fall asleep while they were performing, only go to performances because they were obligated.

The musician's role is one of outward directed communication (Diamond, 1984; Havas, 1979). The subjects in this study seemed to be generally more concerned with their own inner needs and projections with regard to musical performance than with the goal of communicating music to the audience. This state of excessive self-involvement seems to be an attribute of most adults with neurotic anxiety (Diamond, 1987). It is possible that subjects may have unconsciously perceived the audience as a parental object, whose rejection of
them at a critical growth period had created ambivalent feelings: the desire to be accepted and loved coupled with feelings of hopelessness, despair and anger from perceiving themselves as unlovable. It was hypothesized that subjects were repeatedly re-enacting this inner conflict in the guise of musical performance, with the hope of some resolution of the painful feelings that had become a part of their self-systems.

Because of the intensity of the above-mentioned submerged feelings, the audience is perceived by the highly anxious musician as something to be feared, and if his trauma was great, to be avoided. Those anxious musicians who do perform often seem to enclose themselves in a "narcissistic shell" which prevents them from really making contact with the audience. Because their fear was so great, subjects may have pretended that the mother/father (audience) was not really there, which is indicative of defensive denial. They may have been trying to prove to mother, through the performance experience, that they wouldn't fall apart without her (Kernberg, 1982) (even though they have never completely introjected her in the first place - which is the cause of their deep sense of insecurity).

Performing then became a test of mastery as opposed
to a gift of giving, i.e., "Can I get through this [the performance] without making any mistakes?"

The above-mentioned component of performance anxiety was again related to subjects' unresolved dependency issues. The music therapist first helped the subject to bond with his own music and cultivated the soil of the subject's own musical identity. Once the subject began to establish a positive relationship with his own music, he was then encouraged to share his music with group members during group improvisations and actual performance situations. In this way, the subject began to bond musically with others. As the subject began to strengthen his bond with his own music and his relationships with others, he was then encouraged to use his own music (both vocal and instrumental) creatively in the form of improvisations and compositions, utilizing storytelling techniques, imagery, and the creative will, to resolve emotional polarities and to fill the holes in his development. According to Kenny (1985), "Music is the expressive connective tissue guiding us into wholeness" (p. 9).

Subjects' descriptions of their experience of group music therapy as a positive force in helping them to understand and effectively deal with performance stress were summarized and categorized
under the headings of the four integral components of the music therapy group process:

1. Breath and relaxation exercises. At the start of the group, most subjects reported that they were not aware of their breath patterns or the relationship of the breath to musical expression. When subjects were asked to pay attention to their breath prior to, during and after performing, many became aware of blocks in their body/mind which inhibited the free flow of breath while playing music. After participating in a few breath awareness/relaxation exercises prior to the group improvisations, group members began to report feeling more relaxed, more spontaneous and less blocked in their musical expression. A few subjects mentioned that they were using these techniques at home and in actual performance situations with good results. They reported that by concentrating on relaxing and centering prior to performance, they were able to stop worrying about what everyone else (the audience) was thinking.

Note: The breath awareness exercises included the practice of watching the breath, allowing it to become deeper and fuller and more rhythmic, and the concept of breath being the force behind musical expression. Relaxation exercises included systematic relaxation of different parts of the
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body, mental unwinding, playful movement and toning.

2. Group improvisation. Most subjects found that the "inner critic" did not seem to be present while they were improvising on instruments other than their major instrument. Improvisation helped them to become aware of and express hidden feelings and allowed them to follow creative instincts through the music. It was difficult for some subjects to participate in such an unstructured musical environment. One subject reported that it was scary opening up closed doors into the depths of being.

When improvising, subjects felt more spontaneous - there was no "right" way of doing it. Most subjects were able to relax and have fun while improvising. The group dynamics brought up issues of when to lead and when to follow, cooperation, empathy, and exploration of different parts of the self through music.

3. Verbal processing and discussion. Most subjects reported that they benefitted from having the opportunity to talk about their stress-related problems with like-minded peers. Discussion of the group dynamics which occurred during the musical improvisations as well as the subjects' experiences of the individual music therapy techniques
apparently helped to clarify the issues of performance anxiety thereby aiding in their resolution. Verbal sharing among group members seemed to be more important during the first half of the experiment (sessions one through seven) than actual musical sharing. The verbal discussions helped to dissipate some of the nervousness, possibly disarming the group members so that they could feel safe in expressing deeper aspects of themselves through the music.

4. "Reality rehearsal" performances. Through awareness techniques introduced to the subjects by the therapists during "reality rehearsal" performances, subjects unearthed and explored the following performance issues:

1. Being true to oneself when playing music vs. changing one's musical orientation in order to win approval and acceptance from significant others.

Subjects began to learn that it was important to find the inner meaning in the music which they were performing, to merge with their music and to give it as a gift to the audience. They found that it was important to let go of personal idiosyncrasies and to merge with the original intention of the composer. This produced a deeper level of thought and feeling in their musical performances. Subjects also realized that they could not please
everyone in the audience and learned to fully connect with the music first and then to give the music out - if the audience didn't like it, it wasn't their (the musicians') problem.

2. The idea of trusting in oneself and in others during performance as opposed to maintaining a separatist consciousness. Subjects realized that while performing solo, they did not have to alienate themselves from the audience. They were able to recognize and participate in the cycle of giving and receiving with the audience in musical performance.

3. The difference between being performance oriented and expression oriented (self-involved vs. audience-involved). An example of a musician who was performance-oriented might have been the late pianist, Liberace. This type of musician is one who attends to the trappings of performance and is self-involved. Typical thoughts of someone who is performance-oriented might be, "How do I look?"; "What is the audience thinking of me?"; "Are they going to like me?" An example of a musician who was expression-oriented might have been the late pianist, Glenn Gould. This type of musician is concerned with projecting the inner meaning of the music to the audience and is not concerned with personal matters while performing. Of course,
there is not one musician who is purely performance-oriented or expression-oriented. Most musicians are a combination of the two. It is when the performer's orientation is out of balance that there is stress in performance.

Upon coming into the group, subjects seemed to be more performance-oriented than expression-oriented. They realized through music therapy how this orientation limited their enjoyment of performing as well as their ability to communicate musically to the audience. They learned that worrying about their appearance or feelings or how the audience would receive them took a lot of energy which could have been channeled into the music for a better performance.

4. The importance of putting one's whole self into one's musical expression. Subjects explored the idea that mastery of the self is the highest goal of the performing musician (Havas, 1979). They discovered that the process of self-mastery requires the continuous maintenance of the balance between the rational and intuitive minds (thinking and feeling). It also requires activation of the will (music/self), clear intention and the ability to focus on the task at hand (communication of the music).

5. The idea of relaxing and centering prior to
performing and not worrying about what everyone else is thinking. Subjects learned that their energy must be balanced prior to performing in order for the mind and body to be synchronized. In order to create this balance, subjects were asked to focus on their intention for performing and to prepare themselves physically, mentally and emotionally before they approached the stage. This was achieved through breath awareness and visualizing a successful performance. As a sense of purpose and clear goals were developed in the subjects, they reported that their worries about the audience's response began to subside.
Analysis and Interpretation of Qualitative Data From Study 2

A methodology, similar to the one used in Study I, was used in this study to analyze data extracted from video dialogue, post-group questionnaires and logs. The five stages of the qualitative analysis were as follows:

1. The researcher viewed each of the 14 session videotapes and summarized the relevant verbal dialogue of each group, typing it onto a word processor. She also read through all of the weekly logs and post-group questionnaires of each subject.

2. The researcher then read through the dialogue summaries, logs and post-group questionnaires again slowly, looking for individual descriptions of subjects' perceptions of the underlying causes of performance stress and how these were related to their stress symptoms and self-involvement, their experience of music therapy and their report of change due to music therapy intervention.

3. The researcher then categorized subjects' individual descriptions under the above headings.

4. The researcher then reflected upon the given categories and extracted pertinent information of each category from the given data.

5. The researcher then attempted to interpret the
meaning of the above categories in the light of current psychological and music therapy theory.

The following were found to be the underlying constituents of performance stress as extracted from the qualitative data of Study II. The constituents are ranked according to the frequency of qualifying statements made by the subjects.

1. Inner critic. The inner critic represented the introjected judgmental voices of parents and teachers which had become a part of the self-structure of the anxious musician. According to subjects, this was the most prevalent underlying cause of their performance stress. The following quotes from subjects are an example of the workings of the inner critic: "Giving a bad performance would end in a catastrophe. If I made a mistake, I would be punished." "What if I 'screw up', then I'll really feel like a fool." Most subjects felt the need for perfection in their musical performance, otherwise, they would be rejected by significant others.

In this study, it is clear that family problems were at the root of most subjects' performance problems. Several subjects experienced trauma related to their early musical expression involving either the mother, father or siblings. Because musical expression is intimately related to
the expression of self, it is the self that is wounded in the event of a musically-related trauma. At the point in time when trauma occurs, the part of the self which is wounded often becomes developmentally "frozen", so that that particular aspect of the self does not develop normally and retains its primitive level of functioning on into adult life.

With respect to their musical-self expression, it is suggested that most subjects were developmentally arrested (in varying degrees) at an early period where they were still dependent on their parents for approval. The separation/individuation phase of development (Mahler, 1975) had not yet been completed with respect to subjects' ability to express themselves as autonomous beings. Most subjects still clung to the past judgments and wishes of parents. One subject blamed her parents for her lack of success in music. She felt that if she were to become successful, her parents would be envious and reject her. Others believed that they were not allowed to express powerful feelings because their parents had prohibited it. Most subjects seemed unable to let go of the past and to move forward from a strong center of self. They were holding on to the energy of past traumas. When asked if he could let go of some of his inner
critical voices, one subject replied, "Who's going to push me if I (the critical voices) don't?"

Negative criticism from parents and teachers often creates a masochistic "music child" who is not allowed to "play" and enjoy music, but rather must "suffer" in order to succeed; again, introjected voices of misguided parents and teachers.

Because they were still holding on to unfulfilled expectations from parents, some subjects expected the therapists to give them the answers to their problems, without their putting much effort into it themselves. They were unable to take full responsibility for their own growth and development.

Because of the negativity generated by the inner critic, most subjects felt unworthy of expressing their whole selves and enjoying their music. Subjects often adopted rigid thinking patterns and found it difficult at first to be imaginative and playful. The joy of self-expression seemed to be dampened. Most subjects still seemed dependent on receiving permission from the therapist(s) and/or introjected parents to "let go and just be". After all these years, they were still waiting for permission to be themselves.

2. Repression of feelings. Upon coming into the group, most subjects were not aware of the feelings
underlying their performance stress. For some, the flow of the feeling state was completely blocked. One subject experienced the sensation of nothingness when asked about his feelings. He further elaborated on this with an image of being buried alive. During the group process, feelings such as despair, hopelessness, resentment and guilt began to emerge from subjects. The intensity of these feelings, when repressed, seemed to create a heaviness in subjects which prevented them from expressing themselves. Many feared looking back and contacting the root of their painful feelings again. They were afraid of being open and thus vulnerable to being hurt, and chose instead to shut down their emotional/expressive selves. It was this fear that caused subjects to become rigid and controlling, unable to have fun with their music and share it with others.

