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## CLINICAL-MUSICAL RESPONSES OF NORDOFF-ROBBINS MUSIC THERAPISTS: THE PROCESS OF CLINICAL IMPROVISATION

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### ABSTRACT

The purpose of this study was to investigate the clinical-musical responses of Nordoff-Robbins Music Therapists while improvising with clients and specifically examine what was going on in the therapist's consciousness moment-to-moment. Five Nordoff-Robbins music therapists were asked to listen to a memorable individual session with their client and describe (a) what they perceived about themselves while improvising; (b) what they perceived about their clients and their music while improvising; and (c) how they musically responded to these apprehensions and perceptions. Tape-recorded interviews were transcribed and analyzed. Therapists' intrapersonal perceptions while improvising included: empathy toward the client; thoughts about the co-therapist; awareness of feelings and stamina; intuition; musical ideas/inspiration; musical freedom; tension; searching; listening; internal voice/transpersonal guidance; and faith in music/oneself. Therapists' perceptions about their client while improvising included: observing clients' emotional, physical, and behavioral responses; awareness of dynamics in the client-therapist relationship; and awareness of the client's music, interpersonal, and personal growth. Therapists spoke about their awareness of music while improvising in five dimensions: what they were receiving from it; their feelings toward it; how they experienced it; how they were clinically using it; and how the music seemed to be affecting their clients. Conclusions and implications for clinical practice, theory, research, and training are discussed.

### INTRODUCTION

Improvisational music therapy is the free or guided extemporaneous use of music to help clients improve or maintain health: it is used extensively in music therapy with a wide range of clientele, from nonverbal children to verbal adults (Bruscia, 1987). Typically, the goals of improvisational music therapy are: to help the client be more aware and attentive to self and others, to aid in self-expression and communication, to promote insight, and to develop personal and interpersonal freedom (Bruscia, 1987). One of the first

and most significant models of improvisational music therapy to be developed was Nordoff-Robbins Music Therapy (NRMT), a creative, improvisational approach to individual and group therapy developed by Paul Nordoff and Clive Robbins in 1959.

In NRMT, typically two therapists work at a time with an individual client, helping the client to engage in spontaneous musical interactions with instruments and/or the voice. The two therapists work as partners with specific roles and clearly defined responsibilities: the primary therapist improvises at the piano and is responsible for formulating the clinical-musical focus, and the co-therapist supports the client's participation by working directly with the client, helping him or her to respond to the improvised music and to the clinical intentions of the therapist at the piano (Robbins & Robbins, 1977).

This study is concerned with the experiences of the therapist improvising at the piano. The typical NRMT session involves almost continual music making. Thus, a real challenge for the therapist is knowing what to play from moment-to-moment to engage the client, while responding continually to the client's efforts at self-expression and communication. How does a therapist know when to play a chord, or when to introduce a melody? How does a therapist know when to play loud or soft, fast or slow? What is happening within the therapist's consciousness to guide these decisions?

## RATIONALE FOR THE STUDY

Despite the numerous benefits of the team approach traditionally followed by NRMT practitioners, sitting at the piano and clinically improvising with a client is a very solitary experience, full of moments of potential for both client and therapist—but also moments of doubt and searching for the therapist. One of my personal motivations behind this study stems from a need to become more familiar with the shared aspects of daily work of Nordoff-Robbins therapists, even in light of our varied ways of approaching clinical improvisation, based on who we uniquely are. Still, I do find it a paradox that while the therapist's music is of utmost importance in the NRMT approach, very little has been written, or is included within NRMT discourse, about the experience of the therapist who creates the clinical music him/herself.

Shortly after I obtained certification in NRMT, I was fortunate to join the staff at the Creative Music Therapy Studio, where I could continue to work as a Nordoff-Robbins therapist in the traditional team format, receiving supportive feedback from my colleagues while having the space to take risks, both musically and personally. I began to ask questions of my colleagues after sessions: What were you experiencing at that particular moment when the client musically responded to you in that way? What was happening when you shifted into that altogether different mood in the music? How did it feel to remain in the Spanish idiom for the entire session and what was behind this decision? The questions began to flow both ways, and routinely between breaks, if time permitted, such informal questions provided a glimpse of how much Nordoff-Robbins therapists have to say—and can learn from one another—about the nature of the work through

speaking about their own experiences, insecurities, and questions brought forth by clinical improvisation.

These questions were not only being raised by me in the context of my work; I was also asked questions directly from parents who sat in on intake sessions and NRMT sessions with their children. They not only wanted to understand the clinical goals that emerged as the sessions proceeded, and how NRMT could address them, but often inquired about the specifics of our work. Following a session, some parents would ask why I decided to go with one particular musical idea rather than another, or what I “heard” about their child in his/her music, and their potential for relationship, or what I was thinking about when I was singing to their non-responsive child. These are all valid questions that arise out of a natural curiosity to what can sometimes seem like an elusive clinical process, to therapists, clients, and parents alike.

It is interesting to note that in the music literature, the experience of the improviser has been written about extensively by jazz musicologists and musicians (Berliner, 1994; Mathieu, 1984; Nardone, 1996; Sawyer, 1992; Sudnow, 1978). However, in the music therapy literature, with the exception of two phenomenological studies conducted by Forinash (1992) and Fidelibus (2004), research on the experience of improvisational music therapists, especially concerning their clinical-musical responses to clients, is very limited. Just as jazz improvisers have studied their own improvisational processes to illuminate their experience (Milano, 1984; Sudnow, 1978), music therapists, too, might gain new understandings about themselves and their clients within the complex process of clinical improvisation by undertaking similar research endeavors.

The purpose of this study is to examine the clinical-musical responses of Nordoff-Robbins Music Therapists while improvising with clients. Within the context of this study, a musical response is defined as any vocal or instrumental, melodic, harmonic, or rhythmic decision made by a therapist in response to him/herself or the client while improvising. Improvisation is defined as “the art of spontaneously creating music while playing, rather than performing a composition already written” (Apel & Daniel, 1969, p.140).

## RELATED LITERATURE

The process of improvising has been explored from diverse perspectives, utilizing a number of different approaches, including cognitive, musicological, psychological, and phenomenological. For example, Pressing (1988) presented a theory of improvised behavior in music, built upon an extensive survey of pertinent research from a number of different disciplines. Although he includes a brief overview of research on the phenomenological treatment of improvisation, Pressing’s theory is explicitly cognitive in its formulation, and is centered on the more general question: “How do people improvise?” (p.129), rather than being a more specific examination of the musical response process between improvisers.

## The Improvisational Process in Jazz

There are several qualitative studies on the psychological experience of jazz musicians that focus on the consciousness of improvisers. Berliner (1994) conducted an extensive qualitative study considering the improviser's world of consciousness, compiling statements from jazz musicians about their improvisational experiences, and offering a thoughtful, thorough presentation of the life-world of the jazz improviser. Sawyer (1992), analyzing a single jazz performance to explore improvisational creativity, discovered that musicians experience shifts in levels of consciousness while improvising. According to Sawyer, a significant tension in consciousness exists during improvisation, as musicians must consistently move along a continuum between two extremes. At one extreme, musicians direct the solo with full consciousness, and at the other, musicians play in a "heightened state of consciousness," where the mind seems removed from the process, and the solo emerges from a deeper place (p.256). Thus, "each musician must continuously resolve this tension to achieve a balance appropriate to the moment" (p.256).

Additionally, Milano (1984) presented one improviser's perspective in his interview with jazz pianist/psychiatrist Danny Zeitlin, who offered a holistic description of his experiences while improvising, including the intrapersonal challenges he has faced while immersed in the process.

