

Between Pre-Objectivity and Objectivity: A Phenomenological Study of Nordoff-Robbins Music
Therapists' Experiences of Healing in Music

By

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Abstract

Following four months of fieldwork at the Nordoff-Robbins Center for Music Therapy in New York City, this thesis investigates the experiences of Nordoff-Robbins music therapists who work with “hard to reach” clients from a phenomenological perspective. The “hard to reach” client is conceptualized as having a disorder of communication which therapy restores. Based on therapists’ experiences, three phenomenological problems are addressed: the problem of training therapeutic habits of perception, the problem of creativity, and the problem of language to describe lived experience in music. It was found that creative music therapists learn to listen and respond with clinical intention, guiding the pre-objective, synaesthetic perception of the client. In improvisation, determinacy and indeterminacy are negotiated with each musical expression, moving between pre-objective and objective experiential realms. Finally, therapists’ lived experience is partial and indeterminate and is expressed through metaphor and poetics to best capture the pre-objective experience of the world.

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Introduction

This thesis is an ethnographic study of the phenomenological structures of human experience that are intrinsic to music therapists' experiences of working with "hard to reach" clients. The music therapy practice that has been chosen for this study is called the Nordoff-Robbins approach. Humanistic in its orientation, the approach focuses on creative clinical improvisation to create a musical relationship between the therapist and the client. The "hard to reach" client is one who has difficulty forming meaningful social relationships and experiences disorders of communication. The goal of the therapy is to restore social communication and bring the client back into relationship with other people in the world, constituting a major existential shift. I will argue that improvised music effects therapeutic change because sound has both form and flexibility, expressing what otherwise cannot be expressed. Through the indeterminacy and pre-objectivity of experience, the music therapist can create a milieu in which they can meet the client and understand one another without objectifying experience in words.

Music therapy is a sought after option for many people with communicative and physical disabilities. Empirical studies have shown that music can significantly improve functioning in all levels of human experience, particularly the application of various forms of music therapy. There are many approaches to music therapy, some which focus on the neurological processes of the brain in response to music, while others are more humanistic and experientially-oriented. While music therapists at the Nordoff-Robbins Center are collaborating increasingly with psychologists and neuroscientists, the approach as it is taught is fundamentally humanistic and creative.

The Nordoff-Robbins approach is classified as a model of improvisational music therapy, using creative musical improvisation as its primary therapeutic tool. According to Bruscia (1987), Nordoff-Robbins is called "creative" for three reasons: the therapist creates and

improvises the musical material, the music therapist creates the therapeutic experience by improvising music that seeks out and establishes contact with the client, and the music therapist creates a progression of experience that guides and supports the client's development (Bruscia 1987:24). In addition to the creative application of music to achieve therapeutic goals, the therapists create the musical resources that they use in therapy with their own bodily performance. Recordings of music are not used in therapy; rather, each music therapist performs in session with the client in a live music-making experience.

The research for this project took place at the Nordoff-Robbins Music Therapy Center at New York University (NYU) in New York City. Not only does the Center have a clinical practice that draws from local school board programs and private clientele, but they are also one of the few Nordoff-Robbins training facilities in the world. Each year, about ten music therapists are accepted into a one-year professional certification course for one of three graduated levels of training. The music therapists with whom I worked had completed either the second or the third level of certification, and trainees were typically taking the first level of certification. Training consists of classroom-based courses and clinical practice under the supervision of a senior music therapist. The Center also runs shorter programs during the summer for those interested in the approach to music therapy but who cannot take the year-long training.

Though small in scale, the Center was always buzzing with activity. Often described by interns as a "bee hive," there was hardly a quiet moment and I would often arrive to find a full waiting room and music emanating from different ongoing sessions. Clients ranged from pre-school children up to middle-aged adults, some of whom were new to the Center that year, while others had been coming for over a decade. They seek help for one or more issues related to physical challenges, neurological conditions, and cognitive, psychological, and emotional

disorders. I witnessed many clients making marked improvement during my time there, while other clients' progress was less apparent to me as a newcomer to the Center. The therapists evaluated improvement in many ways depending on the therapeutic goals: increased interpersonal communication, expanded emotional expression, improved self-awareness and awareness of other people (often described as "waking up"), as well as improved physical and motor capabilities. There was a constant positive atmosphere and belief among the staff that improvement was attainable for any client.

Science has not yet explained entirely why music therapy has the profound healing effects that it does. Moreover, science explores the objective, the examinable, and the visible, but the change that takes place in music therapy does so prior to these categories of measurement. Phenomenology, the study and description of lived experiences, has a language and an approach that is able to grasp and make sense of experience that takes place prior to what is "known" or "thought." Transpersonal work happens at an existential level that can best be described through metaphor.

This study will answer the research question: what are the fundamental phenomenological structures of experience essential to music therapists who work with "hard to reach" clients? As human beings, music therapists begin their work with a set of natural abilities for musical sensitivity and perhaps even for playing music, but through Nordoff-Robbins training they acquire another set of resources that shape their perception and experiences of working clinically with another person. Over the course of the historical and ethnographic chapters that follow, the structures of indeterminacy, pre-objectivity and pre-reflectivity, and synaesthetic perception of the world will be articulated in terms of music therapists' narratives and my own experience as a co-therapist in the field.

Approach to Fieldwork

The fieldwork for this project began with a week-long visit in June, 2012, to the Nordoff-Robbins Music Therapy Center (the Center). During that week, I adopted the position of a participant observer in order to get a sense for whether the field would be a good fit for my project and to see if I would be a good fit for this field. I attended the one-year memorial lecture for Clive Robbins, the co-founder of the Nordoff-Robbins approach and founder of the Music Therapy Center at NYU. Later, I realized that when I approached music therapists at the NYU Center and elsewhere, mentioning that I had flown down from Canada to attend Clive's memorial helped to establish rapport between us which in turn facilitated open communication. During the visit to New York City in June, I attended the senior Nordoff-Robbins students' case presentations. This experience gave me a good idea of what to expect during my longer fieldwork at the Center and once again demonstrated to the music therapists my commitment to doing meaningful research with them.