3. Identity problems. Most subjects seemed to lack a strong center of self on which they could rely during the times of stress and confusion associated with the creative process. Subjects were primarily externally-oriented, relying on outside mirroring and feedback to ground their vulnerable sense of self. This external orientation seemed to be related to the lack of a strong somatic sense in subjects (feeling of being
grounded and connected to the body). The lack of connection with the body would also seem to be related to the above category, repression of feelings, as feelings are alive in the body, and when they are chronically inhibited, the body eventually shuts down and movement becomes rigid and disconnected. One subject asked how he could free himself from a lifetime of controlled behavior.

Subjects seemed to exist mostly in their thinking selves. Many expressed that their musical communication was blocked because they were thinking too much. When one is worrying about what others are thinking of him, authentic expression becomes difficult. Self-consciousness due to holes in self-development prevented the subjects from really being aware of others and making contact with them. Subjects appeared to be inflexible at times, unable to think creatively and harmonize with others.

It is hypothesized that some subjects denied powerful feelings within themselves and created "false selves" which they presented to the public as a defense against what they were unable to accept in themselves. One subject asked during one of the first sessions, "When I'm together, am I really together, or is there some thick mask saying
everything's ok? I really want to know that."

Later, the same subject explained, "When I'm anxious, my intention gets uptight, and I can't connect with people."

When a person is forced to repress his anxious feelings repeatedly, he often gets to the point where he begins to deny his real feelings and pretends that he is confident and in control. This is the "false self" which may appear to be "normal" and functioning, but is only a mask, as the subject mentioned above, which prevents him from engaging in deeper relationships with others.

4. Psycho-biological problems involved in playing music. Because of the lack of internal focus and a strong somatic sense, the subjects were often dissociated from their feelings and impulses which resulted in a lack of coordination, lack of emotional expression and lack of consistent pulse and rhythm in their music. Because the ego often becomes fragmented due to trauma, most subjects had a need for self-organization which required the integration of the mental, emotional and somatic components of the self.

5. Social implications of performance stress. The professional developmental cycle of most subjects was achievement-oriented. For most subjects, playing music involved competition and compulsive-
ness, starting in the home, moving to the schools and on into the professional arena. There seemed to be a limited amount of space in most subjects' lives for laughter, spontaneity, play, a sense of community, and repose. Competitive judgment related to performance was the cause of much of their anxiety. Subjects often compared their abilities to other musicians and were envious of musicians they thought were superior to themselves.

6. Issues surrounding performance stress were related to other stressful issues in subjects' lives. Subjects learned that their music reflected all of the emotional ups and downs which they experienced in their daily lives. They found that they could not separate their expression of self as people from their expression of self as musicians.

7. Performance coming from a place of need, rather than from a place of giving. Most subjects expressed a desire to be listened to, to be accepted, to be praised for their musical expression. One subject explained that she performs, "so that people will get to know me better." At this level, subjects were self-involved as their main motivation for performance was not to communicate music to others for their pleasure, but to receive acknowledgment and acceptance. This created stress in that the
subject was not presenting his music from a place of strength and desire to give, but from a place of doubt and neediness.

8. Subjects identify with the "product" of their music. For most subjects, if their music was rejected, they felt personally rejected. This meant that they were "bad". Most subjects had a problem receiving criticism. This could be due to splitting, which often occurs in narcissistic individuals between the "good" and "bad" parts of the self. Subjects identified with the "good" and rejected the "bad". It was important for them (during the group process) to be able to deal with feelings of being rejected and to learn not to judge themselves so harshly. One subject had written "passionate" music for his viola, but was terrified of expressing it publicly for fear that if his music was rejected, he would be rejected. It seemed that he lacked a frame of reference within himself to be able to love his own music.

9. Splitting between serious and playful parts of the self. This issue was prevalent throughout the group process and is related to other issues previously mentioned. Because of their rigidity, their inability to be playful and enjoy music, and their need to achieve and compete, most subjects were overly serious about their music, overly self-
involved with the mechanics of playing and did not
give themselves the opportunity to relax and have
fun while playing alone or with others. Music
became a chore for them, something that would
validate their self worth, "if they worked hard
enough", as opposed to something that would enliven
their spirit and bring joy to others.

Qualitative Change Due to Music Therapy
Intervention

The qualitative data regarding subjects'
experience of change due to music therapy
intervention are presented below. Subjects'
statements were categorized under the following
headings:

1. Increased awareness. Subjects reported that
the weekly logs and post-group questionnaires
provided the impetus for them to become aware of
their internal psychological processes related to
musical performance. Subjects also reported that
the group music therapy context gave them the
opportunity to step back and reflect on their
relationship with their primary instrument, to
their own bodies, to musical performance, to the
audience and to the other group members. This gave
them greater insight into the underlying causes of
their performance stress.

2. Stronger sense of identity. Some subjects felt
that it was "scary" dealing with the real issues underlying their anxiety. One subject reported that through the help of music therapy, she no longer needed the approval from teachers and therapists to "let go" in the music. She began trusting in her own positive feelings about her playing. Most subjects reported that they were beginning to understand the concept of integrating their "musical" selves with their "everyday" selves. A few subjects reported that they were using the relaxation and meditation exercises as ways of dealing with life stress as well as performance stress.

One subject now sets aside time each day just to "play". Another subject reported having a major change in attitude from being "too serious" about performing music - to enjoying the process of playing music. She also began listening to music again for her own enjoyment and not just for work-related reasons. Another subject reported that the "cave" exercise (See Appendix I) allowed her to contact new musical ideas and feelings which she was able to use in her song-writing. One subject shared that she was gaining insights about herself in the group, learning to stand up for herself and her music, taking charge of her life. Another subject found that it was important for her to
choose music to play that she could personally identify with - just for herself, or to share with a few intimate friends - in addition to the music which she was required to learn for her professional repertoire.

3. Increased communication. Most subjects reported that musical improvisation was a welcome relief from the stress they felt from, "always having to play the right notes". Improvisation offered them a more personal form of expression which helped them to communicate parts of themselves which they had never shared publicly.

With respect to performance, subjects reported that by focusing on giving their music to the audience as a gift, they began to enjoy the process of playing music more. One subject reported that it felt great to really communicate her music to outside audiences, as well as to the group members. Another subject learned to release her fear of being in contact with the audience and found that this really helped her to become more musical. She had found a focus. She also realized that communication was her real reason for playing music, not being self-involved. One subject asked a rhetorical question, "How can you communicate anything musically if you're worried about what people are thinking of you?"
4. Developing a sense of community. As the group process unfolded, subjects reported experiencing a stronger desire to give something of themselves in the group. They also reported feeling more connected (both musically and emotionally) to the other group members. Subjects reported that the group process involved much risk-taking, facilitated the experience of letting go, and fostered deeper communication with others. In the group, subjects learned to support each other musically in the spirit of play and healing; they were able to take the focus off themselves.

4. Body/mind integration. Most subjects reported that the breathing and relaxation exercises helped them to become more relaxed and focused. As a result, subjects began to feel more confident about their playing. One subject reported that the visualization exercise helped him to realize that he could control his own internal states and could also create more positive ways of dealing with life's issues. Another subject (operatic tenor) found that with regular practice of the breathing and relaxation exercises he had regained the use of the upper register of his voice which he had lost due to extreme performance stress.

One subject realized that by learning to control her breathing, she could also regulate her
internal states. She reported being less affected by the "chaos" that was going on around her. This helped her to feel more confident when taking auditions and performing solo. She also learned to coordinate her breathing with her music. While playing with the pulse she found that she was less distracted by outside influences and could focus more on transmitting the essence of the music to the audience.
APPENDIX E

Theoretical Framework of the Music Therapy Intervention

The following theoretical framework was conceptualized from a synthesis of certain relevant components of psychoanalytic, humanistic, cognitive/behavioral and music therapy theory. The framework is holistic in that it relates to the problem of performance anxiety on all levels of human functioning - the mind, body, emotions and spirit, and revolves around the central theme of the musician's relationship to his own music and to the audience.

The theoretical framework is divided into the following sections: (1) the relationship between music and primary narcissism; (2) the relationship between music and mothering; (3) the separation/individuation crisis and its relationship to performance anxiety; (4) the use of music therapy in helping the musician to bond with his music/self; (5) self transformation through music; (6) developing self-control through music therapy; (7) integration of the body, mind and spirit through musical performance; (8) self-empowerment through music therapy; (9) the music therapy group context as a safe, non-judgmental and consistent
environment for change to occur.

1. Origins of music in the human organism. Most psychoanalytic writers on music believe that music has its origins in the early narcissistic period of psychological development (Noy, 1967). During this stage, the infant is symbiotically fused with the mother. Because his ego is still undeveloped, the infant relates to his world mainly through primary process thinking. In this mode of consciousness, the memory image of an object that the infant needs to reduce his tension (i.e. when he is hungry, the image of the mother's breast) is believed to be the same as the object itself (Freud, 1932).

Music seems to come from this state of primary process thinking. Its inner structure and meaning have been compared with the psychological laws by which the dream is formed. According to Noy (1967) music brings pleasure because of the listener's ability to identify with it and to recognize the latent wishes within the musical structure. This identification then allows him to gratify his own wishes insofar as they resemble the musical structure (p. 82).

2. The psychoanalytic literature also describes music as being synonomous with mother (Benenzon, 1982; Salk, 1955; Diamond, 1986). Diamond (1983) writes about the origin of music as being the
mother's lullaby:

All the healing powers of music relate to the divinity of the mother's love for her baby, and the wish to fully communicate this to him, to relieve every stress and discomfort and bathe him totally in the glory of her love (p. 56).

The baby receives the mother's lullaby and through his cooing and lalling responds to her with his own message of love. This is the first stirring of musical communication in the human being. Because this memory is deeply imprinted in the psyche of most people, music has the potential to re-awaken in the listener or performer feelings of symbiotic ecstasy, nurturance and security.

Diamond (1986) has found that there are two ways in which the musician uses music to fulfill his wishes with regard to his psychological relationship to the mother. One way, which is typical for the musician with performance stress, is to turn to music as an escape from the painful areas of his life, and through musical activities to pretend that all is well and that he is loved by the mother. Music is actually used here as a defense against resolution of inner conflict, thereby preventing real union with the loved object.

Another way is for the musician to use his music as a way of repairing or re-creating the object lost in childhood (Klein, 1935; Kris, 1952;
Racker, 1951). Through deep insight into the self, the troubled musician is able to mourn the loss of mother's unconditional love and acknowledges the suppressed aggression and consequent guilt related to his early mothering experience. He is then able to transform his painful feelings through his own music by giving back to his mother love for her love. Menninger (1938) writes about the process of overcoming self-destructive tendencies through music,

... by encouraging and strengthening the erotic element, the element which we have already seen to be the saving and neutralizing force operating in opposition to destructive tendencies to accomplishing the salvation of the part or the whole (p. 381).