## Phenomenological Studies on Jazz Improvisation

Researchers have also conducted several phenomenological studies on the experiences of musicians engaging in improvisation as an artistic activity. For instance, Pike (1974) utilized a descriptive approach to present a phenomenology of jazz, emphasizing that "tonal imagery" is the fundamental creative focus in jazz improvisation (p.88). Unlike Sawyer (1992), Pike describes the improvisational process as primarily conscious, rational, and cognitive, in that it is "guided by goals and is methodical rather than erratic" (p.91). For Pike, jazz ideas may "leap" to the musician's mind and fingers, but such "flashes" occur "only as solicited and related events in the midst of a rational creative process—not as uninvited intrusions of the unconscious mind" (p.91).

Sudnow (1978) conducted a descriptive, phenomenologically informed inquiry where he provided a description of how he learned to play improvised jazz, focusing his study upon the body's "improvisational ways" in an effort to clarify the nature of the human body and its creations (p.xiii). Similar to Pike, Sudnow believes that there is an "orderly course" to improvisation, and refers to a sense of knowing the structural format and direction of the music while improvising (p.101). However, while Sudnow describes being conscious and present to the musical process, he also speaks of being simultaneously outside the process and fully observant of it, which allows him to move fully within and through the musical flow itself. Further, concomitant with a "definiteness of aim" throughout an improvisation, Sudnow experiences a sense of "being guided" by the mu-

sic, thereby becoming aware of a “singing body,” or a “new I” which is fully present to the music (p.152).

Mathieu (1984) analyzed the improvisational process in solo as well as music-dance duet improvisations. She found that throughout an improvisation, the musician listens “through” the sounds for what they bring forth (p.104). In so doing, the musician grasps the “sounding tension” of the music, which can inform him/her of potential musical directions (p.105). At the same time, the musician openly attends to meaningful musical elements appearing in his/her consciousness and questions their latent ones, which, as the music progresses, actualizes itself and becomes immediate. Mathieu concluded that “the musician through a continuous listening-attending-reaction-questioning presence allows the fulfillment of his own activity, and the music improvisation is brought into being” (p.109).

Nardone (1996) studied the range and structure of the experience of improvisation as an artistic activity in the life-world of five jazz musicians. Echoing findings in the Sudnow (1978) and Sawyer (1992) studies, Nardone discovered that three constituents exist paradoxically in music improvisation. One paradox is the desire to direct and ensure spontaneous musical variations while simultaneously allowing musical possibilities to emerge. The second paradox is that one is conscious of being present to the musical process while at the same moment being outside the process and fully observant of it. A third paradox is that while engaged in the spontaneous musical flow, there is an intention to allow the music to act as “guide” toward a musical terrain that is both familiar and unfamiliar (p.130).

These studies seem to reach similar conclusions; namely, that as a creative process, improvisation challenges the jazz musician to focus simultaneously upon one’s musical aim while remaining open to the music coming “through,” thereby allowing oneself to be musically “guided.” While these studies offer valuable insights for the music therapist into the process of improvisation from the jazz musician’s perspective, they also highlight the need for further research on the psychological processes unique to clinical improvisation from the therapist’s perspective.

## Improvisational Music Therapy

Several music therapy writings reflect a growing interest in studying various aspects of improvisational music therapy, including: the therapist’s music and its impact on the musical relationship; the psychological process of the client while improvising; and, the relationship between consciousness and improvisation for the therapist.

Coming from a position that the therapist’s music does not receive enough attention in the music therapy literature, Procter (1999) studied his own NRMT clinical work to establish whether the therapist’s musical input is of significance within the musical relationship. Procter found a link between predictability in the therapist’s musical input and the musical connectedness between therapist and client, concluding that the therapist’s input must be regarded as significant for the relationship. He stressed that, given

this, therapists must hold themselves clinically accountable for everything they do in music, and that neglecting to do this abandons their claim to therapeutic awareness.

Nolan (1994), on the other hand, claims that the bulk of the literature on improvisational music therapy “seems to focus primarily upon what the therapist does, i.e., musical skills, degrees of structure, techniques, and clinical models or orientations” (p.84), rather than on the client. Thus, he sought to describe the inherent psychological processes involved for the client while improvising, focusing on the ways in which the “therapeutic response” in improvisational music therapy positively affects clients on a psychological level (p.84).

Examining the psychological processes involved for the therapist while improvising, Usher (1998) investigated possible links between Greenfield’s Concentric Theory (1995) and the development of musical gestalts within a clinical music therapy context. While Usher’s interest in linking a theory of consciousness to improvisational music therapy is primarily centered upon the application of Greenfield’s theory, she does provide a glimpse into her own, conscious psychological process while improvising. She writes: “Even in very free improvisations I am aware of connecting structures; I imagine myself weaving a musical form by moving from side to side while going forwards” (p.5).

There have also been studies that have examined the concept of time and creativity in NRMT. Robbins and Forinash (1991) developed a concept of time as a multi-level experience in improvisational therapy. To this end, the authors proposed four levels of human temporal experience: Physical Time, Growth Time, Emotional Time, and Creative Time, or Now Time. They assert that “performers living consciously in music as it is produced become simultaneously active on all four levels of time, and in performance the interrelationship between the four levels becomes dynamic” (p.54). Robbins and Forinash state that these theoretical ideas and concepts offer value to clinicians in “knowing practically when one is moving with a child from one level of time experience to another” (p.56).

The concept of “Creative Time” or “Now Time” described in Robbins and Forinash (1991) is also echoed by Turry (2001) in his description the “Creative Now,” which he defines as: “The potential of the creative moment in which the therapist is open to receive and respond to what the client is presenting—either in active playing or merely in presenting him/herself in the room—as music” (p.352).” Turry (2001) asserts that Nordoff-Robbins therapists improvising clinically are “poised in the creative now” and that clinical musicianship consists of six interrelated components: creative freedom; expressive spontaneity; controlled intention; clinical responsibility; methodical musical construction; and intuition (p.353).

During their partnership, the founders of NRMT, Paul Nordoff and Clive Robbins, created a large volume of writings describing their improvisational approach to individual and group music therapy. These writings contain detailed descriptions of clinical goals, techniques and procedures, philosophical beliefs, specific case studies, evaluation scales, and exercises for developing musical resources for use in therapy (Nordoff & Robbins, 1971, 1977; 1982; 1983). While Nordoff and Robbins did not conduct quantitative or qualitative research during their partnership, Aigen (1996) points out that they

were incorporating qualitative research methods and tools into their work. To my knowledge, only two quantitative studies have been conducted in NRMT (Aldridge, D., Gustorff, D., and Neugebauer, L., 1995; Mahoney, 2005). Within the past few years, however, several qualitative research studies on NRMT have emerged (Aigen, 1996; 1997; 1998; Forinash, 1992, Fidelibus, 2005. See also the studies by Turry and Sorel in this volume).

### Qualitative Research Studies on Nordoff-Robbins Music Therapy

Forinash (1992) was the first researcher to conduct a phenomenological study of Nordoff-Robbins music therapists' lived experience of clinical improvisation. In this study, the most important aspects of the improvisation experience for the eight interviewees included: therapists' personal histories, musical biographies, and the learning which occurred during post-session analysis. Other emergent themes included: facing the unknown; vulnerability; spontaneity, creativity, and intuition; and the interplay between intuition and rationality and rational, conscious choice. Forinash observed that therapists experienced difficulty putting the experience of improvisation into words due to it feeling like a "vague," multi-leveled process that essentially happens on a nonverbal level (p.131).