The formal fieldwork for this research required a combination of participant observation, semi-structured interviews, and archival research to collect data. In September, 2012, I moved to New York City. Finding an apartment in New York for four months was a challenge. In the end, I rented a room at the Jewish Cultural Center's student residence on the Upper East Side of the city. Initiating participant observation at Nordoff-Robbins was difficult because the Center was small, with limited amounts of extra space. Additionally, without a NYU student card, access to buildings was incredibly restricted and every visit to the Center required persuading the door security guard that I was expected upstairs at the Center. For the first few weeks, I went to the Center when I had someone to meet with, but did not spend great amounts of time there.

By fortunate chance, I had the opportunity to volunteer to transcribe a series of Clive Robbins' lecture videos; since the recordings had to stay at the Center, so did I. Ultimately, I was recruited as a music therapy session filer, which allowed me to watch more sessions live, but in a small filming room adjacent to the therapy room. While this was closer to the real feeling of being in the session, it was still outside the active therapy performance. In early October, I had learned that the Center was closing for a week so that the staff could attend the American Music Therapy Association's annual conference in Saint Charles, Illinois. After checking that it was alright for me to join the group, I travelled to Saint Charles and attended the conference. This conference program was significant for Nordoff-Robbins music therapists because, in honour of Clive's passing, they were given full panel schedules of presentations each day of the conference, more than ever before. Special Nordoff-Robbins training sessions and memorial celebrations were also held to honor Clive, along with speakers remembering his life and work. Once again, my attendance demonstrated my commitment to learning as much as possible about the Nordoff-Robbins approach and the people who practice it. A few weeks later, in late October, I was offered to take over from a music therapy student as co-therapist with one of the senior primary music therapists at the Center, giving me access to the experience of helping conduct a music therapy session.

By this time in October, I was spending most of the weekdays at the Center, doing archival research, filming sessions, and now participating in a weekly session as co-therapist. As a co-therapist, I was required to participate in the indexing of sessions. Indexing is a core component of this therapeutic approach and requires that both primary and co-therapist watch the video and document what transpired each minute of the session. On Saturdays, I also went to the Center, usually to do archival research, and attended the noon-hour staff meetings among

primarily interns and a few senior music therapists. These experiences were significant for my research.

As I became a known presence at the Center, I began conducting semi-structured interviews with the senior music therapists. In total, eight senior music therapists were formally interviewed; seven are known in this thesis by the pseudonyms: Albert, Beth, Joan, Leon, Lynn, Nancy, Shelley (one interview fell outside the scope of this thesis). Seven of the interviews took place at the Center and one in Boston, Massachusetts. All interviews lasted from one to two hours. Participants signed informed consents for both participating in the research project and for being audiotaped during the interview. I used the same broad interview schedule with each participant, and because I had in most cases seen a month or so of their work already, during the interview I was able to draw on clients we had both seen. The certification students were not formally interviewed for my research at the behest of the director, because they were deemed too new to the process and still perhaps too uncertain about their own approach to respond in a meaningful way. During my participant observation, I still interacted and spoke with all of the trainees and student interns at the Center. These discussions shaped my experience and were contributory factors in the fieldwork.

Outline of Chapters

Chapter One offers a brief overview of important literature about healers and performances of healing from anthropology as a foundational prelude to the details of the experiences of music therapists. Research from the field of music therapy is presented to contextualize the study of first-hand experiences of professional music therapists, specifically those who practice Nordoff-Robbins music therapy. There are many research methods that

scholars have used to explore the topic of lived experience, yet only a handful have employed phenomenology as their primary research tool; the few who have done so approach the subject from a psychological, individualist orientation, as opposed to the socially-oriented phenomenological analysis that this thesis takes up.

Chapter Two documents the development of the Nordoff-Robbins approach from its beginning to contemporary practice today. The story of Clive Robbins and Paul Nordoff begins with the Curative Education Movement, guided by Rudolf Steiner's philosophy of Anthroposophy. Continuing the timeline of their international teaching engagements and clinical demonstrations, the history's focus is shifted toward their teaching the approach to other music therapists. Nordoff's lectures about the power of music as therapy and the practice of clinical improvisation are outlined with reference to Steiner's theory of intervals from Eurhythmy, and Zuckerkandl's theory of the tone as an event. The Nordoff-Robbins approach was also influenced by American humanistic psychology in that the therapeutic interaction between the therapist and the client in a transpersonal relationship in music was regarded as paramount for healing to take place. Through music, they sought to expand the client's life, help the client realize his or her potential, and guide the client toward greater engagement with the social world. The chapter brings the reader through the core principles of the Nordoff-Robbins approach to the contemporary practice of the music therapists I worked with at New York University and their perspective about the sociality and universality of music as a social relation.

Chapter Three is a theoretical chapter that details the phenomenological perspective that will be used throughout the thesis to analyze the ethnographic material. The chapter begins with a vignette of a music therapy session in which I participated as co-therapist, in order to illustrate both the principles described in Chapter Two as they are practiced and to provide a scenario to

which the reader can refer as they encounter the phenomenological concepts. The key ideas from phenomenology that will be used throughout the thesis are the indeterminacy of the world and the body, the pre-objectivity and pre-reflectivity of experience, and the synaesthetic nature of perception. In association with these, the concept of the “hard to reach” client and the qualities of music that make it a powerful therapeutic medium are explained. Moreover, the role of music as play and its ability to frame the therapy session and fix the client’s disorder of communication and social relationship will be detailed. These comprise the background from which the experiences of music therapists will be explored, from training to the performance of healing.

The next three chapters analyze the ethnographic material gathered from interviews, participant observation, and archival lecture material from Clive Robbins that I transcribed during my fieldwork. These chapters are ordered to reflect the lived process of learning to be a music therapist in a broad sense, as well as to provide a sense of the smaller moments of interaction between the therapist and client in the therapy session. The music therapist first listens to the client before responding to them with music, and over the course of this cooperative repartee they eventually transition into playing music together. Learning to listen deeply and learning to respond creatively are important embodied skills that therapists need to have available to them in the spontaneous moments of the session performance. The chapters continuously draw upon the concepts of indeterminacy, pre-objectivity, and synesthesia as basic phenomenological structures to analyze the music therapists’ experiences.