Menninger continues,

Many will begin by loving art and end in loving one another ... Self destruction is combated by anything which draws from us some further flow of love that is implicit in joy (p. 386-7).

Artistic creation can help the musician to transform the unconscious drives and desires which limit his personal and musical growth. However, Kris (1952) explains,

The success of a work of art depends on the extent to which the activity itself has for any particular individual become autonomous, i.e. detached from the original conflict (p. 29).

In this respect, Priestley (1975) believes that the creative process of clinical improvisation
offers the individual an opportunity to become the observer of the powerful emotions that are moving through him during a cathartic musical experience. She describes clinical improvisation as the spontaneous use of music and sound to release energy bound up in repressing images or memories in the unconscious because of fear of their disturbing emotional content. According to Priestley, when the individual is no longer in the grips of a particular emotion, he can then use that energy for transformation and creativity.

3. The origin of psychological patterns which predispose an individual to neurotic anxiety are in his early relations with his parents, especially with his mother (May, 1954; Spielberger, 1979). Shields (1984) writes that musicians' personalities have shown general profiles of dependency conflicts and depression, indicating early disappointments with the mother (p. 243). It is hypothesized that many of the conflicts experienced by musicians stem from an incompletely separated/individuation crisis, where the musician, in his struggle toward autonomy, wants to separate from his dependency on significant others, yet still has expectations that they will fulfill his basic needs. The anxious musician may feel that if he tries to assert himself against the regressive pull of symbiosis,
the significant other(s) would withdraw his (their) love and admiration (Gabbard, 1979). This would be extremely threatening to his vulnerable sense of self.

It is suggested that a primary conflict for the anxious musician stems from the paradoxical situation involving his desire to play music and return to the metaphoric state of oneness with mother, versus his fear of performing music on his own - a state where he must separate from mother and present his individuated self.

Ultimately, musical performance offers the musician an opportunity to be both one with mother through bonding with his music, and also to resolve his ambivalence towards mother by working through the depressive position (Klein, 1935); recognizing that mother will not always be there, that mother is both good and bad. He lets go of his idealized expectations and accepts the real situation of their actual relationship - from that point only is he able to be truly creative, moving towards complete autonomy.

4. The musician bonds with his own music-self. Through the music therapy process, the musician is helped to re-engage and complete the separation/individuation process. Through bonding with his own music, with his own self, the musician becomes
motivated to separate from his dependency on the introjected mother. However, he must first deal with the pain of letting go of primitive expectations of being "mothered" from external sources. Through improvisatory role playing (Priestley, 1975), he may become aware of the destructive aggression which he had directed towards his mother at a very early age (while he was still involved in primary process thinking) which caused him to believe that he had actually damaged or destroyed her (Segal, 1954). These previously unconscious memories and associated feelings are often found to be the root cause of the musician's anxiety syndrome (Diamond, 1988).

Music therapy can help the musician to bond with his music-self in the following ways:
a. Self-awareness in a group context. Using music as the medium for self-awareness and expression, the musician presents his music-self to the group and receives mirroring, feedback and support from group members and therapists. Self-consciousness is slowly transformed into self-awareness and acceptance as the musician begins to integrate split-off thoughts, feelings and blocked bodily sensations with the support of the group.

Because of the competition for jobs, many musicians feel they have to "suffer in silence", 
and as a result feel isolated and afraid of reaching out to other musicians. The music therapy group context helps musicians to release feelings of isolation and opens up lines of communication and sharing among group members.

b. Inner awareness. Through a combination of breath and relaxation exercises, focusing (Gendlin, 1978) and guided imagery, the musician is guided towards his inner self where he can begin to integrate the unexplored inner reality related to his early performance experiences with his here and now experience of performance. As the musician becomes aware of the thoughts, feelings and bodily sensations that are limiting his performance experiences during his participation in the music therapy group process, he is encouraged to find solutions to specific limitations in the moment, through musical imagination exercises, clinical improvisation and breath control.

c. Musical identity. Clinical improvisation provides the musician with raw material for creativity and personality development. According to Friedman (1960), "Within music occur archetypal conflictual situations where very intense personal experiences find a structure and format for expression." (p. 134). Through his desire to experience oneness with the mother, whether it be
the biological mother or the archetypal Mother, the musician is able to resolve the splitting that divides the self into good vs. bad, and through the love inherent in the music itself, he is able to repair or recreate the objects that were lost in childhood (Klein, 1937). According to Diamond (1988), this is the basic aim of psychotherapy, "... achievement of this total love, through reparation to complete union." (p. 61).

Through musical-self exploration, musicians receive inspiration for song writing, spontaneous composition, and new performance material which helps them to release and re-integrate repressed feelings, thereby creating more wholeness within the self structure. Musicians eventually are able to penetrate deeper levels of the self: the feeling level on the one hand, and the imaginal realm on the other. When these two levels are functioning together under the direction of a strong will, creativity results. Musicians are encouraged to listen to their inner music and not to judge what they hear, but to develop a sense of equanimity and calm acceptance, knowing that they have the power to create their own lives through correct use of the will, via the music-self.

d. Bonding with the audience. Once the seeds of musical bonding begin to sprout within the self of
the musician, he can then begin to reach out from that place of self-security and bond with others. In the music therapy group context, the musician can begin working through fears of rejection related to performance while receiving support, feedback and mirroring from group members and therapists.

The musician is then encouraged to focus on giving his music to the audience as a gift, as did Beethoven in his magnificent work, the Missa Solemnis, onto which he inscribed, "From the heart it comes, to the heart it may go." This is the highest form of communication, that which helps the musician to transcend all ego limitations (Diamond, 1987).

5. Self transformation through music. The process of self-development for the anxious musician requires a willingness to first acknowledge the critical inner voices and fears of being rejected, and then to choose to move forward creatively, in spite of them, guided by a stronger life urge. During the music therapy group process, each musician is encouraged to bring out and cultivate his own unique musical gift and to share it with the group. According to Jung,

All the greatest and most important problems in life are fundamentally insoluble. . . They can never be solved, but only outgrown. This outgrowing proved on
further investigation to require a new level of consciousness. Some higher or wider interest appeared on the patient's horizon, and through this broadening of his outlook, the insoluble problem lost its urgency. It was not solved logically in its own terms, but faded when confronted with a new and stronger life urge" (1956, p. 87).

As the musician is moved by his desire to give his gift to others, the old critical voices begin to lose their power and gradually fade into the background. Master musician Hazrat Inayat Khan (1962) explained,

By the power of music the mind may become exalted so that it rises above the thought of illness; then the illness is forgotten. . . What kind of music can heal man? . . . Singing is the most powerful, for singing is living. . . The voice is life itself. However, behind this voice there must be a heart, charged like a battery with what is needed. And with what is it charged? With what we call love and sympathy, the greatest power there is." (p. 92).

6. Developing self-control. As mentioned previously, one of the most common symptoms during an anxiety attack is the feeling of being out of control. Paradoxically, by trying to control the anxiety situation, one actually loses control. In dealing with this physiological component of anxiety, the music therapist teaches breath awareness and relaxation techniques to help the musician to understand the body/mind relationship. According to Ostrander and Schroeder (1982), "The breath is the bridge between the body, emotions and mind and the most accessible means of changing
inaesthetic states." (p. 62). By learning to relax and center his attention on his breath, the musician has the feeling of being in control of himself, rather than letting peripheral things cause him to be out of control. It is most important for the musician to be aware of his breathing while he is playing music. This will help him to connect to the inner pulse of the music, to stay focused and to put his whole self into his musical expression.

Usually in a performance anxiety situation, the musician is holding back threatening feelings, holding his breath, and letting the energy of the feelings build up until they become overwhelming. This is when the anxiety symptoms prevail and the performer finds it difficult to focus. He becomes self-involved and is unable to communicate. The science of yoga (Rama, 1984) teaches the art of yielding vs. controlling. Through the process of becoming aware of the breath and its relationship to the flow of emotions within the body/mind, the musician becomes the observer and master controller of his own emotional states. He develops a new attitude toward playing music by getting into the mode of being rhythmic with himself.

During times of stress, the music therapist encourages the musician to affirm his purpose for
performing. The musician performs not only for himself, but for the audience. A stronger will comes when the musician realizes that he is dedicating his music to serving others. In this frame of mind, it is easier to let go of threatening feelings. Musicians are encouraged to find the larger picture of performance (Hesser, 1987), expanding outward with love, as opposed to contracting inward with fear.

The practice of self-control involves maintaining a proper attitude, breath awareness and centeredness. It is important that this practice be incorporated into the musician's daily practice of music. He is encouraged to practice both with determination and aspiration and to be responsible for keeping himself "tuned", just as he keeps his instrument in tune.

7. Integration of the body/mind and spirit in musical performance. The music therapist helps the musician to develop a sense of holistic awareness during his musical experience. The music becomes the point of focus which unites the musician's purpose and intention, his aesthetic (emotional) interpretation, and the inner pulse which moves outward through the body. If one of these components is blocked, the musician will be unable to put his whole self into the music. From this
perspective, musical performance can actually be experienced as a means of self-organization which will help to strengthen the musician's identity, allowing him to overcome splitting in his personality and fully communicate his music.

8. Self-empowerment. The music therapist acknowledges the musician as a person first, and sees the musician himself as an artistic "work-in-progress". The musician's musical expression is the key to unfolding his self. Through the process of music therapy, the musician begins to listen to his inner music and accepts the truth of his own being. He begins to use his own music to create harmony where there is discord in the music of his life and to access unexplored areas of the psyche. This helps to awaken energies which are needed for continued growth and personality integration.

9. Music therapy context provides a safe, non-judgmental and consistent environment for change to occur. For anxious musicians, the music therapy group becomes symbolic of the "good mother", the all-accepting and nurturing space where they can begin to unfold some of the unacceptable parts of themselves and be acknowledged and supported by like-minded peers and therapists. The group creates a foundation of security and consistency for musicians - a foundation that is often lacking
in anxious individuals.

It is suggested that the concept of accepting oneself and one's music and deepening interpersonal relationships through the common bond of musical expression increases self esteem, and thereby decreases anxiety. Underlying issues of competition, compulsion and dualism begin to dissolve as group members become more related. This corresponds to Adler's theory (1967), which states that anxiety can only be dissolved by the bond which binds the individual to humanity. "Only that individual can go through life without anxiety who is conscious of belonging to the fellowship of man" (p. 145). May (1954) also emphasized the importance of community in resolving anxiety in the individual's relating himself to others in love as well as in creativity.