Four years later, Aigen (1996) undertook a qualitative study based on the transcript of a concentrated 6-month training course conducted by Nordoff and Robbins in 1974 at Goldie Leigh Hospital, London, England (p.1). As these lectures represented the most developed presentation of ideas and the final teaching collaboration of Nordoff and Robbins, Aigen was motivated to illuminate and put into perspective the essence of Nordoff-Robbins music therapy. One emergent concept from Aigen's research which is relevant to the present study is that of the "Psychological Moment" (p.15). Aigen explains the Psychological Moment as the psychological intuition on the part of the therapist which allows for the clinically potent timing of various interventions. The Psychological Moment is a type of "empathic awareness" from which the therapist shapes a session structure that is most appropriate for a given individual, and is a product of a therapist's intuitive awareness and skillful clinical intent (p.15).

In the book *Healing Heritage*—an edited transcript of the 1974 course entitled the "Nordoff-Robbins Preliminary Training Course in Music Therapy" at Goldie Leigh Hospital, London—Nordoff speaks extensively about the personal and musical resources needed by the therapist to effectively practice NRMT (Robbins & Robbins, 1991). While Nordoff did not, in these lectures, directly address his own psychological process while improvising, he did emphasize that real therapy takes place when there is a sense of "timelessness" when working with a child. He describes this time as "tonal," with the dynamics of tone and all its forces and beauty, and as "experiential," in that the therapist and the child are together in a musical experience (p.65).

Again drawing upon the NR archives, Aigen (1998) conducted an extensive qualitative study on NRMT which resulted in his book *Paths of Development in Nordoff-*

*Robbins Music Therapy*. In this document, Aigen presents a comprehensive analysis of eight case studies that emerged from the early work and life context of Nordoff and Robbins. Significant concepts and constructs were therefore examined in order to study the growth processes of both the children and the Nordoff-Robbins approach. Aigen's seminal 1996 and 1998 qualitative studies offer explorations of both philosophical beliefs manifest in Nordoff-Robbins practice and the team's pioneering clinical work in its original formulation, examined from a contemporary perspective.

Although the findings and ideas in the music therapy literature emphasize the importance of exploring the improvisational process in therapy, the psychological processes involved in the therapist while improvising has not been well articulated. To be sure, the complex nature of clinical improvisation is, as Aigen points out, "a notoriously difficult area to define and research" (Aigen, 1991, p.239). However, studies such as Procter's (1999) indicate that the impact of the therapist and his/her music on the therapeutic process is significant and deserves closer examination. Further study of what improvisational music therapists are psychologically experiencing within the "doing" can support the development of a more conscious awareness of oneself as a clinical improviser.

Nordoff-Robbins literature and research reflects ongoing efforts by clinicians and researchers alike to continually develop theoretical ideas and concepts of NRMT. However, as studies such as Robbins and Forinash (1991) reflect, the extent to which these concepts become part of the moment-to-moment psychological experiences of Nordoff-Robbins therapists while improvising is unknown, because specific application and utilization of these ideas have not been further discussed in the Nordoff-Robbins literature. Forinash's (1992) phenomenological study on the lived experience of clinical improvisation among Nordoff-Robbins therapists provided a valuable beginning point for further research that could extend beyond holistic description to include more specific explorations of the therapist's conscious, internal processes while improvising. In this way, clinicians could begin to voice their improvisational experiences, as Nordoff briefly did in 1974, in ways that may illuminate and deepen our understanding of improvisational music therapy.

The present study, then, departs from previous qualitative Nordoff-Robbins studies in its aim to more closely examine clinical-musical responses in the moment-to-moment improvisational experiences of Nordoff-Robbins therapists. Through a more in-depth study of Nordoff-Robbins therapists' apprehensions about themselves, perceptions of their clients, and their subsequent responses to these apprehensions and perceptions within the clinical-musical experience, it is hoped that further insights may be developed regarding the relationship between Nordoff-Robbins therapists' psychological processes while improvising and how NRMT is conceived of and practiced. Thus, the purpose of this study is to examine the clinical-musical responses of Nordoff-Robbins music therapists while improvising with clients. It will focus on exactly what is going on in the therapist's consciousness from moment-to-moment while improvising to engage the client.



## PROBLEM STATEMENT

The purpose of this study is to examine the clinical-musical responses of Nordoff-Robbins Music Therapists while improvising with clients. The main research question was: What is going on in the therapist's consciousness from moment-to-moment while improvising to engage the client? Subordinate questions were:

1. What are therapists apprehending about themselves and their own music while improvising?
2. What are therapists perceiving about their clients and their client's music while improvising?
3. How do therapists musically respond to these apprehensions and perceptions?

## METHOD

### Design

This study is phenomenologically informed, focusing on therapists' experience of clinical improvisation. In conducting this research, my stance was not to categorize the validity, truth, or realness of each therapist's experience. Rather, my intent was to search for the "meaning and relevance" (Forinash, 1995, p.368) of Nordoff-Robbins therapists' clinical-musical responses through illuminating their lived experience of clinical improvisation. This emphasis on phenomenology as a method "that remains with human experience as it is experienced" (Colaizzi, 1978, p.53) is also reflected in the study's subordinate questions: 1) What are therapists apprehending about themselves and their own music while improvising? 2) What are therapists perceiving about their clients and their client's music while improvising? 3) How do therapists musically respond to these apprehensions and perceptions?

### Participants

Five Nordoff-Robbins music therapists (three male, two female) served as participants for the study. I originally contacted six Nordoff-Robbins music therapists at the Nordoff-Robbins Center for Music Therapy at New York University through a mailing using addresses listed in the directory of The American Music Therapy Association. Of these, five gave their consent to participate. To participate in the study, each therapist must have been certified by the Certification Board for Music Therapists (CBMT), have acquired certification in the Nordoff-Robbins method of music therapy practice, and have had at least five full years of experience working as a Nordoff-Robbins music therapist. Partici-

pants were asked to sign a written consent form to take part in the study. Participants were also asked to sign a written consent to be audiotaped during the interview. A third consent form was presented to the participants concerning the use, storage, and disposal of the video data, in addition to safeguards to protect the anonymity of participants and their clients. This study and its findings were reviewed and accepted by the Institutional Review Board at Temple University.

## Research Instrument

Music therapy sessions at the Nordoff-Robbins Center are typically videotaped for use in the ongoing clinical assessment process. Every parent or legal guardian of the clients whose sessions were viewed and discussed for this research signed a release form that gave permission for their child's session tapes to be used for educational and/or research purposes. Copies of these release forms are on file at the Nordoff-Robbins Center. Before proceeding with the study, I checked to see that each therapist's selected client for video data had a parent or legal guardian consent form on file that was updated by the current year. No full names or other identifying information of clients were contained on these tapes.

## Data Gathering

Participants were asked to submit up to two videotapes of a memorable 30-minute music therapy session, each with the participant working with a different client. Thirty minute sessions were chosen for this study as this is the typical length of most NRMT sessions. Each participant chose to submit only one videotape for review. Prior to the interview, participants were asked to reflect on the meaningful musical segments consisting of significant vocal or instrumental-rhythmic responses of both client and therapist during the session. These segments served as specific experiences of clinical improvisation that were the focus of the interview.