Chapter Four explores the problem of learning to listen in music therapy. How does the music therapist hear the totality of the client when perception is always partial and incomplete? From my own experience in the field, narratives of music therapists, and archival lectures, learning to listen to the Other is argued to be a fundamentally synaesthetic experience that is

always open and indeterminate. The therapist learns to be poised in the “Creative Now,” a term designating the notion of a space of receptivity and intuition, taken up habitually as a perspective and perception of their work. In this state of hyperawareness they are ready to make sense of whatever utterance or gesture the client has to offer. Guided by the clinical intention to help the client and bring them closer to social relationship, the therapist listens to the client’s style that they can capture and reflect in musical expression. In music they can have an experience of the client and express their empathy and intention to understand them.

Chapter Five takes up the problem of creativity in music therapy. How do therapists learn to be creative? How do they know what to play when and to what effect? What is the balance of free improvisation and structured compositions, and how is music a universal medium that speaks to everyone? These questions and others like them are addressed in relation to phenomenological structures of experience throughout this chapter. Within the Creative Now, the creative act happens as a single unified expression of thought and movement, flowing between the realms of pre-objective and objective experience. The therapists’ use of improvisation, pre-composed songs, and clinical themes is discussed in relation to the intersubjective relationship between therapist and client. Finally, the debate about the subjectivity versus the universality of music is addressed.

Chapter Six looks at the performance of music therapy and the way the training of listening and creativity discussed in the previous two chapters are mobilized in the moments of the session. Perhaps more than the earlier chapters, the ethnographic material presented here highlights the importance of the interpersonal relationship and music’s role in creating and supporting the connection among participants. The therapeutic milieu and the inclusive nature of music are introduced, as well as the function of co-therapists in engaging the “hard to reach”

client in music-making. Forging a relationship with the client begins with extending an invitation to join in making music. Then, before actually playing together meaningfully in music, the client and therapist go through a dance of approach towards and withdrawal from one another. The issue of rejection and its role as a form of communication is also discussed in this chapter. Finally, the experience of what therapists call “the real thing,” or the social communication with the client, is described with a session vignette from my experience as a co-therapist.

Chapter Seven takes up the problem of finding a language to describe and explain what happens in music therapy at the pre-objective transpersonal level of existential, or therapeutic, change. Gathering the remarks and references to this language problem, also referred to as the music therapist’s dilemma, throughout the earlier chapters, the role of metaphor is addressed in terms of its impact on practice and teaching music therapy. As discussed in Chapter Two, documenting sessions and reviewing them through the practice of indexing is a core principle of the Nordoff-Robbins approach, as a way for the therapist to catch something about the session they felt they missed while they were performing. The paradox of being a body and having a body is discussed in terms of indexing and the objectification of the session as a different experience from participating in the session itself. This chapter concludes by challenging the idea that music therapists have failed to perceive something during the session, insisting instead that such “failures” are an inherent part of perceptual experience. The thesis will suggest that the field of healing arts, of which music therapy is a member, adopt the language of phenomenology presented in this thesis as a way to acknowledge the structures of indeterminacy, pre-objectivity, and synesthesia that govern perception and experience.

Chapter One

Literature Review

This thesis draws upon literature from anthropology, psychology, and music therapy.

Upon review of the literature, there are very few studies that have investigated the experiences of music therapists in the first place, let alone those of Nordoff-Robbins music therapists. Typically, therapy research focuses on the outcome, not the process, where the agenda is to assess treatment efficacy for the client in terms of quantitative measures or experiential narrative. The therapist's experience is rarely taken seriously as a component part of the process, let alone the outcome. In a therapeutic approach like Nordoff-Robbins that relies on the client-therapist relationship, it is necessary to consider the experience of both participants in order to grasp the nature of the work.

Further, there are a limited number of studies that have considered music therapy from a phenomenological perspective, particularly a phenomenology that diverges from the typical psychological towards the more anthropological by focusing on the communicative aspects of music and restoration of social relationships through therapy. Many research studies about lived experience of music therapists do not use participant observation as a main method for gathering data. As an anthropologist I was an outsider entering the music therapists' culture; however, as a classically trained violinist and violist of 20 and 12 years, respectively, a violin teacher, and an active orchestral and chamber musician, I had elements of musical practice in common with music therapists, but I was still not an insider to their culture. While I possessed a good knowledge of music, both theoretically and practically, I only had academic knowledge about how music was used as therapy, which kept me from making assumptions about what music therapists would say about their experience of doing music therapy.

This thesis fills the mentioned lacunae by providing an apprentice-based account of music therapists' experience of working with "hard to reach" clients analyzed with an anthropologically-informed phenomenological lens.

Anthropology and the Study of the Healer and the Performance of Healing

Anthropological research has traditionally looked at indigenous healing rituals, practices of magic and sorcery, and shamanism. There is a wealth of literature in anthropology about healing rituals that focuses on the practice and personal experience of the healer or shaman. This section will focus on a selection of work that exemplifies the structural analysis of therapy cross-culturally, as well as a selection of relevant ethnographies that approach the phenomenological perspective used in this thesis.

From the perspective of symbolic anthropology, Lévi-Strauss explored the healing ritual of the shaman, Quesalid, in "The Sorcerer and His Magic" (1963). Quesalid effected healing transformation by manipulation of symbols with his clients, and despite his own skepticism about the process became a renowned shaman: "Quesalid did not become a great shaman because he cured his patients; he cured his patients because he had become a great shaman" (1963:180). This essay highlights the structures of the therapeutic relationship and the central role of intersubjective communication and the therapeutic milieu, with all of its symbols and trappings that activate the potential for personal transformation in the patient. Lévi-Strauss details the way cure is brought about by giving objective expression to the felt and un-thought experience of suffering through an interpretation that the patient can accept. Therapeutic efficacy, he argued, relies on the shaman's training, their ability to perform the songs and recite myths convincingly, and finally, the shaman's and patient's own faith in magic.