The music therapy group becomes a positive context for performance, which counteracts the musicians' habitual anxiety-provoking experience of projecting fears of being judged and rejected onto the audience. The group becomes an arena for musicians to practice new ways of relating to an audience and breaking down unrealistic projections.
Descriptions of Music Therapy Interventions Used in Study 2:

1. Group improvisation. Group members were asked to choose instruments (either from an assortment of instruments for improvisation provided for them, or their own), and to sit quietly together for a few moments prior to playing. They were then asked to allow themselves to tune into their inner music, and as they felt moved, to share this with the group. The group members were also asked to become aware of each other's music, to listen to the movement of the group's music and to focus on the goal of giving and receiving music.

Subjects' reactions were mixed with respect to the group improvisations. Because improvisation requires spontaneity and a creative spirit, for those who were rigid and controlled, this was quite difficult at first. There was a need for structure in the improvisations. The structure seemed to create a feeling of safety which helped to assuage the fear of the unknown. During the first few sessions, subjects seemed most comfortable improvising with percussion instruments as opposed to melodic instruments. Subjects seldom improvised on their primary instruments (see qualitative analysis from pilot study). For the
music therapists, the group improvisations were diagnostic with respect to subjects' levels of personality integration, self-involvement, musicality, social anxiety, participation in group dynamics and unconscious conflicts.

2. Improvised musical/self statements. Music is a mirror of the inner life of the musician (Priestley, 1975). The self-statements encouraged the subject to turn inward and to move with his inner impulses and feelings in the here-and-now. The subject's relationship with his music became evident in his self-statement. This relationship was then mirrored back to him through group members' and therapists' comments, questions and feedback. The self-statements encouraged spontaneity, trust in self and in the group, and an allowing attitude. Subjects could allow the mind to let go of its limitations, by trusting the inner flow of creativity, and allowing the right brain to be activated, thereby stimulating emotional expression, play, fantasy and wholeness. The self-statements allowed the subjects to be truthful and to build the foundation of self through turning what is inside - out. This was then mirrored back to them in an unconditionally accepting environment. Some subjects could make musical self-statements and allow themselves to be
supported by the group. Others resisted at first and did not see how this could really help them in the "real" world. Subjects slowly began to open to the concept of, "As in life, so in music."

The therapists introduced the self-statement exercise as a way of helping subjects to deal with the lack of musical/self identity. The group members were to become the receivers of the subject's expression and facilitators to help him go as far as he could in the music. The subject received support and mirroring from the group. He was told that it was all right for him to just be himself with the music. He was really listened to and received empathy. Many of the subjects' self-statements revealed feelings of sadness, bitterness, anger and frustration. Therefore, it was important for the subjects to have allowed themselves to be where they were in that moment and to have accepted themselves without judgment. This non-judgmental attitude helped them to move through their blocked feelings and to gain self-realization in the process. Not all of the group members were willing to participate in making self-statements.

3. Breathing/relaxation exercises. The therapists conducted several breathing/relaxation exercises prior to the musical improvisations. This process helped subjects to let down their defenses and to
be more connected to their body/egos, thereby allowing them to merge more deeply with themselves and with others through the music.

4. Musical role playing. One of the prevalent polarities experienced by group members was that of seriousness vs. playfulness. Most subjects felt that they "should" be working harder at their music and did not allow themselves time to play. The therapist suggested that two subjects with this problem improvise together, one playing the "serious" role and the other playing the "playful" role. They were asked to become aware of the dynamics of the interaction between the two states of being. After improvising together for a while, the subjects were asked to switch roles. Subjects reported feeling imbalanced when they were only playing from one side of the polarity. They soon realized that the integration of the qualities of "seriousness" and "playfulness" allowed them to be more creative, more whole. For both subjects, the truth underlying the conflict seemed to come out spontaneously in the music. Subjects received feedback from the group and shared insights with each other.

5. Focusing attention on communicating music. Most mistakes in performance seem to derive from a
lack of focus and confusion - the mind gets cluttered and becomes chaotic. The music therapists taught the subjects to put their full attention on the music and to connect with their purpose for wanting to share it. In this exercise, the therapist asked a subject who had a focusing problem to allow herself to make contact through her music with one group member. This subject realized that she was self-involved and only concerned about the response she would get from the group members. She was not focusing on giving her music to her "audience". According to Wilbur (1985),

In performance we are projecting our own interest in people, so that everybody seems interested in us. Instead of actively looking, we feel looked at. We give our eyes to the audience, so that their natural interest in us seems blown out of proportion into a massive amount of interest zeroed-in on us personally, watching every move, every detail, every action. And so naturally we freeze. And will stay frozen until we dare to take back the projection - to look instead of feeling looked at, to give attention instead of being clobbered by it (pp. 94-95).

For the above-mentioned subject, singing exposed repression; she was unable to "let go" with her music. The subject's sense of self was shaky and she was unable to reach out and share her music. She tried to get more into the music by extraneous movement. This movement only dispersed her energy, showing a lack of focus, lack of
center. The therapist suggested that she feel a strong root in her belly and from that rooted place, to watch her breath, allowing herself to become still. She was then asked to focus on her intention of giving the music to her colleague, imagining that he was being uplifted by her singing. It took her awhile to overcome her self-consciousness, but when she was able to see her colleague as separate from herself and as wanting to receive her music, she was able to let go and genuinely give her music. This gave her a feeling of being powerful and autonomous and increased her confidence in her musicianship.

6. Using sound and imagery to make contact with the inner self. The therapist asked subjects to think of a theme around which to create a group vocal improvisation. One group member suggested that they imagine that the group was gathered in a cave in ancient times, sitting around a fire at the end of the day. It was time for everyone in the community to rest and entertain each other. Other group members added their ideas and the scene was set. The therapist played a steady drum beat and asked group members to experience the image of the cave - the sounds, colors, smells and feelings - and to allow themselves to make sounds coming from that place. The improvisation moved from primal
vocal sounds to more elaborate instrumental expression and ended in a peaceful silence. Subjects then shared the following experiences:

"I felt very connected to some place deep inside of me. . . I had to go to the piano. I was very much at one with the sounds. . . inside and outside, no break, no borders."

"I felt freedom - it didn't have to be in a key, pitch or tempo."

"Our ancestors had a spirit world that we sort of lost touch with."

Some subjects reported being self-conscious, afraid to differ from the group with their musical ideas. One member could not even enter the "cave".

7. Paradoxical music therapy - how to deal with repression? This was a fearful issue for most subjects. At one point during the group process, the therapist asked them to go within and to listen to the "sound" of their repression - to get a glimmer of the feeling/sounds of that which they fear. The subjects shared the following descriptions of their repression:

"Screaming, driving rock music is a like a metaphor for my inner anxiety - I can release my anxiety vicariously through the rock musician."

"Like being in a glass box in which I could only make a muffled sound - no one would really
"Every part of the body is clenched - there is a scream inside - like the way you feel on the subway."

"Angry sounds beneath a little sound - wanting to let loose on the gongs, but only being able to tap them lightly - the frustration of knowing that power is there, but not being able to get it out."

"A squeak covering over bottled-up emotions - feeling real tight."

These repression sounds became metaphors for the state of being of the fearful parts of subjects' inner selves. The exercise seemed to reduce the emotional charge of the fear of the unknown inside themselves. Subjects reported feeling more in control of themselves after confronting their repression.

8. Developing one's musical identity and leadership ability. The following exercise was created to help subjects to release their fears of being in an authority position, taking the lead, and being autonomous. One subject, a bassist, who had expressed fears of being in the "spotlight", was asked to imagine being the leader of his own musical group. He was then asked, on the spot, to create a group concept and to assign musical roles to various group members in order to bring it to
life. He would then direct the music, while playing his bass at the same time.

This exercise challenged the subject's self esteem, self-motivation, spontaneity and creativity. The group members, in turn, mobilized their energy to work together to carry out the project. Self-involvement was surrendered to the group goal. Group members were playing and having fun, yet working to support the "leader" in order to get a unified group sound. The leader/follower polarity among group members was resolved through empathy and cooperation. At the end of the improvisation, group members encouraged the leader to be more authoritative and to move to the another level in the next improvisation by introducing a melodic theme: moving from the primitive level of the rhythmic "groove", which was the subject's primary expression during the improvisation, to a more refined level of self expression.

9. Overcoming self-involvement. Prior to performing, an anxious soloist was asked to imagine the audience receiving her music and being uplifted by it. This helped to take the focus off herself and her insecurities by changing her orientation to being concerned with the audience and giving her music to them.

10. Reducing self-involvement through
communication. Subjects took turns communicating their music to the group. The therapists suggested that they release the need to make excuses, apologies, and comments on their own music by directing all their attention on giving their music with love to the receptive group members.

11. Reducing self-involvement through laughter. The music therapists encouraged humor, play, teasing and fun as ways of releasing pent-up emotional energy in the group. This helped to lighten the "seriousness" involved in the process of growth and change. For example, one subject shared with the group, "I really know that when I come to the group, it's going to be like a laxative." Another subject responded, "With friends like you, who needs enemas!" Joking and teasing, along with musical interaction, helped to create cohesiveness and intimacy among therapists and group members.

11. Developing inner listening and intention. One self-involved subject was asked to focus on what she wanted the audience to receive from a performance piece she had been working on. The audience (group members) was then asked to sense what her intention was as they listened to her music. This playful exercise helped to develop the performer's intention, focus and musical will, as
well as to develop the listener's intuitive faculty and ability to receive music. According to Havas (1979),

The more the player learns to summon the imagination of the inner ear, the more he is able to forget about the extraneous part of his playing, such as his technique, his tone, the impression he makes on his listener, etc. until eventually he can forget about himself (p. 77).

Only in this way can the musician connect with the inner pulse of the music and transmit it freely to the audience.

12. Working through unresolved traumatic feelings in the music. During the group process, a subject shared that she was experiencing a block in her musical expression, which she felt was related to a traumatic situation that happened when she was eleven years old. After a brief induction, she was asked by the therapist to go back to the original feeling state of the childhood trauma and to allow her unexpressed communication to find a voice in her music. With the support of the therapist(s) and other group members, she was able to use the music to express feelings of helplessness and frustration stemming from a parental conflict. Once she contacted these feelings, she was then able to make a self-statement in the music, communicating that she has a right to be who she is and not to be manipulated
by her parents (at this point, the subject had regressed to an earlier time in her development).

The subject's musical expression was a step towards individuation and separation from the negative voices of introjected parents. It also helped her to develop a stronger musical identity. Her feelings had to be acknowledged first, before she could use them as the materials for transformation and growth.
Review of Related Music Therapy Literature

Music Therapy Defined

Music therapy, as used in this study, is a process-oriented treatment modality which uses music as the medium for the reparation and integration of the body, mind and spirit. It has been defined by Boxill (1985) as "the process by which music, as an agent of change, is used to establish a therapeutic relationship, to nurture a person's growth and development, and to assist in self-actualization" (p. 5).