Data for this study was gathered by interviewing participants about their experience of clinical improvisation during musical segments of sessions that they deemed meaningful through participant interviews and reflective analysis. Each interview was audiotaped and transcribed verbatim. During the interview, each participant was asked to review his/her selected videotaped session(s) of a memorable 30-minute individual music therapy session. At each meaningful musical segment identified by the participant, the researcher stopped the videotape and asked the participant to describe his/her experience, including: 1) what they were perceiving about themselves; 2) what they were perceiving about their client; 3) how they were musically approaching the client through clinical improvisation; or, 4) how they were using the music clinically at this specific point in time during the session. Within the context of this study, a musical response was defined as any vocal or instrumental, melodic, harmonic, or rhythmic decision made by a therapist

in response to him/herself or the client while improvising. Improvisation was defined as “the art of spontaneously creating music while playing, rather than performing a composition already written” (Apel & Daniel, 1969, p.140).

## Data Analysis

After transcribing the interviews, an initial organization of data into categories was created based on the nature of the research question, such as: therapist’s perception of self; therapist’s perception of the client; and therapist’s musical response. I read the transcriptions, listened to each interview for the second time, and created further lists of categories which became themes. These themes were refined by finding core themes and sub-categories for each interview. This was done by cross-analysis of the different responses generated in each interview. The findings consisted of a description of themes based upon the analysis of the research conducted across the five cases. To help ensure the trustworthiness and credibility of my findings, I consulted with my project advisor and peers throughout the analysis process. The process of member checking was also utilized, whereby each participant was given a copy of his or her own profile, and was asked to check the categories against their own experience. This was done in order to ensure that I understood meanings as the participants intended to convey them. I then re-edited each profile, integrating the participants’ comments and suggestions into the text.

## CAVEAT

The ideas and reflections of the therapists interviewed for this study do not represent all NRMT beliefs and practices; rather, they include only what they were consciously aware of while improvising moment to moment, whether or not their experiences were directly related to the approach. Furthermore, despite the breadth of therapists’ responses, these reflections are not meant to represent or outline NR therapist’s entire field of consciousness while improvising.

## RESULTS

In this section, results are offered in three separate sections. The first section contains themes which emerged from therapists’ reflections on their intrapersonal awareness while improvising. The second section contains themes that emerged following therapists’ perceptions about their clients within the clinical-musical experience. The third section contains themes which emerged following therapists’ perceptions about the music while clinically improvising. Initials were used to refer to participants throughout each section.

## Therapists' Intrapersonal Awareness

While improvising, the therapists were conscious of their empathy toward the client, their awareness of the co-therapist, their awareness of feelings that arose during the session, how much stamina they did or did not have, their use of intuition, musical ideas that emerged, musical freedom that they experienced, the tensions they experienced in the session, and their searching questions about the unknown. They were also conscious of their experiences of intense listening, the presence of an internal guiding voice, and having faith in the process.

### *Empathy toward the Client*

While improvising, therapists try to enter the client's world, internalizing the client's experience through trying to imagine his/her thoughts, feelings, and ways of being both in and outside of the therapy room. For example, one therapist related that something about the client's musical response and his tears seemed to communicate: "I'm frustrated being in this body, or situation, or it's hard being me . . . it's like [he's saying] there's something in me . . . that's not right" (A).

As another therapist reflected:

I'm very much intensely in the music here. I'm thinking that, here's this child, he can't talk. What is his life like? He can't express himself in any way. How frustrated he must feel. So I'm very happy that he can come to music and beat the hell out of this drum . . . what can he do in life that's expressive? I think he's very limited. So it felt very special, these moments. I felt very grateful that I could be part of his world, really. (D)

Through empathy, the therapist not only communicates that he/she is present for the client, but also gains more understanding of how to shape his/her interventions so that the musical experience may be as meaningful as possible for the client. One therapist noted that the client was "very much on [her] mind, what he's like in life," and thought that it would therefore be wonderful if he could experience calm through the use of melody in the session (E). Another therapist's connection between the client's overall treatment approach and life difficulties grew out of his effort to imagine the client's thoughts and intentions:

[The client] relates to us . . . in a provocative way . . . but that's his agenda, almost: "I'm going to come in and do things that demand your immediate attention. You've got to stop me from doing these things, and that's how we're going to relate." The thing that I'm offering is this boundless opportunity to relate in other ways that don't involve any of that, that don't involve creating hostility, and that are ultimately more fulfilling. So the question is how to maintain that possibility while dealing with the

immediacy of his demands. (C)

### *Thoughts about the Co-therapist*

The co-therapist plays an important role in the improvisation experience as his/her interpretations, feelings, decisions, musical ideas and/or suggestions, relationship to music, and overall involvement in the session is continually being filtered through the therapist's awareness:

I'm enjoying [the client's] playfulness and his interaction with [my co-therapist]. I also wonder what [my co-therapist] is going to do. Is he going to let him play or what's going to happen here? (E)

Another therapist spoke about wanting to be supportive of his co-therapist's willingness to facilitate the client's spontaneous impulse to dance, as neither she nor the client knew how to dance, and therefore felt self-conscious and nervous about it. As a way of monitoring her comfort level, the therapist kept checking in with her to see if it was alright to continue. (C)

At times, the co-therapist's suggestions may not be in alignment with the therapist's musical intuition or direction. Working with this can be a challenge:

We're walking such a tightrope . . . sometimes what [my co-therapist] suggests is something I don't feel. So, it's an accommodation . . . the worst of it can be a distraction. In the moment, to try and incorporate somebody else's idea [when] there's so much going on is hard. It's not where I am. (B)

However, it is the co-therapist's presence and the space that he/she creates in the room that may impact the therapist the most:

I am definitely affected when someone else is in the room and who that person is. I have worked with my co-therapist before so I feel comfortable with him. I really respect him and actually his relationship to music is very inspiring to me. So I may play in a different way because he's there . . . I think he really somehow can create a space in there for me to make music with my client. And he only moves in if he's needed. (E)

### *Awareness of Feelings*

Feelings that arise during an improvisation may relate to oneself, the client, and the music being created. The therapist may simply bring awareness to them, or use them more directly to help guide clinical-musical decisions. As one therapist observed:

When I'm making choices of tones, I'm considering how I'm feeling and [the client] is feeling . . . there's a combination between hearing the music and feeling the spatial relationship with my hands. I know my hands are going in a certain way because of the mood. (A)

The therapist's immersion in the feeling of the music may also help reflect underlying feelings that the client may be struggling with, and communicate to the client that he/she can resonate with these feelings:

I felt like I was kind of captured by the music. I felt like I was almost crooning, I was almost sorrowful: this is what's happening, we have to acknowledge it. It's a sad song. So part of my use of the voice was that I, myself, was affected by the sadness. (C)

However, as one therapist asserts, it is important to consider that what the therapist is feeling may not be indicative at all of what may be happening within the client:

I don't trust my responses to the music as being identical to [the client's]. I can rest pretty well assured that when I'm getting bored, that has nothing to do with what the client is feeling. I may be able to watch clients and have a sense from their body language and the way they play that they're losing interest, but not from what I'm doing or my responses. (C)

### *Awareness of Stamina*

The sheer physicality of playing an instrument, combined with the mental and emotional energy that clinical improvisation requires, can be exhausting for the therapist. Although therapists with clinical experience are accustomed to the demands of the work, the stamina that is needed even within only a half hour session is significant.

Therapists attributed several factors to the physical and emotional strain that sometimes occurs both during and following clinical improvisation. One is the need to stay "immediately mobile, poised to go," when creating music with a client, and be completely spontaneous (B). Another is the need to "pull on all of [one's] resources" when improvising with a client (D). Attunement to the client's cues and ongoing focus on relating to the shape of one's hands and the intervals (A) was also observed to contribute to strain experienced in the work. However, therapists noted that growing clinical experience (A); pacing oneself (A); and utilizing musical resources or idioms that allow oneself to breathe, yet still being present to the client (D), can help one cope with the demands of clinical improvisation and maintain one's stamina during the course of a session.