The common symbolic structures of healing psychotherapeutic practices have been detailed by Frank and Frank in *Persuasion and Healing* (1993). They offer a comprehensive account of healing rituals and practitioners in both industrialized and non-industrialized societies and draw out common theoretical threads that are found across the groups. The authors categorized the nature of the therapies, be they psychoanalytic, directive, or evocative, as well as the universal characteristics of patients who seek healing and the people who become their healers. Of particular relevance for this thesis is the description of evocative therapy models, with which the Nordoff-Robbins approach shares many therapeutic components. Developed from the work of American psychologists like Abraham Maslow and Carl Rogers, Frank and Frank (1993) argue that the school of evocative therapy seeks to create a relationship and setting that encourage and promote a client's total positive development towards the realization of their full potential as human beings (188, 190). The onus is on the client to make changes for themselves, overcoming internal conflicts or emotional barriers with the assistance of the therapist who deploys facilitative therapeutic techniques, such as creative clinical improvisation in the case of music therapists.

A central feature of evocative therapy is that it is client-centered: the therapist maintains a constant attitude of serious, respectful, positive regard that makes the client feel accepted. The relationship between therapist and client is important for calling forth strong emotional reactions which can then be worked through constructively in the therapeutic milieu (Frank and Frank 1993:191). In Nordoff-Robbins music therapy, therapeutic change takes place when therapist and client attune to each other whilst making music together. The process is improvisational and does not follow strictly timed activities. Music creates its own symbolic world in which playing different music is akin to manipulating symbols for healing transformation.

Following the work of Frank (and later Frank and Frank), Dow (1986) proposed a universal structure which he believed all symbolic healing practices shared. He argued that the experience of the healer and those they heal is generalized by both a common cultural myth with which the patient must agree, and acceptance of the therapist's power to define for them their relationship to the mythic world. The therapist associates general symbols with the emotions of the patient, particularizing the general world to the patient's personal life. In so doing, emotions can be evoked and the patient's response to their suffering can be guided by the therapist's manipulation and re-organization of these symbols. Dow believed that shamanism and Western psychotherapy, particularly psychoanalysis, work according to the same structure, where healing transformation comes from modulating a client's emotional response to everyday situations. The best healers, Dow asserted, were those who could most effectively project the magical world for the patients and persuade them to experience their world differently, as was seen above for Lévi-Strauss' Quesalid and as will be seen in this thesis for Nordoff-Robbins music therapists.

The importance of the intersubjective experience for therapeutic transformation has been studied ethnographically by anthropologists who were interested in ritual healing from the phenomenological perspective. Central to this scholarship is the work by Bruce Kapferer and Thomas Csordas, who have studied the performative aspects of shamanic healing rituals in traditional cultures. Kapferer (1979) used a phenomenological approach to investigate the intersubjective relationship between patient and healer in a case of demonic possession in Sri Lanka. He paid special attention to the cultural typifications, or objectifications, of the patient as the victim of a demonic attack, explaining how this operates as a social form of Othering in both the contexts of illness ("abnormality") and of being made healthy ("normality"). The social construction of the self in the context of demonic illness transforms the social relationships

between the patient and their community, as the members try to assume the subjective perspective of the patient, and as, ultimately, the patient must assume the shared perspective of the larger social group in order to be healed (Kapferer 1979:118).

In “Words from the Holy People” (2002), Csordas took up a phenomenological approach to his study of the experience of illness in terms of embodiment and culture. Csordas observed that a person’s experience of being-in-the-world includes all domains of their social life. In his ethnographic case, the marked absence of a given social domain, or communicative medium, was also found to be integral to his informant’s experience of being-in-the-world in general, and his illness experience in particular.

Anthropologists have also considered the aesthetic component of healing rituals, particularly healing that is effected through music. Stephen Feld, an anthropologist and musicologist, conducted a study on the use of song and emotional expression among the Papua New Guinean Kaluli (1990). Although Feld did not focus explicitly on therapeutic relationships between members of the society and the use of song and sound as therapeutic tools, his investigation uncovers and explores important phenomenological questions about the relationship between healing and music. Feld analyzed the use of poetry, metaphor, and tonalities of the Kaluli’s weeping and singing to understand how song works socially as a mode of expression which communicates individual subjective reality. Moreover, he argues that the songs were adapted by the Kaluli to meet their own socio-historical needs, and that the sounds of weeping and the composed songs are important expressive forms for men’s and women’s grieving.

Friedson (1996) conducted an ethnographic study of the musical experience of possession and healing among the Tumbuka in Malawi. He argues that musical experience in *vimbuzza* spirit

possession, like Kapferer's exorcism and Feld's weeping, is an anchor of intersubjective communion. He found that everyone becomes a participant in music-making, intensifying the experience such that the spirit and the Tumbuka meet and are transformed. While Friedson focuses on the powerful social effect and transformative power of music in a possession ritual, he does not attend in depth to the experience of the healers themselves as this thesis will do. In anthropology, therapy has been framed as a performance ritual in which the healer creates an environment in which the client will feel safe and supported in their exploration of new experiences of the world, be they symbolized as myth, or expressed in music. The concept of therapy as a performance is important for framing and contextualizing the Nordoff-Robbins approach to music therapy and the experience of music therapists.

Lived Experience of Music Therapists

Research in music therapy has described the influence of music on the intersubjective relationship in the context of healing. Alan Turry (2010:128) argues that the music therapist's life-world gives significance to particular tones and that the therapists must respond musically to a client's sound in order to evoke a different emotional experience and confirm the client's own life-world. Case studies of particular clients have been published by music therapists, detailing the client's developmental progress through music and his or her relationship to the music therapist(s) across a series of music therapy sessions (Nordoff and Robbins 1977; Robbins 1998; Nordoff and Robbins 2004). A seminal case which will be referred to in this thesis is the therapeutic work that Paul Nordoff and Clive Robbins did with a young psychotic-autistic boy named Edward (Nordoff and Robbins 1998; Rolvsjord 1998; Aigen and Bergstrøm-Nielsen 1999; Robarts and Neugebauer 1999). "Singing-Crying" or "Crying-Singing" was a particular

concept coined by Nordoff and Robbins during their early work with this client to describe the phenomenon where Edward would cry melodically in the key of the music in which Nordoff was playing. Nordoff and Robbins remarked that such crying in tune with music is a universal feature of children.