Foundations of Music Therapy

The foundations of much of the early music therapy work both in Europe and the United States has come from the psychodynamic models of music (Ruud, 1977). According to Wheeler (1981), the main use of music therapy in a psychodynamic framework is based on music's ability to bypass conscious verbal censorship and to reach deeper parts of a person's psyche, to facilitate nonverbal expression and communication, and to build ego strength (p. 18). As a therapeutic tool, music facilitates both regression and ego mastery (Ruud,
1977) - which can be seen as the prominent polarity in the musical life of the performing musician.

**The Psychodynamic Meaning of Music**

In order to understand the psychodynamic implications of the music therapy intervention as it relates to the intimate relationship between the musician and his music, the psychoanalytic literature on music was explored. A comprehensive psychoanalytic theory on the meaning of music does not currently exist. It was found, however, that most psychoanalytic writers believe that music is related to the early narcissistic period of psychological organization, where the ego cannot as yet separate the boundaries between self and reality. Pfiefer (Noy, 1967, p. 20) asserts:

> Music is a kind of initiatory pleasure which has become an end in itself, its organization being narcissistic and pregenital. . . Music, by granting pregenital libidinal pleasure, induces regression to this state.

Coriat (Noy, 1967, p. 20) writes:

> Music increases narcissistic pleasure, it re-animates it as pure libido gratification rather than an intellectual process.

Psychoanalytic writers also describe music as being synonymous with mother (Benenzon, 1982; Salk, 1955; Diamond, 1986). Auditory memories of the mother's internal sounds, especially her heartbeat
(heard by the infant while floating in the womb), and the gentle sounds of her lullaby, are recorded in the sonic core of the human being and represent the fulfillment of his safety and security needs. Music/Mother becomes a symbol of nurturance and unconditional love. According to Racker (1950),

Music in itself not only seems to represent a means to obtain the good object but itself represents that good object, which loves and therefore is loved (p. 120).

In his attempts to understand the psychology of the creative musician, Branfman (1955) concludes that musicians are often orally fixated. Music is used by these musicians as a form of "self-feeding" through which they express that they do not need the mother any more. In this way, they defend against the pre-oedipal bad mother, and the masochistic pseudo-aggressive attachment to her (p. 4). Racker (1951) believes that music is used by the ego as a defense against the depressive anxiety of disintegration. Through musical activity, the individual is able to overcome infantile aggression and related guilt feelings toward the mother and is therefore able to preserve the loved object and maintain a sense of wholeness and unity within the self structure.

Throughout the psychoanalytic literature on music, it is suggested that music plays a major role in resolving internal polarities such as
love/hate, perfection/imperfection; mother/child, ego mastery/regression. According to Noy (1967), music also resolves the polarity of chaos/order.

Music induces the intricate experience of struggle between chaos and order which always ends in victory of the latter. Music reflects the experience of the ego in its integrative activity (p. 90).

In summary, the psychodynamic meaning of music represents one aspect of the workings of the creative process of the individual self in its quest for unity and wholeness. During musical activity, primary process (unconscious) material is activated, often involving threatening feelings or images related to one's early relationship with the mother. In his desire for wholeness and self-mastery, the individual, through the music, is able to resolve a particular internal conflict and attains a state of equilibrium/harmony.

Reparation Through Creativity

Aside from the psychoanalytic reports mentioned above, there is a dearth of literature which explores the creative process of music. Melanie Klein (1936) applied psychoanalytic theory to the field of art. It is suggested that her theory concerning the purpose and meaning of artistic expression can also be applied to the field of music. A brief summary of Klein's theory
on the origin of creativity follows.

According to Klein (1936), the earliest phase of infant development is the paranoid/schizoid position in which the infant splits off his experience of mother into good and bad components. His main anxiety at this point in life stems from the fear that his ego will be destroyed by the bad object. Evolving out of this phase of development is the depressive position, during which time the infant begins to recognize the mother as a whole person, separate from himself. As his ego becomes more defined, he also becomes aware of his ambivalent feelings of love and hatred toward the mother. Because of his need to totally possess the mother, his jealousy of others related to her, and his feeling of helplessness due to his dependence on her, he fears his own destructive impulses and experiences pain and guilt at the thought that through his aggressive fantasies, he might have damaged or destroyed her. Segal (1964) writes:

The pain of mourning experienced in the depressive position, and the reparative drives developed to restore the loved internal objects, are the basis of creativity and sublimation. . . Feelings of guilt and the drive to make reparation are intimately bound up with the emotion of love (p. 75).

Reparation involves the individual's decision to identify with the ideal object (good mother) and
to overcome his destructive impulses (hatred/death instinct) through his desire to preserve or restore the ideal object. This involves the activation of the creative life urge (love). According to Klein, during the process of reparation, love is brought directly into conflict with hate, and it is active in both controlling self-destructiveness and in repairing the damage done. Segal continues:

It is the wish and the capacity for reparation of the good object, internal and external, that is the basis of the ego's capacity to maintain love and relationships through conflicts and difficulties. . . . Failure of reparation leads to despair, its success to renewed hope (p. 73).

The depressive position is a critical period for the development of the individual self. May (1954) defines self as the capacity of the human organism to have conscious awareness of its activities, and through this awareness to exercise a measure of freedom in directing these activities. Each time the infant chooses to activate the life urge or the so-called death instinct (destructiveness), he is giving birth to his self-identity. The seeds of self-concept are planted during this very early period of life.

According to Segal, the depressive position is never completely worked through. It is activated each time a person experiences a loss or trauma of some kind. Thus, it would seem that the concept of
reparation through creativity has important implications for therapy, especially for anxious and narcissistic individuals who may have experienced loss or trauma early in life, before they were able to communicate verbally.

Reparation through creativity can be activated both through the process of improvisation (play) and through prayer. Often during free improvisation an inner problem is externalized, and through the combination of imagination and creative expression, the individual tries to resolve it. According to Winnicott (1971),

The reason why play is so essential is that it is in playing that the patient is being creative... And it is only in being creative that the individual discovers the self (p. 54).

According to Diamond (1983), reparation is also activated during periods of prayerfulness, when the individual acknowledges his faults and asks the Divine for grace, that he may perfect himself and be more able to fulfill his purpose in life through his creative expression. Diamond believes that music composed by the great composers in this state of prayerfulness is symbolic of the creative life urge - the evolving Self.

The Creative Process of Music Therapy

Music therapy can be viewed as a creative
process for anxious and narcissistic individuals in that the individual, along with his music, actually becomes the "work-in-progress". In the Nordoff and Robbins approach of clinical improvisation (1977), musical responses are viewed as a mirror of the client's psychological and developmental condition, bringing to light both forward-moving qualities and pathological factors and serving a diagnostic function as well (Bruscia, 1987). For example, when used therapeutically to explore an unresolved conflict, musical improvisation is a creative process. The flow of improvised music becomes a bridge between the conscious and unconscious mind. Unconscious repressed memories, thoughts and feelings related to the conflict are brought into conscious awareness during the process of musical expression to be explored in a non-judgmental way and integrated into the self. Often these memories and feelings are so repressed that the client is not aware of their underlying dynamics in the music. The therapist will then mirror back to the client what she heard, often exaggerating a particular dynamic. She might ask the client to repeat his musical expression and to be more conscious of the energy involved and what feelings might be emerging (Hesser, lecture notes, 1984).

During group musical improvisation, the
creative encounter is a search for and partial resolution of a problem, something that is incomplete and incongruous on the group level as well as on an individual level. According to May (1974), the problem usually involves energy that is blocked, most often by fear of excitement or strong emotions. May believes these emotions include sexuality and anger, as well as the expression of the higher self, love, tenderness, self-righteousness, self-worth and assertiveness (p. 68).

Related Music Therapy Theory

A brief summary of the work of music therapists Paul Nordoff and Clive Robbins, Mary Priestley and Florence Tyson will be presented for its relevance to the development of the theoretical framework for this study.

Paul Nordoff & Clive Robbins (1977) developed an improvisational approach to music therapy which they called Creative Music Therapy. Although they worked primarily with handicapped children, their work in contacting and expressing the self through music is relevant to the focus of this study. Nordoff and Robbins believed that at the core of every individual is a "music child" which they described as "the individualized musicality inborn in each child which reflects a universal
sensitivity to the order and relationships in tonal and rhythmic movement." The "music child" represents the "organization of receptive, cognitive and expressive capabilities" (Nordoff & Robbins, 1977, p. 1). Their theoretical framework was based on the teachings of anthroposophist Rudolph Steiner, as well as concepts derived from humanistic psychology.

Mary Priestley developed her system of Analytical Music Therapy in the early 1970's. She describes it as the use of words and symbolic music improvisations by the client and therapist for the purpose of exploring the client's inner life and providing the proclivity for growth (Priestley, 1980). Priestley was influenced by the psychodynamic theories of Freud, Klein, Jung and Lowen. She believes the purpose of analytical music therapy is to remove blocks which prevent the client from realizing his full potential and from achieving personal goals. According to Priestley, group music therapy gives the individual an opportunity to become aware of and express inner feelings, to identify, establish and defend one's identity - particularly in reference to a group, and to build skills in relating to others (Priestley, 1975).

Florence Tyson developed a psychoanalytic
model of music therapy and worked together with her patients' primary therapist in both diagnosis and treatment. In working with schizophrenic and borderline patients, Tyson offers music as a substitute for the primary object onto which the patient can project his primary love. Contrary to the Freudian model, she believes that the mutual sharing of interest and love of a safe third object (music) helps to reduce the authoritarian component of the therapist/teacher role and allows a more equal and direct relationship. According to Tyson, the musical instrument and the music itself become symbols of feelingful relationship during the therapeutic transition period.

In her book, *Psychiatric Music Therapy*, Tyson (1981) describes a case study of her work with a professional drummer with anxiety neurosis who had difficulty with breathing and concomitant psychosomatic symptoms. Over a period of time, music therapy, in conjunction with psychiatric counseling, helped the patient to improve his body awareness, to work through repressed traumatic experiences (some of them relating to his music) and to use his breath consciously. According to Tyson, he began to act more independently and exercise initiative and creativity.
Related Music Therapy Research

There are no systematic, empirical, controlled outcome studies in the music therapy literature which focus on the use of group music therapy in treating "normal" neurotic anxiety disorders.

Fagan (1982) used music therapy to treat anxiety and fear in terminal pediatric patients. In her clinical analysis, Fagan reported that music therapy helped to open the channels of communication between the sick child, his family and the medical staff.

In a study with chronically ill hospitalized patients, Levine-Gross and Swartz (1982) compared group music therapy with group psychotherapy as a method of treating anxiety. After eight weeks of music therapy treatment, Levine-Gross and Swartz found that trait anxiety scores were significantly reduced in the experimental group as compared to the control group. State anxiety scores were also significantly reduced after one music therapy session.

In his study on the effects of a music therapy program upon awareness of mood in music, group cohesion and self esteem among hospitalized patients, Henderson (1983) found a significant increase in mood awareness among experimental subjects. Significance was not achieved, however,
for scores on group cohesion and self-esteem.