### *Intuition*

The therapist's use of intuition may be especially important when working with clients who have communicative limitations. Through intuition, the therapist opens him/herself to possibilities of what the client may be experiencing intrapersonally, interpersonally, and/or through the music. For one therapist, the slow, deliberate way a client reached out to the piano seemed especially significant in light of not only how emotionally difficult the session had been, but also the client's overall difficulty in directly communicating with anyone. Through the client's musical efforts, the therapist's intuition led him to sense that the client was trying to communicate something affirming, such as: "I hear you" [you are with me] (A).

### *Musical Ideas / Inspiration*

Although difficult to put into words, many therapists tried to describe the process through which new ideas, or inspirations, come through when they are improvising. The music—as an extension of the therapist's voice—may sound his/her message, or clinical intention. In this way, the music itself may help the therapist become conscious of his/her thoughts, or become aware of what he/she wants to say to the client (A).

Musical inspiration can also emerge through careful attunement to the inherent direction of the music. As one therapist explains:

The idea, the inspiration for the next phrase [can sometimes feel] inherent in the music, the music wants to change . . . it is directing me from its inherent tendencies to move into different places [even though I am creating it]. (C)

At times, certain clients may simply bring out music within the therapist that just "feels right" but is beyond his/her understanding. Therapists related their pleasure and wonder about these kinds of musical experiences and relationships.

### *Musical Freedom*

Musical freedom is something that many clinical improvisers strive for, and experience as an especially rewarding part of the therapeutic process and relationship. While instances of musical freedom are most likely as varied and unique as each course of therapy, several therapists shared their feelings of excitement about its emergence in sessions along with the more practical conditions under which it occurred. For these therapists, musical freedom was experienced when playing dramatic music (D); when moving out of song forms into pure improvisation (D); when the musical environment was able to capture a clinical situation (C); and when the therapist was free of an agenda (A).

For one therapist, working with a client who was very disabled lifted the pressure he sometimes experiences when working with clients who are more musically sophisti-

cated. Released from having a musical agenda, he found that the most important thing for him was “to play music that matters”; that the work was about “being in the musical environment and [playing music that] matters, not trying to create music “to make [the client] do something” (A).

### *Tension*

It is a paradox that clinical improvisation has such potential to pull its creators into the moment, because when one is actually improvising, the fullness of the moment cannot be fully savored. There are many data streams that the therapist must simultaneously negotiate—parallel and converging lines of thought, intention, action, feeling, and intuition (E). In the effort to open oneself fully to all that is being presented, there is inherent tension and challenge:

There wasn't even time to enjoy it in the moment because it's always about the next moment . . . so I'm not even thinking, “Oh this is a wonderful experience now.” It's more the anxiety of—not anxiety in a negative way—but the tension of what's going to happen next. Because I've got to keep going, we can't just stop this. We're in the middle of something . . . . (D)

In addition to the tension of creating the music, the therapist also experiences tension—physically and emotionally—as the music unfolds or as he/she takes in aspects of the client that may be related to the dynamics of the therapy. For example, one therapist related a gradual increase in tension as he recognized that he was experiencing being his client's shadow (C). Another spoke of feeling at one with the tension in the music, experiencing it not only in the moment, but just as intensely during the interview itself, just upon re-hearing it (B).

Divergence of client and therapist in the music can also produce tension in the therapist, as uncertainty about what the next moment will bring—particularly regarding the therapist/client relatedness—is so dynamic in improvisation. One therapist spoke of her tension in not knowing:

. . . if [the client] was going to come around to meet me? . . . Who's going to compromise, or are we just going to go our separate ways and nothing will happen? Will we be playing two different things? Or is one of us going to accommodate the other? . . . If I don't do what he does, how will he react? . . . is he going to follow me or not? (D)

### *Searching*

Searching is a natural and inevitable part of improvisation, as the therapist continually searches: the self, for one's own intentions, personal responses, and motivations (A, C, D,



E); the client, for his/her responses to the music and the meaning the experience may hold for him (A, B, E); and the music, for what is happening within it, where to go next, and its effectiveness in the ongoing process (C, D, E).

The experience of continually moving into the unknown—and the searching that accompanies this process—are well articulated by a therapist who is questioning herself about what is happening in the moment:

I wasn't sure that he was so happy with what I was doing. I was trying to go for singing because I think it's important that he express himself vocally . . . I think he likes the warmth of the voice because he's quietly listening, but he's not responding so much. And I'm wondering, why? Why am I not pulling from him what I was hoping to pull from him? (D)

### *Listening*

Listening is an essential part of clinical improvisation—perhaps as much of an art and a discipline as actually creating the music. One therapist observed:

It's interesting that he can't tell me what he wants in life, but . . . he can tell me musically what he wants [and] I understand. And I think that's why he's connected to me, because he knows I'm hearing him, that he's being heard. (D)

Therapists spoke of listening not only to specific qualities in the client's music and of the client's being, (A, B) but also the importance of listening through immediate sounds, behaviors, or session occurrences (C) to get to the heart of what matters most:

. . . I'm trying really hard to listen, listen to his breathing, how is he phrasing, listen to what the possible tones are, listen to the quality of the crying, what kind of crying is it. Is it an agitation cry, is it a tragic cry, is it a mournful cry . . . I'm trying to hear, trying to understand it. (A)

Sometimes, the client and therapist's listening together can open up new possibilities for creating and experiencing music that neither could have achieved alone (B), and can therefore produce a real connection.

### *Internal Voice / Transpersonal Guidance*

The therapists' own music, clinical decisions, or interactions with co-therapists elicit a myriad of internal responses that can serve to further guide—or hinder—the therapist in the therapeutic process. These internal responses, connected to the personality, can occur as a guiding “voice” that is neutral, critical, or benevolent. One therapist observed that hindering, critical internal voices were elicited by several elements in therapy; for exam-

ple, experiencing countertransference, feeling stuck, and/or relationship dynamics with clients or co-therapists (E). For this therapist, “tuning into more neutral messages” (E) as well as deciphering one’s personal reactions to the music from internal guidance one is receiving can be a helpful and important part of the process:

[I try] to distinguish between my own response to the music I play, my own reactions, and new inspirations that come through . . . so I’m changing the music based on another criteria which is telling me, “Here’s the next thing to do” . . . I’m less likely to respond to [thoughts like] “Oh you’ve got to stop that,” or “You’ve got to change that.” (E)

Guidance can also come through what has been described as “another place,” beyond the self (C). Connection with this source can lead to an inner clarity through which one can hear the significance of the unfolding music to the whole. Sensitivity to this inner guidance therefore holds great potential for the development of clinical-musical perception and action. As one therapist explained:

. . . there is another place, another whole range of responses, feelings, emotions, which is whispering “Yes, yes, this is what we want.” I think there’s something . . . that is listening in the clinical way, and recognizes this. My sense is that there’s . . . the broadest range of sensitivities to all these different internal reactions which then begin to govern how you feel and what you’re going to do next. And this, I think, really develops or not. But in this situation, that’s what you’re sensitive to. And that has an inordinately strong input into how you’re perceiving the situation and how you move through it. (C)

### *Faith in the Music / in Oneself*

Faith is a part of the improvisation experience, particularly when working with clients who are profoundly disabled and who may not directly respond to the music. In moments when a client does not react to the therapist’s musical ideas or when the therapist cannot clearly point to what the client did or accomplished in any given session, having faith in the music—and in oneself—becomes essential:

It’s like you just have to have faith. He’s not always going to react to [my musical ideas] . . . but at least what I’m doing I feel good about . . . I have to take satisfaction in my choices rather than what his responses may be . . . it was just about my choices and maybe how long did I maintain faith in my ideas or the music in general. So maybe there’s something about him that makes me feel I still believe in this [way of working]. (A)

Taking satisfaction in one’s musical choices, enjoying the music as it unfolds, and believ-

ing in one's approach or rationale can help to maintain this faith; but ultimately, believing that the musical experience can be meaningful for the client, and striving to create music that is meaningful, may be the most important elements:

I want to believe that my choices have meaning for him, and I'm trying to learn more about what music can do for him . . . just being with him and creating a possibility that what he's doing has more meaning for him than when he's by himself is worthwhile . . . I mean, the most important thing for me when I'm in there is to play music that matters. (A)

## Perceptions about the Client

The therapists' perceptions about their clients within the clinical-musical experience included: observing the client's emotional, physical, behavioral, and musical responses; being aware of the dynamics in the client-therapist relationship; and, being aware of the client's musical, interpersonal, and personal growth.