Aigen's *Being in Music* (2005) offers an overview and analysis of the essence of the Nordoff-Robbins approach to music therapy. In this qualitative research study, Aigen analyzed transcriptions from a training course given in 1974 by Paul Nordoff and Clive Robbins at the Goldie Leigh Hospital, in London, England. Aigen outlines the historical development of the Nordoff-Robbins approach, as well as its conceptual framework and matters of clinical practice. Categorized in themes, he considers, in turn, issues such as clinical strategies, the therapeutic relationship, the therapeutic process, and the demands and implications of clinical work for the client and music therapist alike. While Aigen is not a Nordoff-Robbins music therapist, he is a trained music therapist with considerable knowledge of the Nordoff-Robbins literature. The personal themes Aigen drew from the literature, thus, reflect a first-hand interpretation of the essence of this approach to music therapy, particularly the potential for social relationship in music. This thesis follows Aigen's work by integrating material from lectures given by Clive Robbins which I transcribed during my fieldwork, as well as interviews with current Nordoff-Robbins music therapists, and participant observation. The current analysis goes beyond previous work, offering a phenomenological analysis of music therapists' experience.

There is a limited amount of qualitative research about music therapists' experience of practicing music therapy with a variety of populations, and a general absence of well-developed research from a phenomenological perspective. Some of the literature has investigated music therapists' experience of working clinically and conducting research with particular client

populations, such as clients with autism (Kim, Wigram, and Gold 2008; Raglio, Traficante, and Oasi 2011; Wigram and Gold 2006), children in coma (Dun 1989), and people living with HIV/AIDS (Hartley 1998). Previous research has tended to focus more on the experience of music therapy for clients, than the experiences of the music therapists.

Qualitative studies have explored professional issues for music therapists. These include questions of identity, such as experiences of identity transformation from being a musician to a music therapist (McGuire 1984), and the experiences of music therapists from particular cultural backgrounds (Kim 2010; Petersson and Nystrom 2011). Studies also consider music therapists' experiences of effectiveness in their work (Comeau 2004), as well as their experiences of motivation and burnout (Decuir and Vega 2010). Hesser (2001) considered the personal and professional development of the music therapist from an autobiographical perspective, arguing that music therapists must experience the healing power of music for themselves before they can bring such healing to their clients.

Turry (1998) investigated the dynamics between the music therapist and client in Nordoff-Robbins music therapy sessions. From his own perspective as a music therapist, he considered the role transference and countertransference play in the therapeutic process, both musically and personally, and offered insight into the music therapist's complex lived experience of performing music therapy. The experience of teamwork in the Nordoff-Robbins approach is addressed by Turry and Marcus (2005). In their article they consider the interpersonal dynamics of teamwork, offering a narrative account and analysis of the personal experiences of teamwork during a music therapy session from the perspectives of the primary therapist and the co-therapist. While the research for these articles is grounded in lived experience and the analyses

provide exceptional perspectives of the music therapist's experience, their theoretical frameworks did not explicitly include or mobilize phenomenology as this project will.

Phenomenological Analyses of Music Therapists' Experiences of Clinical Work

The application of phenomenology to the experiences of music therapists is increasing in the literature, but there is still much work to do. A small number of phenomenological studies have investigated various subjective dimensions of the music therapist's experience in the therapist-client healing relationship. Michele Forinash and David Gonzalez (1989) reported their own experiences of working as music therapists with a dying patient in her final moments of life and her passing. Clive Robbins and Michele Forinash (1991) published an article about the experience of time in music therapy. They proposed a phenomenological model of various temporal phenomena that are experienced during the music therapy session: physical time, growth time, emotional time, and creative or now time.

In another study, Forinash (1992) interviewed music therapists at the Nordoff-Robbins Center for Music Therapy at New York University about their lived experience of clinical improvisation. From the interviews, Forinash identified themes having to do with experiences of vulnerability, pressure, and music therapists' sense of self, natural ability, and their musical biography. The interviews also highlighted experiences of spontaneity and creativity, as well as intuition and rationality.

Forinash and Grocke (2005) proposed a phenomenological framework for analyzing music therapy. They note that phenomenology was used to investigate music therapy as early as the 1980s, when studies primarily took up Ferrara's (1984) phenomenological approach to music. Here, Forinash and Grocke synthesize and compare stages of phenomenological

approaches, including Van Kaam (1969), Giorgi (1975), Colaizzi (1978), Moustakas (1994), and combinations therein. The authors argue that phenomenology is a useful tool to understand the existential complexity of music therapists' clinical experiences, particularly through the use of detailed interviews and rich descriptions from clinical sessions.

Recently, Michelle Cooper (2010) conducted a study with Nordoff-Robbins music therapists to learn about their experiences of using musical improvisation to communicate with clients in terms of their reported awareness of the client-therapist dynamic, their perceptions of their client's response and growth within sessions, and the music therapists' own perceptions of the music. The results showed that music therapists described their perception and awareness of music along 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 the client. Cooper's research approach is the effort closest to this research project, which employed an empirical phenomenological method in order to uncover structures of the music therapists' experience of music, the Self, and the Other in the therapeutic context.

This thesis aims to fill the lacunae within the literature about the phenomenological structures of music therapists' experience of practicing therapy. In contrast to previous research that has focused on the client's outcome, this thesis focuses on the music therapist's experience in the context of learning to become a Nordoff-Robbins music therapist and the clinical practice of music therapy. In the following chapter, contemporary practice of Nordoff-Robbins music therapy will be contextualized within the history and ideology of the approach, and then in Chapter Three, the phenomenological concepts inherent to music therapists' experience will be explained, drawing on Frank and Frank (1993) and phenomenologists such as Merleau-Ponty

(2012), Schutz (1976), and Straus (1958) to inform the ethnographic analysis that follows in subsequent chapters.