In summary, it was found in the above three studies that music therapy helped to stimulate communication, reduce both state and trait anxiety, and increase mood awareness in anxious hospitalized patients.
APPENDIX H

Discussion of Normal and Pathological Narcissism As It Relates to Musical Performance Anxiety

Anxious musicians are often described as being overly self-involved and narcissistic (Kendrick, 1979; Ferenczi, 1950; Freundlich, 1968; Waite, 1977). Several psychoanalytic theorists have described the stage fright reaction as stemming from a developmental arrest experienced by the musician during the separation/individuation phase of ego/self development. During this phase the infant is not aware of "other"; he is the center of his world. Self-involvement/narcissism is the key note of this phase.

In her clinical research on the development of the self structure in infants (0-3 years), Mahler (1975) concluded that the ego/self progresses through three phases: autistic, symbiotic and separation/individuation. The last phase is divided into four sub-phases: differentiation, practicing, rapprochement and consolidation. During the practicing subphase (9-15 months), according to Mahler,

Narcissism is at its peak. Libidinal cathexis shifts into the service of the rapidly growing autonomous ego and its functions and the child seems intoxicated with his own faculties and with the great-ness of his world (p. 335).
At this stage, the infant is still narcissistically fused with the mother.

Normal narcissism as experienced by the child during the practicing sub-phase is represented by the child's sense of his own omnipotence and his need to show mother how great he is and to have this mirrored back to him. An individual may experience a developmental arrest during the practicing subphase (primary narcissism) because of a lack of empathy and mirroring from the mother and/or rejection by one or both parents. If the child's narcissistic energies, which represent his emerging self identity, are not properly mirrored by the mother, they may turn backwards and regress. As a result, future situations involving the expression of self will be filled with anxiety and fear, and the child's sense of identity will be chronically undefined.

According to Winnicott (1971), deficient maternal empathy during childhood necessitates the development of a precocious and vulnerable sense of autonomy in an individual, supported by fantasies of omnipotence around which the grandiose self develops. If the child's mother is narcissistically disturbed and needs the child to mirror her own frustrated exhibitionistic needs, the child, fearing the loss of mother's love, learns to be
compliant, never exploring his authentic self and its needs. He develops a "false self", lacking in autonomy and spontaneous feeling, which functions to keep the true self hidden.

If the anxious musician was a gifted child, Miller (1981), in her analysis of narcissistic disorders, believes that he may have become the object of parental envy (if indeed his parent(s) suffered from a narcissistic personality disturbance). In order to protect himself, the child identifies with being special and dissociates from the feelings of being hated (Lowen, 1983). He then projects his powerful negative feelings relating to his primary love object(s) onto other objects. According to Klein (1937), the narcissist identifies with the good object and denies any difference between himself and the good object (p. 50).

Because of the splitting that occurs within the child's psyche between the good and bad object and consequent denial of bad feelings, the narcissist is fearful of being carried away by his unacceptable feelings. According to Lowen (1983), the experience of these feelings raises a fear of insanity, against which the individual will mobilize all his defenses. "In this patient's mind, to lose control of oneself is equated with
going crazy" (p. 100). Because of this fear, the narcissist's actions are often dissociated from feelings or impulse and are justified by the ideal image.

According to Schwartz-Salant (1984), a major complaint of an individual with a narcissistic personality disturbance is lack of identity and self esteem. Self esteem is defined by Winnicott (1971) as the nature of the inner image against which we measure ourselves, as well as on the ways and means at our disposal to live up to it (p. 80). Self esteem is based on the authenticity of one's own feelings and not on the possession of certain qualities (Miller, 1981). Lowen believes that narcissism develops from denial of feelings of sadness and fear. The expression of these emotions makes the individual feel vulnerable. "Denial of sadness and fear enables the person to project an image of independence, courage and strength, but this image has no force - that resides in the strength of the individual's feelings" (p. 75).

According to Lasch (1979), the narcissist seeks to recreate a wished-for love relationship which may once have existed with the mother, and simultaneously wishes to annul the anxiety and guilt aroused by aggressive drives against the frustrating and disappointing object (p. 80). One
might hypothesize that the anxious musician seeks attention and approval from the audience, onto whom he projects "mother", in order to meet his frustrated exhibitionistic needs. This relates back to the compulsion to repeat. The intense anxiety felt by the musician each time he is about to perform may be the stirring of deeply defended emotions of envy, rage, hatred and consequent guilt related to the mother, mixed with the need to win mother's love and approval. On some level, the musician wants to resolve this inner conflict, but because the "bad" feelings are still denied, no resolution is possible.

According to psychoanalytic theorists Klein (1947), Winnicott (1971) and Kohut (1971), creativity is a cure for narcissism. The integration of split-off parts of the self can be achieved safely through the creative process and through play. The narcissist can also receive the empathy and mirroring he lacked as a child through his deepening relationships with others in an ongoing group therapy context (Stone & Whitman, 1979).
APPENDIX I

Development and Design of Video Rating Scales

The stress symptoms scale was adapted for use in this study from the Kendrick (1979) time-sampling checklist of behavioral signs of performance anxiety.

The self-involvement scale was developed by the researcher with the assistance of a clinical psychiatrist. The purpose of developing this scale was to be able to distinguish whether the performer is inner-directed (self-involved) and focusing on inner cognitive, somatic and/or emotional matters, or outer-directed (audience-involved) and focusing on the music and communicating the music to the audience. The psychiatrist was asked to describe which observable characteristics he felt were common to those patients who seemed to be overly self-involved and/or had narcissistic personality traits. The following characteristics were accumulated both from the observations of the clinical psychiatrist and researcher and from the literature on narcissism (Kernberg, 1976; Kohut, 1976; Lowen, 1985) and self-consciousness (Fenigstein, 1974):

1. Affected behavior (acting)
2. Apologizing to group before, after or during performance
3. Excessive self-reference to "I", or "me"
4. Lack of eye contact
5. Glazed and/or fixed expression
6. Inability to make contact with others (communication)
7. Speaking about irrelevant issues
8. Disconnected from feeling sense
9. Cutting off others during conversation
10. Excessive speaking or rambling
11. Excessive judgment of self
12. Overly concerned with appearance
13. Disconnected from body sense
14. Exploitativeness
15. Manipulative

With respect to musical performance:
1. Appealing to the audience to accept him
2. Clapping for oneself
3. Takes more time than allotted to play
4. Looking down
5. Collapsed posture
6. Extra-musical activities
7. Lack of preparation (verbal statement)
8. Makes a sigh of relief after performance is over
9. Forgetting lyrics and/or notes

The above list of self-involvement characteristics was given to five music therapists
who were asked to view one performance videotape and one music therapy group videotape from the first study and to choose the characteristics of extreme self-involvement which they felt they could observe most easily and that were relevant, in general, to musicians with stress. The music therapists all agreed that the following characteristics of extreme self-involvement would be easily observable and relevant to the proposed study:

Signs of excessive self-involvement during music therapy group:
1. Affected behavior
2. Apologizing to group before, during or after a music improvisation
3. Excessive self-reference to "I" or "me"
4. Lack of eye contact with group members
5. Lack of communication of music to group members
6. Speaking about irrelevant issues
7. Cutting off others in group
8. Excessive speaking or rambling
9. Excessive judgment of self

Signs of excessive self-involvement during performance:
1. Affected behavior
2. Apologizing to audience
3. Forgetting the lyrics or notes
4. Excessive self-reference to "I" or "me"

5. Lack of eye contact with audience

6. Lack of communication of the music to the audience

To develop a scale for musicality (musical expressiveness), the researcher collected several definitions for the following words: music, musical, musicality, expression and performance (The Oxford English Dictionary, 1961; The American Heritage Dictionary, 1969; Grove Musical Dictionary, 1985).

The researcher eliminated the redundencies and came up with the following generalized statements concerning "musicality":

1. Music - that one of the fine arts which is concerned with the combination of sounds with a view to beauty of form and the expression of emotion; the art of making compositions of definite structure and significance, according to the laws of melody, harmony and rhythm

2. Musical - melodious, harmonious having the nature of "tones", as distinguished from mere "noises"; fond of, or intelligently appreciative of music

3. Expression - communication of an idea, emotion, etc.

4. Performance - to carry out, fulfill; to give a public presentation
The researcher then presented the above-mentioned definitions to a group of professional musicians/music educators and asked them for their comments regarding the definitions, and also for suggestions as to what they thought might represent observable characteristics of musicality in professional musicians.

The musicians/educators came up with the following suggestions:

1. Emotional expression
2. Aesthetic value
3. High energy level
4. Consistency in rhythms/tempos
5. Musical articulation
6. Accuracy in music and lyrics
7. Phrasing of music
8. Being in tune
9. Technical ability
10. Having the nature of tones as distinct from noise (with respect to musical improvisation)

After the video rating scales were designed, two raters (one professional musician and one psychologist, who was also an amateur musician) were trained to use them in rating observable signs of extreme self-involvement, stress symptoms and musicality in both subjects' musical performances and their participation in the music therapy group.
The video rating scales were pilot-tested for inter-rater reliability by the two raters on two of videotapes from the first study (one performance and one music therapy group). The raters worked independently from video recordings which were presented in counterbalanced order, with raters blind as to group membership and performance order.

Statistical analysis of the inter-rater reliability showed almost perfect agreement between raters on all variables with the exception of Group Stress Symptoms, where a lower reliability was found. It was therefore decided that these scales could be successfully utilized as part of the research methodology of this study.
APPENDIX J

Table 9

ANOVAS For Group Comparability Between Experimental, Attentional and WLC Subjects on Personality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif of F</th>
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<tbody>
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<td>17.78</td>
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Table 10

Pre/Post ANOVAS Between Experimental and Attentional Control Groups on Observer-Rated Video Measures

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Table 11
Pre/Post ANOVAS Between Experimental, Attentional and Waiting-List Control Groups on Personality Measures

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Table 12
ANOVA Comparing NPI means of Experimental, Attentional and Waiting-list Control Groups

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Scheffe Procedure - Ranges for the .05 level - 3.72

Means
Experimental Group  2.62*
Attentional Group   - .60*
WLC Group           .67

(*) Denotes pairs of groups significantly different at the .05 level.
Table 13

Correlations of Video Measures and Standardized Tests

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<th>PSIA</th>
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Note: Asterisk (*) indicates significance p < .05
Figure 1
Plot of PRCP Change Scores vs. Initial STAI Scores

Figure 2
Plot of PRCP Change Scores vs. Initial NPI Scores
Table 14

Correlations between Standardized Test Change Scores and Video Rating Scale Change Scores

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<th>PSSDIF</th>
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</table>
APPENDIX K

QUESTIONNAIRE

This questionnaire is for research purposes only. All information is entirely confidential.