### *Observations of Client Responses*

Throughout the session, therapists are continually observing clients' responses in emotional, physical, behavioral, and musical domains. Clinical observations are often guided by areas that the therapists are working directly to address, as well as salient responses from the client. For example, one therapist noted a client's emerging qualities of initiative, playfulness, and interactiveness with the co-therapist through his work on the drum (E). Another therapist linked a client's changing breathing patterns to a shift from agitation to a profound sense of sadness (A). Hearing that a client was starting to make more playful vocal sounds, this same therapist initiated a new musical intervention that would support this change (A).

Therapists also observe how the music may be impacting the client, or the moment-to-moment significance of the music in light of the client's overall treatment. One therapist felt that because the client's inner life seemed turbulent and lacked peace, the quiet moment they were having in the music was significant in that it gave him a place to come back to (E). Observing that his client was "in the music" in spite of disruptive, provocative behavior, another therapist spoke of the hope that emerged, as an important divide was being bridged in a certain way (C).

### *Client-Therapist Relationship*

Therapists attuned to the client-therapist relationship through their awareness of three basic factors. One factor included how the client and therapist were relating to one another both within and outside of the music. For example, one client's attempt to physically reach out to the therapist during a period of distress moved a therapist to try and musical-

ly communicate his empathy, intention, and presence to the client's pain (A). Another therapist spoke of the heightened sense of intimacy he experienced when he and the client were singing together (B).

The second basic factor in attuning to the client-therapist relationship included therapists' awareness of the emerging dynamics between them. One therapist described a client's need to take on the role of teacher, continually trying to "teach" the therapist-student something on the piano, and wanting her to musically do something with it (D). For another therapist, a client's willingness to move closer to him at the piano instead of wander around the room signaled the client's readiness to "center around the issue" of his difficulty in relating to him and others (C).

And finally, attunement to the potential connection between the client-therapist relationship and the outside world was reflected in the words of one therapist, who said:

[The client] knows I'm hearing him, that he's being heard. I wonder how he takes it from the music out into the world . . . I do believe that somehow the experience changes you. At least he knows that it's possible to feel that he can be successful in communicating an experience. (D)

### *Client's Growth*

Moments of growth reflecting therapeutic change were spoken about by the therapists with wonder, excitement, and reverent attention. Even the smallest steps toward a new way of living, relating, or being in music were celebrated. Therapists recognized emerging areas of: 1) musical growth, such as being able to transition from one instrument to the other (E), and listen more deeply to the music (B); 2) interpersonal growth, as in being able to relate, accommodate, and listen to another person (C), abandon one's typical way of relating and try something new (C), and musically reach out to communicate with others (A); and, 3) personal growth, such as one's openness to listen to another part of the self (E) and invest oneself in the music (B).

### **Perceptions about the Music**

Therapists spoke about their awareness of the music in five dimensions: what they were receiving from it; their feelings toward it; how they were experiencing it; how they were clinically using it; and how the music seemed to be affecting his/her client. Although therapists were actively improvising the music—most often co-creatively with their clients—it is notable that the music was rarely given a personal referent. Rather, clinical music was consistently referred to as "the music," a third party in the process which seemed to take on its own force and life within the session.

### *Clinical Use of the Music*

At different times, each therapist spoke about the clinical use of the music, referring to his/her: 1) intentions behind the improvised music; 2) techniques used to evoke clients' musical responses, expressive freedom, and interresponsiveness; and, 3) awareness of reasons for changing the music in response to various clinical situations.

### *Musical Techniques*

Most therapists who spoke about their use of musical techniques described what they were doing musically and the rationale behind their choices. One therapist felt that framing a client's musical experience in a pleasing way allowed his client to be more creative and come up with other musical ideas in turn (B). Another therapist decided to experiment through playing a song the client may know to encourage a musical response (E). For a client who tended to be provocative in sessions, one therapist spoke about finding that he could often elicit the client's musical responses through being totally unpredictable (C). "Teasing" the client musically was also a way one therapist was able to elicit musical responses from her client and encourage interresponsiveness (D). One therapist spoke of his efforts to maintain the musical environment through playing a quiet, consistent rhythm (E), while another played dramatic music to match his client's intensity, support the intense expression, and allow the client freedom to release his feelings (A).

Therapists often spoke of their awareness of needing to change what they were improvising in order to respond fluidly to what was happening in the music and the relationship. One therapist hoped that the introduction of romantic music might capture a client's underlying sadness (E). In response to the perception that the music was becoming too thick and dense, another therapist lifted the pedal to dry up the musical texture so that the client could be heard through the music and reconceptualize what he was doing (D). One therapist spoke about introducing the deliberate use of silence to reflect that the client's responses were moving out of the musical realm (E). Perceiving that her client's music and energy was accelerating, losing control, and sounding painfully loud, one therapist introduced more melodic, calming music to bring the client's energy level down and relax the intensity (D). Later in the same session, the therapist decided to musically hold back an immediate response to a client's struggle to release his own energy, yet accommodate the therapist's different mood. She wanted the client to know she would wait for him (D).

### *Musical Intentions*

Therapists related the musical intentions they recalled being conscious of during the session. For instance, one therapist deliberately chose not to go with a client's drumming, instead trying to offer the client other musical possibilities:

I'm trying to give him a different musical experience . . . I'm saying,

here's a whole different musical experience, a whole different world to live in. Can you come with me? (D)

One therapist intended to engage the client in a musical dialog in order to further encourage the client's initial efforts to communicate with him (A), and also spoke of his intention to reach out to his client through creating spaces in the intervals (A). Use of the voice to communicate a therapist's intentions to console the client (A), respond to a client's warm smile, or convey a therapist's connection to his client's sadness (E) was also mentioned. Lastly, one therapist described his intention to maintain the musical environment through offering something the client could respond to, while relieving him in a certain way of his shadow (E).

### *Receiving the Music*

At times, therapists seemed to talk about the music in sessions as something they were receiving, as they described associations, feelings, or thoughts that the music elicited. For one therapist, repetitive, descending chords elicited an association of a lullaby, which he experienced as very calming (A). Receiving a sense of purpose through the music was especially helpful and consoling to this therapist, as he was working with a distressed, nonverbal child (A). In this case, the music offered a form of expression wherein his reaction to the client could have somewhere to go, even when the immediate clinical direction was unclear.