Chapter Two

The Nordoff-Robbins Approach to Music Therapy

The Nordoff-Robbins approach to music therapy developed over many decades of work by special educator, Clive Robbins, and musician and composer, Paul Nordoff. Throughout the history of the Nordoff-Robbins approach, the point was made that this was an *approach* to music therapy, not a method; it has a theory, but not a technique. The word “method” conflicted with the worldview of openness and possibility shared by its founders. According to Beth, a senior music therapist, “They wanted to make sure it was coming from the human being to the other human being without being a method.” The history of the approach, from its origins in anthroposophy and arts-based healing for children with special needs, to its early core principles and contemporary practices, will be discussed in this chapter. This overview will provide a contextual frame through which the reader can grasp the spirit of humanism that infused the creation of this approach to healing and music.

Clive’s picture hung in the waiting room of the Center and hardly a day passed without reference to the founders and their early work. At the Clive’s memorial, one music therapist remarked that Clive had what he called a “gift of recognition.” He was able to recognize what was unique in a person and engage with them in such a way that even a brief interaction could take on greater meaning for each person who interacted with him. Due to this close connection among the music therapists I worked with to the memory of Clive, he became like an omnipresent informant for me during my fieldwork. I did not once hear Clive referred to as “Robbins” or Paul referred to as “Nordoff.” Accordingly, their first names will be used throughout this thesis.

Rudolph Steiner and the Curative Education Movement

In the beginning of his career Clive Robbins worked as a special educator (a “Curative Teacher”) at the Sunfield Children’s Home. Sunfield was a “Steiner home,” a residential school in Worcestershire, England, that was established under the guidance of Rudolph Steiner and his philosophy of Anthroposophy to care for children with severe mental and physical handicaps. Steiner’s Curative Education Movement began in Germany in 1924. The first Steiner home was named the “Curative and Educational Institute for Children in need of Care of the Soul, where “in need of” was deliberately de-emphasized in small letters and “Care of the Soul” was written in large letters (Allen 1960:13; Robbins 1960:20). The Curative Education approach considered that “all things and qualities that exist in both world and man must have an evolution behind them” (Robbins 1960:21). The child who comes to Curative Education must have those capacities for normal relation to the world restored through training and developing new capacities to participate in social life (Robbins 1960:22).

Curative Education is said to heal by working with both the healthy spirit of the child and the disabled body within which it is housed. Healing interventions at Steiner homes included the use of natural supplements, working on experiences of sleep in which the child was thought to meet and work on their disability each night, and finally, through creative arts, referred to as the “art of being a human being” (Robbins 1960:28). This approach to art was the source that first inspired the Nordoff-Robbins approach:

The arts are our most powerful therapeutic tools; in them we have a means of communication whereby we can reach and stimulate all children...If we can find the right medium through which they can express themselves they will show an awareness and drive that is all too often to remain dormant...Art provides possibilities for the development of the human soul that the practical life of the community cannot offer. A child who can do no more than seize upon a congenial rhythm in music or a colour in painting, can be led through repetition into enlarging this experience so that it will embrace and structure and discipline within the art form. This will be an incarnation

experience for him, a step toward a more complete development of his potentialities...Possibilities for fundamental therapy lie in the rhythms, melodies and forms of music. (Robbins 1960:25-26)

Curative Education focused on healing through the arts, particularly through dramatic play and eurhythmy. At the time of the early Steiner schools, eurhythmy was a new art of movement, a controlled use of the body through space. Connected to music, speech, and gesture, eurhythmy as a healing art was intended to offer the child an opportunity to develop self-expression, poise, and concentration. Dramatic play involved dressing up and acting out stories like the Grimm's Fairy Tales *Cinderella* and *Pif-Paf-Poltrie*. The practice and performance of these plays allowed the child to "live in the stories and make an experience of them his own" (Robbins 1960:27). Education and the arts overlapped for Steiner, as education and therapy overlapped for Clive. The guiding principles of the healing arts used in the Steiner schools carried over into the development of the Nordoff-Robbins approach to music therapy.

Returning to the introduction of Clive and Paul, Clive recounted, during a lecture to a class of music therapy trainees at the Nordoff-Robbins Center at NYU, how he and Paul met. In 1958, Paul was on sabbatical from Bard College and traveled to Europe to learn more about how music was being used to help children with special needs. He was directed to the aforementioned Sunfield Children's Home. Paul met Clive during a class in which Clive was reading the story of *Cinderella* to the children. Paul admired the style in which Clive recited the story, and in turn, Clive became a great admirer of Paul's musicianship. After seeing Paul play the night of their meeting, Clive remarked,¹

¹ Throughout this thesis, quotations drawn from Clive's lectures will be presented in italics without quotation marks in order to differentiate them from informants' quotations and academic literature. Informants' quotations will be presented using quotation marks, either in the main text or separated from it depending on their length.

I was on a little balcony looking down on this man singing and playing to this rather stuffy audience. He was warm, he was alive, he was direct, and I could feel the radiance and energy in him, and I thought, “This man is a sun among men. He’s radiating and he’s not afraid to express love...a certain regard for humanity, a certain value in human life, and human suffering, and human need, and human fantasy. All these things I thought were so marvelous!

At the end of his sabbatical, Paul returned to Bard College and requested more time off from his university to stay at Sunfield. When the administration denied his request, he resigned. Paul returned to Sunfield to join Clive in pursuing their goal of helping children with special needs through music. Paul’s music was described as flexible and spontaneous, matching the spontaneous joy that Clive exuded. Music therapists at the Nordoff-Robbins Center commented upon Clive’s great enthusiasm and willingness to experiment with materials and music that would help to meet a client’s needs. His approach to therapy was improvisational, trusting that an element of freedom and spontaneity, rather than defined structure, would best promote the client’s growth and expressivity. Paul and Clive’s gifts eventually coalesced as the Nordoff-Robbins approach to music therapy.