NAME _________________________ DATE _________________________

1. Date of birth ________

2. Place of birth (city/state/country) _________________________

3. Number of brothers and/or sisters you have that are younger than you (circle one), 0 1 2 3 more

4. Number of brothers and/or sisters you have that are older than you, 0 1 2 3 more

5. Mother's occupation _________________________

6. Father's occupation _________________________

7. Age at which you first began studying your instrument ________

8. Age at which you first performed in front of an audience (more than ten people) ________

9. Can you recall your earliest memory of music? Where were you? With whom? How did you feel? Please share any personal insights.

10. Were any of your family members involved in playing music? What instruments did they play? What types of music? Were they professional musicians?
11. Did your parents encourage you to express yourself musically?
Mother -

Father -

12. Do you remember experiencing a trauma at any point in your musical development? Please share any pertinent information.

13. What instrument did you first choose to study? Why? Is this the instrument you are now playing? If not why did you switch?

14. What was your relationship like with your instrument when you first started taking lessons?

15. What is it like now?

16. How did you feel about your first music teacher? And subsequent teachers?
17. Did you parents support and encourage you in your musical studies?

18. Did you have opportunities to perform as a child? adolescent? young adult? In what contexts?

19. Can you remember the first time you performed publicly? What was this like for you?

20. Has your experience of performing changed since then?

21. Was there ever any pressure for you to perform publicly or to become a professional musician? From who?

22. What was/is your basic motivation for performing?

23. What basic needs does performing fulfill in you?
32. How do you feel about the therapeutic benefits of music?

33. How do you personally experience the therapeutic benefits of music (listening and playing)?

34. Do you ever experience imagery when listening to or playing music? Please describe.

35. Is there ever a devotional aspect present in your musical expression?

36. Do you usually feel comfortable in your body while playing music? If not, how does your body limit your expression?

37. How much time do you spend practicing each day? Please give a brief description of your practice routine.

38. Do you feel comfortable expressing a wide range of emotions through your music? Are certain emotions more difficult to express than others? Which ones?
39. Are you involved in any self-development groups? If so, which ones?

40. Have you ever been in therapy? What kind(s)? Did you find this helpful?

41. What is your purpose in wanting to be a professional musician?

42. What do you hope to achieve through participating in this research study on performance stress?

43. Do you have any other comments or feedback?

****THANK YOU****
STRESS SYMPTOMS QUESTIONNAIRE

Rate the severity of each problem according to the scale below:
0 = Not present
1 = Mild .................. The problem is just noticeable
2 = Moderate ............ The problem is annoying
3 = Severe .............. The problem interferes with daily life
4 = Extreme ............ The problem is often debilitating

___ Headaches
___ Constipation
___ Loose bowel movements
___ Faintness or dizziness
___ Hot Flashes
___ Voice quavering or shaking
___ Dry mouth
___ Tightness in jaw
___ Soreness of muscles
___ Weakness in parts of your body
___ Pains in heart or chest
___ Smoking
___ Itching
___ Sweaty palms
___ Feeling tense or nervous
___ Shakiness
___ Bad dreams
___ Your mind going blank
___ Difficulty in making decisions
___ Trouble remembering things
___ Thoughts hard to get rid of
___ Difficulty staying asleep

___ Poor appetite
___ Easily annoyed or irritated
___ Easily crying
___ Loss of sexual functioning
___ Overeating
___ Excessive urination
___ Cold hands or feet
___ Blushing
___ Twitches, tics, spasms
___ Lump in throat
___ Stuttering
___ Grinding of teeth
___ Lower back pains
___ Heavy feelings in arms or legs
___ Heart racing
___ Allergies
___ Tightness in stomach
___ Nausea or upset stomach
___ Thoughts hard to get rid of
___ Difficulty concentrating
___ Difficulty staying asleep
___ Uncontrollable outbursts of anger
___ Fatigue
___ Loss of sexual energy
___ Loss of sexual interest or desire
___ Sore throat
___ Abuse of alcohol or drugs
___ Binge/purge/fast patterns
___ Trouble getting your breath
___ Extreme fear of places or events
___ Feeling fearful
___ Difficulty with breath
___ Feeling inferior to others

Add the numbers for TOTAL SCORE
APPENDIX L

WEEKLY LOG FORMAT

Please answer the following questions before the next group meets (preferably on the Monday of the next session) on looseleaf or notebook paper and leave the log in your questionnaire packet at the end of the session. It is hoped that the process of answering these questions based on your awareness during the week will help you to integrate what is learned in these music therapy sessions into your daily lives.

1. What opportunities to perform (or play music for others) did you have this week? Please list.

2. Did you experience stress in any of the above performance situations? Please describe the specific situation and the thoughts, feelings and bodily sensations that you were aware of which were related to the stress experience.

3. How did you cope with this stressful situation(s)?

4. What changes, if any, with regard to performance stress have you experienced in your music (practice, performance, play etc.) this week which you feel are a result of your participation in the Music Therapy Group? Please describe.

5. What changes, if any, have you noticed this week in your relationship with the audience during musical performance which you feel are a result of your participation in the Music Therapy Group? Please describe.

6. Have you experienced any "peak" experiences this week with regard to your musical performance(s)? Please describe.

7. How would you rate your psychological orientation towards performing music this week? Please choose one of the following - self involved (inner directed); don't know; audience involved (outer directed)

8. What is your goal for the next group session? Please be specific.

9. Have you any other thoughts about Music Therapy Group and/or musical performance that you would like to share?
APPENDIX M

POST GROUP QUESTIONNAIRE

1. Do you feel you have achieved your goal(s) for this session? What, if anything, helped you to do this?

2. Is there anything that you feel is unresolved for you in this session?

3. What do you feel is the most important thing that you experienced in this music therapy session?
4. What did you learn about yourself during the warm-up and group improvisation - musically? in your interaction with other group members and/or group leaders? in your participation in or observing the individual therapeutic work?

5. What instrument(s) did you choose for the improvisation? Why?

6. What do you feel you communicated during the group improvisation? To whom?

7. How did you feel about the therapists' interventions in this music therapy session? Please be specific.
APPENDIX N

PERSONAL REPORT OF CONFIDENCE AS A PERFORMER

This questionnaire is composed of 28 items regarding your feelings of confidence as a performer. After each statement there is a "True" and a "False." Try to decide whether "True" or "False" most represents your feelings as associated with your most recent performance. Then put a circle around the "T" or "F." Remember that this information is completely confidential and will not be made known to anyone except the researcher. Work quickly - first impressions are most appropriate. Please respond to every statement.

1. I look forward to an opportunity to perform in public. T F
2. My body trembles as I am about to perform. T F
3. I am in constant fear of forgetting the music. T F
4. Audiences seem friendly when I come on stage. T F
5. While preparing a performance I am in a constant state of anxiety. T F
6. At the conclusion of a performance I feel that I have had a pleasant experience. T F
7. I dislike to use my body expressively. T F
8. My thoughts become jumbled and confused when I perform before an audience. T F
9. I have no fear of facing an audience. T F
10. Although I am nervous just before getting up I soon forget my fears and enjoy the experience. T F
11. I face the prospect of performing with complete confidence. T F
12. I feel that I am in complete possession of myself while performing. T F
13. I like to observe the reactions of the audience to my performance. T F
14. Although I perform well before friends, I freeze T F
15. I feel relaxed and comfortable while performing.  T  F
16. Although I do not enjoy performing in public I do
   not particularly dread it.  T  F
17. The faces of the audience are blurred when I look
   at them.  T  F
18. I feel disgusted with myself after performing
   before an audience.  T  F
19. I enjoy preparing for a performance.  T  F
20. My mind is clear when I face an audience.  T  F
21. My hands feel cold and weak before performing.  T  F
22. I perspire and tremble just before performing.  T  F
23. My posture feels strained and unnatural.  T  F
24. I am fearful and tense all the while I am
   performing before an audience.  T  F
25. I find the prospect of performing mildly
   pleasant.  T  F
26. At the conclusion of my performance I feel that
   I would like to continue performing.  T  F
27. I am terrified at the thought of performing
   before a group of people.  T  F
28. I have a feeling of alertness in facing an
   audience.  T  F

NAME  DATE
APPENDIX O
SELF-EVALUATION QUESTIONNAIRE
STAI Form Y-2

Name ___________________________________________ Date _______________________

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

21. I feel pleasant .................................................. 1 2 3 4 5
22. I feel nervous and restless ..................................... 1 2 3 4 5
23. I feel satisfied with myself .................................... 1 2 3 4 5
24. I wish I could be as happy as others seem to be ......... 1 2 3 4 5
25. I feel like a failure .............................................. 1 2 3 4 5
26. I feel rested .......................................................... 1 2 3 4 5
27. I am "calm, cool, and collected" ............................. 1 2 3 4 5
28. I feel that difficulties are piling up so that I cannot overcome them .................................................. 1 2 3 4 5
29. I worry too much over something that really doesn't matter ...... 1 2 3 4 5
30. I am happy .......................................................... 1 2 3 4 5
31. I have disturbing thoughts .................................... 1 2 3 4 5
32. I lack self-confidence ......................................... 1 2 3 4 5
33. I feel secure ........................................................ 1 2 3 4 5
34. I make decisions easily ....................................... 1 2 3 4 5
35. I feel inadequate ................................................. 1 2 3 4 5
36. I am content ...................................................... 1 2 3 4 5
37. Some unimportant thought runs through my mind and bothers me .......................................................... 1 2 3 4 5
38. I take disappointments so keenly that I can't put them out of my mind .................................................. 1 2 3 4 5
39. I am a steady person .......................................... 1 2 3 4 5
40. I get in a state of tension or turmoil as I think over my recent concerns and interests .................................................. 1 2 3 4 5

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APPENDIX P
SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name ____________________________ Date ____________ S ______
Age ______ Sex: M _____ F _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

1. I feel calm ............................................................... (i) (ii) (iii) (iv)
2. I feel secure ............................................................. (i) (ii) (iii) (iv)
3. I am tense ............................................................... (i) (ii) (iii) (iv)
4. I feel strained ........................................................... (i) (ii) (iii) (iv)
5. I feel at ease ............................................................ (i) (ii) (iii) (iv)
6. I feel upset ................................................................ (i) (ii) (iii) (iv)
7. I am presently worrying over possible misfortunes .......... (i) (ii) (iii) (iv)
8. I feel satisfied ............................................................ (i) (ii) (iii) (iv)
9. I feel frightened .......................................................... (i) (ii) (iii) (iv)
10. I feel comfortable ....................................................... (i) (ii) (iii) (iv)
11. I feel self-confident .................................................... (i) (ii) (iii) (iv)
12. I feel nervous ............................................................ (i) (ii) (iii) (iv)
13. I am jittery ................................................................ (i) (ii) (iii) (iv)
14. I feel indecisive .......................................................... (i) (ii) (iii) (iv)
15. I am relaxed ............................................................... (i) (ii) (iii) (iv)
16. I feel content ............................................................. (i) (ii) (iii) (iv)
17. I am worried ............................................................. (i) (ii) (iii) (iv)
18. I feel confused ........................................................... (i) (ii) (iii) (iv)
19. I feel steady .............................................................. (i) (ii) (iii) (iv)
20. I feel pleasant ............................................................ (i) (ii) (iii) (iv)
APPENDIX Q

On the following scales, please rate the way you are feeling right now.