### *Feelings about the Music*

Clinical improvisation can also bring forth a myriad of feelings within the therapist about both creating and listening to the music that is unfolding. For example, one therapist spoke of the risk she felt in deciding to sing, as she wasn't sure how the client was going to take it in (E). Another therapist related feeling ambivalent about whether creating music was even appropriate given the difficulty a client was having (A). One therapist spoke of feeling touched by hearing a client discover a more delicate side of himself through melody (E). Another felt moved and affirmed by a client's deliberate, beautiful effort to reach toward the piano, even in the midst of his despair (A).

Therapists spoke of their awareness of not only what feelings the music was bringing forth in them, but also how it felt to create the music itself. Being connected to their feelings about the music not only seemed to be a way to more fully engage in the clinical process, but also reflected their sheer pleasure in music making, both independently and with their clients. Therapists related feelings of physical and/or sensual satisfaction experienced when improvising music (B, E). They described feelings of satisfaction when the music felt whole, or was what the therapist intended (E) and when the therapist liked the way the music or sounds made him/her feel (A, E). One therapist described her satisfaction with being able to create music with clients who are particularly musical:

In a way it was a challenge for me to have to learn how to interact with a client who's really a very active musician. I really enjoy just feeling like a fellow musician with him—not so much always his therapist trying clinically to achieve some goal—but here to make music with him. (D)

## SUMMARY AND CONCLUSIONS

### Therapists' Intrapersonal Awareness

Therapists spoke of a variety of experiences while improvising with a client. One was their faith—in themselves to create, in the therapeutic process, and in the potential of music to bring a sense of meaning to a person's life. Connected to this faith was the sense of receiving guidance not only from the self, but from another source, leading both client and therapist forward. This source was referred to as a “third party,” “another place,” something or someone that is listening and perceiving the clinical situation deeply and through which the created music “comes through.” These reflections by these clinicians seem to imply a spiritual orientation to the work that is both personal and shared. This may stem from the spiritual origins of the work by the original founders, Paul Nordoff and Clive Robbins (Hadley, 1998).

Therapists also spoke of sometimes being conscious of internal responses to the music and/or clinical situations—a “voice” that seemed to require self-awareness and trust in musical inspiration to determine its relevance and helpfulness.

Therapists' awareness of their empathy for their clients was also spoken about as a source of guidance when improvising. This empathy seems to offer a means through which they can communicate their presence and understanding of the client's life-world through music. Therapists gave a variety of responses regarding the relationship between the use of self to perceive and respond to what is happening within the client and the shaping of musical interventions. In essence, therapists' empathy and awareness of feelings provided greater clarity regarding their clinical-treatment approach, a more meaningful musical experience for client and therapist, and an important source upon which to base one's choice of tones. However, as one therapist asserted, one's own feelings, musical responses, and perceptions are independent of the client's, and therefore may not be reliable information.

The emotional and physical demands of improvisation create natural stress in the clinical improviser, and each therapist spoke of experiencing it to varying degrees. This stress was manifest through the impact improvising had on one's stamina; the tension experienced in the interpersonal and intermusical relationships; and the continual facing of the unknown—needing courage to search alone and together with the client. Working with a co-therapist—no matter how positive and supportive the relationship—was also spoken about as being stressful at times. The co-therapist is another person for the therapist to attune and attend to, align with and accommodate, and who creates a presence in the room affecting the whole improvisational field in significant ways. Nowhere was the joy,

excitement, and curiosity of the therapists more apparent than when they spoke about experiencing musical inspiration and freedom in the session. While most therapists tended to link musical freedom to specific musical conditions, perhaps it is the therapist's own state of being that facilitates these exquisite moments most of all. Recently, the topic of mindfulness in music therapy clinical improvisation was explored in-depth by Nordoff-Robbins music therapist, Joe Fidelibus (2004). Illuminating the "being" side of clinical improvisation through such studies offers needed perspectives on therapists' attempt to balance doing and being in their work, and is an integral part of our learning more about the craft of clinical improvisation. Moreover, therapists' attempt to describe how musical inspiration comes to them moment by moment—and the immediate clinical action that follows—provides a glimpse into the heart of the challenge and healing potentialities of this method. The art of transforming musical inspiration to clinical improvisation seems unique to each therapist, and is, perhaps, ultimately unreplicable. However, listening to experienced therapists' musical processes may help us learn more about: 1) how inspiration can be experienced directly through inherent tendencies in the music; and 2) how attunement to the music may actually help us become more conscious of thoughts, feelings, and clinical intent as we are improvising.

Lastly, the focus, openness, and full presence that are needed to truly listen to the client, to the unfolding music, to emerging musical ideas, and to one's own inner guidance, seemed to be an essential aspect of the experience. Perhaps this was not emphasized more fully because it was, for the therapists, as necessary and central as breathing. However, cultivation of this ability—wherein listening provides the ground under which all else in consciousness can emerge—would seem to require an inner discipline worthy of attention and further exploration. One therapist spoke of the distinction between listening "to" qualities in the client's music and being, and listening "through" the music to get to the essence of the experience. Beyond even these distinctions, as one therapist suggests, a client's "being heard" by the therapist in this way creates deeper possibilities for connection in the relationship and is perhaps one of the transformative elements in NRMT.

## Perceptions about the Client

Four main themes emerged as therapists' related moment-to-moment perceptions and apprehensions about their clients while improvising. The first theme included observation of the client. The need to observe clients in therapy is a given; however, the complex data that emerges as a client improvises, and how therapists discern what is important to observe from one moment to the next, requires focus and fluidity. More specifically, therapists spoke of observing clients in the emotional, physical, behavioral, and musical realms, particularly focusing on salient responses in areas they were working directly to address. Therapists also highlighted the importance of observing how the music was impacting the client, and its significance in relation to the client's overall treatment.

The second theme included therapists' attunement to the client-therapist relationship. Consistent with the Nordoff-Robbins belief that the client-therapist relationship oc-



curs in and through the music, therapists tended to focus their awareness on the relationship between: the client's music; the therapeutic relationship; and the client's outside relationships. Based on these factors, three general questions based on therapists' observations emerged: 1) How is the client relating to me in the music? 2) What are the emerging dynamics between us? 3) What is the significance of our clinical relationship in light of the client's outside relationships or life circumstance?

Recognition of the client's growth was another theme that emerged as therapists related their experiences. Therapists celebrated and encouraged clients' musical, interpersonal, and personal growth within sessions, especially moments of change that occurred directly in the music experience itself. During interviews, therapists expressed wonder at having been a part of such moments that were not willed into being by either client or therapist, but rather happened by their own accord, and grace.

The therapist's use of intuition emerged as a final theme, and was noted as being especially important and even necessary when working with clients who have communicative disabilities. While NRMT offers possibilities for clients to communicate in immediate, creative and essential ways, therapists still must often rely on their own intuition to guide them toward what the client may be experiencing intrapersonally, interpersonally, and/or through the music. Kenneth Aigen's concept of the "Psychological Moment" (1998) once again bears mentioning here. Aigen described the Psychological Moment as the psychological intuition on the part of the therapist which allows for the clinically potent timing of various interventions. He goes on to say that the Psychological Moment is a type of "empathic awareness" from which the therapist shapes an appropriate session structure, and is a product of a therapist's intuitive awareness and skillful clinical intent.

## Perceptions about the Music

Therapists related their awareness of the music in five dimensions: what they were receiving from it; their feelings toward it; how they were experiencing it; how they were clinically using it; and, how the music seemed to be affecting their client. Therapists spoke not only about their clinical-musical "action"—including musical intentions, techniques, clinical use of the music, or decisions to change the music—but also being conscious of "receiving" the music as listeners and creators. This research seems to reflect Nordoff-Robbins' idea of how a "living music" (Robbins & Robbins, p.79) becomes a clinical reality: through the active, creative music experience, the client and therapist express life and experience what it is like to be in that life, together.