Raising the First Generation of Nordoff-Robbins Music Therapists

During the time of their collaboration, Paul and Clive received periodic grants for projects that took them to a variety of children’s homes and residential institutions in the United States, Scandinavia, and Australia. From 1962 to 1967, Paul and Clive maintained the “Music Therapy Project for Psychotic Children under 7” at the Day-Care Unit for Psychotic Children at University of Pennsylvania’s School of Medicine (Nordoff and Robbins 2007:xvii). Their work frequently took them to such hospital-based settings for children with developmental disabilities and behavioural problems, for example, in Wichita, Kansas. At this time they were active in giving teaching demonstrations at these institutions and at the Crane School of Music, Potsdam

College of the State University of New York. The titles of the programs and care facilities are indicative of the pathology-based medical milieu in which Paul and Clive worked.

In 1967, they were invited to be Lecturing Fellows of the American-Scandinavian Foundation. This appointment allowed them to travel and teach in several Scandinavian countries. Around the same year, the British Society for Music Therapy introduced a Music Therapy training course at the Guildhall School of Music and Drama, London. By this time, Paul and Clive had published two books and produced numerous audiotaped sessions. Audio tapes were the most frequent way for people to learn about their work when the men were touring the world. Their audio tapes and books attracted the attention of Sybil Beresford-Pearse, a music professor in the United Kingdom. She was so impressed that she persuaded the Music Therapy Charity of Great Britain to fund a Nordoff-Robbins training course at the Goldie Leigh Hospital.

Paul and Clive returned to the United Kingdom to offer a six-month training course to music therapy clinicians and students. The nature of their approach was such that it did not have a discernible “method” per se, making teaching a course a new challenge for both men. Their training philosophy placed great importance on clinical practice and they believed that teaching music therapy should not happen in abstraction from the therapy experience. Aigen quoted Paul as having said, “We wanted to train very much in a clinical setting so the work would not be classroom teaching or academic work, but it would be based around clinical work” (cf. 2005:10). At training presentations, Paul and Clive taught by live demonstration and playing audio tapes of their music therapy sessions, and read from past clinical notes they had compiled documenting therapy sessions with particular clients.

The training of technique was less important than the human-to-human interaction in the therapy session and in teaching. Clive once said during a training lecture: *As an antidote to*

technique you can now hear human contact in music – and technique is just the leather on the soles of your shoes. The argument against Nordoff-Robbins therapy being cast as a method stems in part from Paul and Clive's assertion that as a human being, the therapist will inevitably be a unique individual who will respond to clients differently than another therapist might, and every client will need something new and different at a given time. This was regarded as a significant factor in why this approach could realize benefits to clients and also points to some of the issues with describing the subtle experience of human interaction, let alone human interaction in music. All of this is not to say that Nordoff-Robbins music therapists do not have exceptional musical technique and work to develop a very specific set of musical resources; they do, and these resources will be explained later in the thesis, but the application of these resources was never explicitly dictated in a procedural manner.

In retrospect, the Goldie Leigh Hospital training course was the apex of Paul and Clive's work together and the last time they taught collaboratively (Aigen 2005:2). For a few years afterward, they continued to travel and lecture at the same venues, but it could hardly be called a joint effort. Their respective lectures reflected their diverging visions. Clive once said:

There were times when I feel that the framework that I supplied around Paul's work was becoming a prison to him at the same time, I knew my life had to widen. I knew I too had to stand out of this framework which was also imprisoning me. (Aigen 2005:12)

In 1974, Clive moved back to settle in the United States where he soon met and married Carol Matteson. Carol was a nurse and music therapist, and most importantly was able to work on the piano in therapy much the way Paul had been able to do. Clive was the consummate co-therapist, and he needed a primary therapist at the piano to help him continue to build his vision of this approach to music therapy (Aigen 2005:2). The Nordoff-Robbins Music Therapy Center at New York University was founded in 1989, and Clive and Carol Robbins agreed to work there

for only one year initially. Ultimately, they traveled frequently to train music therapists around the world but continued to call New York their home. While at NYU, they developed the Nordoff-Robbins approach to music therapy, practicing in sessions and training many subsequent generations of music therapists. Carol worked with Clive as a music therapist at NYU until her death in 1996, and Clive continued to work at NYU until his passing in 2011.

The Therapeutic Power of Music

During their work, Paul, a gifted composer and performer, sought to understand more about how the manipulation of musical elements – melodic, harmonic, and rhythmic – could be used as a clinical tool. In *Healing Heritage* (1998), a posthumously published transcription and set of compact disc recordings of Paul’s lecture series which he delivered to music therapy trainees in the United Kingdom in 1974, Paul articulates Steiner’s concept of intervals that were developed for eurhythmics in terms of their relevance to music therapy.² Paul believed that intervals are the secret aspect of music, hidden away in the music we listen to every day. From Steiner, Paul came to understand intervals as powerful emotional entities: we respond emotionally to each tone, but this emotional response is greater than the sum of intervals we hear. These early conceptualizations point to interesting phenomenological aspects of the therapist’s and client’s relationship to one another through music.

Drawing on Steiner’s anthroposophy, Paul conveyed to students that tonal movements represent the human being’s relation to the world.³ In the single tone, Paul taught, there is rest

² A musical interval is the distance between two pitches or tones, can be created by playing two notes in succession or simultaneously, and each distance can be heard and identified by its sound.

³ This conceptualization of tonal movement relates more to the transpersonal beliefs and work of Paul and Clive through Steiner’s teachings than to current debates in academic music theory.

that is experienced within and in relation to one's own body. The interval of the minor second offers movement, but still is felt inwardly. Activity increases with the major second, searching for the rest of the minor third. The minor third is, for Steiner, an experience of inner balance, which in the major third moves from a backward leaning to a position that is more upright. The fourth reaches further toward an outer relationship with the world. In the augmented fourth, there is a choice to withdraw or step forward to the perfect fifth and face the world.

The minor sixth is a gesture that is completely outside oneself, reaching a hand out to the Other. Through the major sixth one is carried out into the world; with the minor seventh a tension between the self and the outside world is reached and felt most potently in the major seventh. Paul noted that the movement in eurhythm for the major seventh is the stretching outward and quivering of the hands. In the octave, Paul notes, one finds oneself reflected perfectly in the outside world. It is not a doubling effect of the same tone, but an ego experience. For therapy, the interval movements outwardly and withdrawing represent important experiences of tension and relaxation that lead to their therapeutic development (Nordoff 1998).