ADJECTIVE CHECK LIST

coop erative .................................................. competitive
pleasure-oriented ............................................. work-oriented
submissive ..................................................... dominant
daring .......................................................... cautious
giving .......................................................... receiving
personal ......................................................... impersonal
powerful ........................................................ weak
emotional ....................................................... unemotional
self-confident .................................................. anxious
close ............................................................. distant
tough ............................................................. tender
a winner ......................................................... a loser
sociable .......................................................... not sociable
intuitive .......................................................... not intuitive
business-like ................................................... unbusiness-like
active ............................................................. passive
strongly motivated ........................................... weakly motivated
friendly .......................................................... unfriendly
effective ........................................................ ineffective
intense ........................................................... mild
accepting ....................................................... rejecting
creative .......................................................... uncreative
supported ....................................................... not supported
APPENDIX R
NPI

Instructions: The NPI consists of a number of pairs of statements with which you may or may not identify. Consider this example: A "I like having authority over people," versus B "I don't mind following orders." Which of these two statements is closer to your own feelings about yourself? If you identify more with "liking to have authority over other than people" than with not minding following orders, then you would choose option "A".

You may identify with both "A" and "B". In this case you should choose the statement which seems closer to your personal feelings about yourself. Or, if you do not identify with either statement, select the one which is least objectionable or remote. In other words, read each pair of statements and then choose the one that is closer to your own feelings. Indicate your answer by drawing a circle around the letter ("A" or "B") that precedes that statement. Do not skip any items.

1. A I am fairly sensitive person.
B I am more sensitive than most other people.

15. A I am not sure if I would make a good leader.
B I see myself as a good leader.

2. A I have a natural talent for influencing people.
B I am not good at influencing people.

16. A I am assertive.
B I wish I were more assertive.

3. A Modesty doesn't become me.
B I am essentially a modest person.

17. A I like having authority over other people.
B I don't mind following orders.

4. A Superiority is something that you acquire with experience.
B Superiority is something you are born with.

18. A There is a lot that I can learn from other people.
B People can learn a great deal from me.

5. A I would do almost anything on a dare.
B I tend to be a fairly cautious person.

19. A I find it easy to manipulate people.
B I don't like it when I find myself manipulating people.

6. A I would be willing to describe myself as a strong personality.
B I would be reluctant to describe myself as a strong personality.

20. A I insist upon getting the respect that is due me.
B I usually get the respect that I deserve.

7. A When people compliment me I sometimes get embarrassed.
B I know that I am good because everybody keeps telling me so.

21. A I don't particularly like to show off my body.
B I like to display my body.

8. A The thought of ruling the world frightens the hell out of me.
B If I ruled the world it would be a much better place.

22. A I can read people like a book.
B People are sometimes hard to understand.

9. A People just naturally gravitate towards me.
B Some people like me.

23. A If I feel competent I am willing to take responsibility for making decisions.
B I like to take the responsibility for making decisions.

10. A I can usually talk my way out of anything.
B I try to accept the consequences of my behavior.

24. A I am at my best when the situation is at its worst.
B Sometimes I don't handle difficult situations too well.

11. A When I play a game I don't mind losing once in a while.
B When I play a game I hate to lose.

25. A I just want to be reasonably happy.
B I want to amount to something in the eyes of the world.

12. A I prefer to blend in with the crowd.
B I like to be the center of attention.

26. A My body is nothing special.
B I like to look at my body.

13. A I will be a success.
B I'm not too concerned about success.

27. A Beauty is in the eyes of the beholder.
B I have good taste when it comes to beauty.

14. A I am no better or no worse than most people.
B I think I am a special person.
28. A I try not to be a show off.
   B I am apt to show off if I get the chance.

29. A I always know what I am doing.
   B Sometimes I'm not sure of what I am doing.

30. A I sometimes depend on people to get things done.
   B I rarely depend on anyone else to get things done.

31. A I'm always in perfect health.
   B Sometimes I get sick.

32. A Sometimes I tell good stories.
   B Everybody likes to hear my stories.

33. A I usually dominate any conversation.
   B At times I am capable of dominating a conversation.

34. A I expect a great deal from other people.
   B I like to do things for other people.

35. A I will never be satisfied until I get all that I deserve.
   B I take my satisfactions as they come.

36. A Compliments embarrass me.
   B I like to be complimented.

37. A My basic responsibility is to be aware of the needs of others.
   B My basic responsibility is to be aware of my own needs.

38. A I have a strong will to power.
   B Power for its own sake doesn't interest me.

39. A I don't very much care about new fads and fashions.
   B I like to start new fads and fashions.

40. A I am envious of other people's good fortune.
   B I enjoy seeing other people have good fortune.

41. A I am loved because I am lovable.
   B I am loved because I give love.

42. A I like to look at myself in the mirror.
   B I am not particularly interested in looking at myself in the mirror.

43. A I am not especially witty or clever.
   B I am witty and clever.

44. A I really like to be the center of attention.
   B It makes me uncomfortable to be the center of attention.

45. A I can live my life in any way I want to.
   B People can't always live their lives in terms of what they want.

46. A Being an authority doesn't mean that much to me.
   B People always seem to recognize my authority.

47. A I would prefer to be a leader.
   B It makes little difference to me whether
APPENDIX S
GUIDELINES FOR VIDEO RATING SCALES

OBSERVABLE SIGNS OF STRESS DURING PERFORMANCE AND THERAPY

1. Face deadpan
2. Rigid body, not allowing it to move with the pulse of the music
3. Lifts or tenses shoulders
4. Hands tremble
5. Shakey, tight or dry voice
6. Gasping for air or breathlessness

OBSERVABLE SIGNS OF SELF-ININVOLVEMENT DURING PERFORMANCE AND THERAPY

1. Affected behavior, i.e. affected hand movements while playing
2. No eye contact with the audience
3. Apologizing to the audience before, during or after a performance
4. Inability to communicate the music to the audience
5. Forgetting the lyrics or notes of the music
6. Speaking about irrelevant issues
7. Excessive self-reference to "I" or "me"
8. Cutting off others in the group
9. Excessive judgment of self either positively or negatively

OBSERVABLE SIGNS OF MUSICALITY DURING PERFORMANCE AND THERAPY

1. Emotional expression and communication to the audience
2. Aesthetic value - having the nature or characteristics of music - mélodious, harmonious, euphonious
3. Energy level - low vs. high
4. Consistency with rhythms and tempos
5. Musical articulation on the instrument
6. Accuracy in music and lyrics
7. Phrasing of the music
8. Being in tune
9. Technical proficiency
10. Having the nature of tones as distinguished from noises
GROUP #

RATING SCALE: 0 - 5
0 being the lowest
5 being the highest

Subject's name

<table>
<thead>
<tr>
<th>Evaluation of Musicality during music improvisation</th>
<th>Overall evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional expression</td>
<td></td>
</tr>
<tr>
<td>Aesthetic value</td>
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<tr>
<td>Technical ability</td>
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<td>Having the nature of tones as distinct from noise</td>
<td></td>
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</table>
GROUP #

Subject's name

<table>
<thead>
<tr>
<th>Signs of self-involvement during music therapy group</th>
<th>Overall evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected behavior</td>
<td></td>
</tr>
<tr>
<td>Apologizing to group before, during or after a music improv</td>
<td></td>
</tr>
<tr>
<td>Excessive self-reference to &quot;I&quot; or &quot;me&quot;</td>
<td></td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>Excessive speaking or rambling</td>
<td></td>
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<tr>
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</table>

| Signs of stress during therapy group                |                    |
| Face deadpan                                       |                    |
| Rigid body                                          |                    |
| Lifts or tenses shoulders                           |                    |
| Hands tremble                                      |                    |
| Shaky, tight or dry voice                           |                    |
| Gasping for air/breathlessness                      |                    |
GROUP #

RATING SCALE: 0 - 5
0 being the lowest
5 being the highest

Subject's name ________________

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APPENDIX T

Explanation of the Study

In this study we will be testing the use of Music Therapy Group as an effective treatment modality for performance stress in selected professional musicians. Participation in this study involves:

1. Attending approximately 14 weekly group meetings (from 6:30-8:00 on Monday nights) starting September 21, 1987.
2. The completion of a battery of standardized tests before and after the study, completion of weekly post-group questionnaires and the completion of weekly take-home logs.
3. Concluding interview.

The Music Therapy Group will use musical improvisation, verbal discussion and various music therapy techniques as a means of developing awareness of the thoughts, feelings and bodily sensations which block creativity and lead to the experience of performance stress. It is hypothesized that as participants come to a greater understanding of themselves through musical expression in a supportive environment, they will experience a reduction of performance stress and heighten their creative potential as professional musicians.

The Music Therapy Group follows the humanistic model which views anxiety as not only contingent on direct psychological traumas but also upon the frustrations of positive goals in an otherwise untroubled individual. This "struggle toward realization" seems particularly relevant to the efforts of the performing artist.
APPENDIX U

Human Subjects Statement

Subjects for this study will be recruited by an announcement placed in the Musician's Union newspaper, Allegro over a two month period of time.

The principal investigator will explain to each subject the purpose for the study and will give a detailed description of the Music Therapy Group intervention.

Subjects will be told that all written data will be held in strict confidence and that the videotapes accumulated during the fourteen weeks of the study will be edited and used in the future as training materials for music therapy students at New York University. Subjects will have the right to destroy any videotapes which contain information that they do not want to be made available for others to view.

The principal investigator will explain to each subject that he or she has the right to withdraw from the study at any time.

Since the music therapy intervention does not involve any health risks, there is no potential physical harm for those participating in this study. The nature of group process will be discussed with subjects to ascertain whether or not they feel comfortable sharing psychological and/or musical issues in a group environment.
CONSENT FORM

PLEASE READ CAREFULLY BEFORE SIGNING

I have agreed to participate in the experiment entitled Utilizing Music Therapy as a Treatment Mode for the Performance Stress of Professional Musicians and hereby give my consent to be a subject. The researcher has explained to me that participation in the study involves the following:

1. Attending approximately 14 weekly group meetings (from 6:30 - 8:00 PM on Monday nights), starting September 21, 1987.

2. The completion of standardized psychological tests and brief self-report questionnaires before and after the experiment, before and after each performance and also mid-group.

3. Each session will be videotaped. Subjects will be given the opportunity to play back their tape and, if they so desire, can ask at that time that it not be used and that it be destroyed.

4. Concluding interview.

Subject's Signature

Louise Montello, M.A.
Principal Investigator
(212) 529-9737

Date

Date