Lastly, the underlying transpersonal nature of this work, although not directly referred to as such, is perhaps best reflected through the fact that the therapists in this study consistently referred to clinical music as "the music," a third party in the process which seemed to take on its own force and life within the session. This dissolution of the self "in and out of moments" within the music experience may perhaps be akin to the words of poet T.S. Eliot, as he refers to "music heard so deeply that that it is not heard at all, but you are the music while the music lasts" (Eliot, 1963).

## IMPLICATIONS

### Clinical Practice

When considering implications of this research for clinical practice in NRMT, two areas emerged for consideration. First, based on data which emerged from this research, the therapist's state of being is one of the central areas of focus as a clinical improviser. For these therapists, the importance of being fully present in the moment required: faith; the release of expectations; a receptive capacity for inner guidance and/or musical intuition to emerge; an empathic stance toward the client and an attunement to the relationship; an ability to withstand tension and uncertainty; an openness to feelings that the music experience is bringing forth; courage, flexibility, and a willingness to experiment and play; and, an ability to listen with one's whole self. Many of these qualities are similarly included in a model developed by Clive Robbins delineating qualities within the therapist that are essential in building the clinical relationship (Turry, 1998). Thus, while therapists' musicianship in creating the highest quality experience for therapy is extremely important, the therapists' state of being while improvising cannot be underestimated.

Second, the therapist's use of self and the role of countertransference in Nordoff-Robbins practice emerged as an area which would seem to benefit from continued open discussion in the Nordoff-Robbins community. Alan Turry's (1998) article describing transference and countertransference in NRMT is an excellent resource reflecting contemporary thought and practice on this subject. Turry acknowledges that Nordoff-Robbins practitioners do not necessarily share the same position on the value of these concepts for neither the method, nor their integration in clinical practice. Still, he asserts that there "may be more differences in how Nordoff-Robbins therapists describe their work than in how they practice it" (p.166). This diversity was also reflected in the present study, as some therapists referred alternately to their countertransference, experience of empathy, and awareness of feelings while improvising to inform—or not to inform—the work.

When considering these differences, it seems possible that Nordoff-Robbins therapists may not only describe their work differently, but think about it differently, as well. Even though clinical practice may not overtly reflect this, continued professional communication about ways these concepts are currently being conceptualized and integrated may offer a clearer sense of how Nordoff-Robbins practice and supervision may be growing.

### Theory

Therapists' reflections on the importance of having faith, receiving or being a conduit for the music, and having a sense of being guided within the clinical-musical experience by "another force," or "third party," elicit three general questions regarding further implications for Nordoff-Robbins theory: 1) Do contemporary Nordoff-Robbins therapists

share—implicitly or explicitly—a certain set of core set of beliefs about the transpersonal or spiritual nature of the work? 2) How do such beliefs currently inform and shape clinical practice, supervision, and research? 3) Has the transpersonal nature of the approach changed since its inception? If so, how and in what ways has it changed? 4) Does practicing NRMT impact the development of one's own spirituality? If so, how has this manifest in the therapists' work over time? Future research focusing on an exploration of these questions may be of interest not only to NR clinicians but also music therapists seeking a more in-depth understanding of NRMT.

## Research

When one considers the extremely facilitative musical role the Nordoff-Robbins therapist has over the course of a client's therapy, further research into Nordoff-Robbins therapists' consciousness seems important for several reasons. Explorations of therapists' experiences both within and apart from the music acknowledge the fact that the therapist—whose perceptions, intuitions, searchings, and emotions all impact the music and the client—is a dynamic force in the therapy. Perhaps, using Nordoff-Robbins therapist Gary Ansdell's (1995) concept, we can more fully grasp the *music between* client and therapist as we develop a clearer understanding of the human being from which the music flows. Research and clinical writings from clinicians such as Turry (2005), Fidelibus (2004), and Lee (1996) reflect a growing sensitivity to the need for Nordoff-Robbins clinicians to more closely examine their own experiences and process, particularly in light of the complex dimensions involved when working with verbal, adult clients.

In short, as clinical populations and settings served by Nordoff-Robbins clinicians expand, research focusing on therapists' moment-to-moment consciousness while improvising may serve to heighten therapists' self-awareness, highlight ways in which therapists are creating and responding to new clinical directions and challenges, and illuminate the relationship between therapists' consciousness and clinical-musical action. The unique and common elements that may evolve from such studies could provide a preliminary model for self-inquiry in Nordoff-Robbins music therapy that would be directly grounded in—and informed by—therapists' own clinical work.

In addition, although Nordoff-Robbins therapists' experience of working in a therapeutic team has been previously examined by Nowikas (1993), given that the co-therapist is another person for the therapist to attune and attend to, align with and accommodate, and who creates a presence in the room affecting the whole improvisational field in significant ways, qualitative studies investigating the therapist/co-therapist's experience during sessions may offer further insight into the nature and dynamics of this unique relationship and enhance our understanding of how the Nordoff-Robbins team approach benefits the client and therapy.

Furthermore, in terms of the therapists' use of intuition, perhaps Aigen's concept of the Psychological Moment mentioned earlier can be further refined in future research to include not only the result of therapists' use of such empathic awareness or intuition—

such as clinically potent interventions or appropriate session structures—but also when and how such intuition is drawn upon during clinical improvisation.

## Training

Although many aspects of therapists' conscious experience reported in this study are already addressed in Nordoff-Robbins training and supervision, the challenges therapists described when improvising moment-to-moment—and the clinical skills and personal qualities needed to meet them—offer points of reference for training that have relevance and meaning for clinical practice.

On a physical level, therapists spoke about the stamina needed to sustain the often high levels of musical tension and intensity in sessions. Perhaps issues of self-care in terms of physical training should be incorporated into Nordoff-Robbins training programs.

Similarly, the ability to withstand and cope with stresses related to both intrapsychic factors, such as one's own internal responses to the music, and interpersonal factors, such as the dynamics of the relationship with one's own client and co-therapist were noted as ongoing aspects of their experience during sessions. Directly working with these aspects as they emerge, and sharing creative ways trainees can recognize and work with them, can prepare trainees for the practical reality of the work.

Many of the clinicians also spoke about being aware of an internal "voice" or inner guidance from "another place" that helped them. Although Nordoff-Robbins supervision would provide an opportunity to explore and work with these responses, perhaps a more formal integration in Nordoff-Robbins clinical training of the spiritual dimensions of the work and the many ways these may be elicited and fostered during clinical improvisation—and creative ways to handle them—would be helpful for trainees.

Moreover, despite the diversity of thought among contemporary Nordoff-Robbins practitioners regarding dynamics such as countertransference and transference in therapy, data from this research suggests that therapists' emotions and experience of their clients often impacted their perceptions and musical decisions. When considering the implication of this for clinical training, the following questions may be asked: How can we raise consciousness in Nordoff-Robbins trainees about the use of the self in therapy? What would be the most important and relevant elements of such awareness, regardless of one's own personal orientation?

Because Nordoff-Robbins is an approach whose emphasis is on active, creative music-making, it seems significant that most of the therapists shared more apprehensions and perceptions about their receptive, rather than active, capacities when speaking about their experiences. Given the importance of being able to draw upon one's receptive capacity to receive musical inspiration, inner guidance, attune to the client-therapist relationship, and listen with one's whole being, clinical training that supports the ongoing development of this capacity would reflect the values of the approach and offer a rich resource for clinicians to draw upon.

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