In lectures, Paul also referred often to the work of Victor Zuckerkandl (1959) who argued that there is experience latent in musical forms, particularly in the musical tone (Aigen 2005:32). In his training lectures for music therapists, Paul used Zuckerkandl's argument that a single tone has musical energy that is activated in melody and harmony, saying in a recorded lecture published in *Healing Heritage*: "Every tone is an event and a tone contains limitless possibilities. [Further,] Musical tones are conveyors of forces. Hearing music means hearing an action of forces" (Robbins and Robbins 1998). Paul believed that creative insight guided the therapist's use of tones, whereby their awareness of the latent musical forces that suggested where a tone wanted to go allowed them to consciously go with the direction or choose to "play off of them"

(Aigen 2005:26). The Nordoff-Robbins music therapist should listen to the child with an awareness of each tone's forces, take in the music the child is making, and reflect it back either by consciously following the tone's natural direction or playing off of the tone toward a new musical direction. This not only was believed to engage the child, but also provide a foundation for more intimate clinical work to enhance the child's inner being (Aigen 2005:25). Paul is well-known for the mantra, "Don't take the first chord, take the right chord."

Drawing on the anthroposophical Steiner tradition, Paul and Clive believed that the aesthetic use of music was vitally important for relating through music with a child. They wanted music therapists to use music as deeply and as powerfully as they could. This meant ensuring that the instruments on which the therapist and the child played were not toy-like, but good instruments that produced beautiful, resonant tones. The founders made every effort to acquire authentic instruments for their clients. This is evidenced by one story about their trip to Greece during which they discovered koudounia bells, locally-crafted cow bells with a unique tonal quality. Rather than purchasing common bells that were sold to the less discriminating tourists, Paul and Clive visited a craftsman and purchased handmade bells of finer quality from him.⁴

Clive and Paul's approach towards children with severe disabilities seemed to combine general humanistic beliefs with anthroposophical metaphors. Their conceptualization of the child included at least three beings: the Conditioned Child, the aspect of the child's way of being-in-the-world that has been trained by the disability (*e.g.*, learning to withdraw, learning not to try); the Being Child, the healthy child within the Conditioned Child that can be nurtured and brought forth; and the Music Child, an aspect of the Being Child that naturally responds to music. The Music Child is the core element of the therapeutic tradition. Music therapists with whom I spoke

⁴ It is of note that Clive himself was known for his craftsmanship, fashioning instruments to facilitate each child's music playing.

knew the concept and defined it as Clive's idea or metaphorical construct that describes innate human musicality, the ability to play music, and the ability for humans to express the self through music. Aigen quoted Clive speaking about his perspective of the Music Child concept:

It is not just a fanciful metaphor, it represents a real constellation of human capacities that plays a vital role in human development, one that could only be discovered through the careful and systematic qualitative observation characteristic of Nordoff-Robbins music therapy. (cf. Aigen 2005:32)

The Nordoff-Robbins approach maintains that each child has their own Music Child that could be engaged and nurtured if met with the right music. They believed that each child's musical responsiveness reflected the developmental process, and that as through therapy, the Music Child would strengthen and overtake the Conditioned Child so that the whole person would grow. Following the Curative Education belief, Clive said that children realize their potential in music.

In his later lectures, after Paul's death in 1977, Clive spoke about his early work in humanistic terms, drawing on the principles of humanistic psychologists like Carl Rogers and Abraham Maslow, and by association the school of evocative therapy discussed previously in Chapter One. The Music Child, conceived as the inner being of personhood, closely resembles Maslow's concept of inner being which can be reached and helped to express itself. By relating to another person in music, something greater flows through therapist and child, and the Music Child expresses itself, or "self-actualizes" (in Maslow's term). This joyful, authentic moment of musical relationship with another person was what Clive called "the real thing," or "peak experience," which opened the gateway to deeper therapeutic transformation.

Clive spoke about the interaction in terms of a transcendental being-to-being relationship, which is less objective and more spiritual than the person-to-person relationship that characterizes the medical relationship. According to the work of Lévi-Strauss (1963) and Frank

and Frank (1993), the therapeutic relationship is the critical component of a therapy. Shamans and healers everywhere are effective because of the intersubjective relationship they establish with their client. Clive and Paul's description of music's role in the intersubjective space presents a sort of early phenomenology of music as therapy. The expression of joyfulness was, and continues to be, considered an important clinical tool because of its transpersonal work in the healing transformation. From the perspective of Nordoff-Robbins as a form of evocative therapy, one can see the importance of joy and of Paul and Clive's phenomenology of music therapy in general, in creating a space for therapeutic change to take place.

Core Principles: Teamwork, Musicianship, Indexing

An important element of the approach was the steadfast belief that it was the music that was being therapeutically effective; it was therapy *in* music, not therapy through music. Musical processes were the primary vehicle of change. It was through clinical improvisation that the work was able to take place. The musical elements or forces – the tonal motion, the intervallic and harmonic structure, and the rhythmic patterns – are used with clinical intent to meet the child in music. The concept of clinical intent behind the use of musical forms to engage and meet the child reflects Paul's insistence that every note is an event and has a significant impact on the child to whom it reaches out. It was important that the music therapist attune to the child's emotional world and create a musical environment that supported new ways of relating.

One of the defining features of the Nordoff-Robbins approach to music therapy is the use of a clinical team, composed of a primary therapist and a co-therapist. In the early work, Paul was the primary therapist at the piano and Clive was the co-therapist. Later, Clive worked in a team with his wife, Carol Robbins, who took over the function of primary therapist. The clinical

teamwork had many advantages and was often necessary for working with a population of children that suffered from multiple handicaps and severe disabilities. Often their physical conditions made it very difficult to play instruments on their own and a co-therapist was needed to work with them. For example, Clive would often model playing, dance with children to engage them, or use hand-over-hand technique to literally move the child's hand for them until they were able to do so themselves. Since the co-therapist was physically close to the child, they had access to different information than the primary therapist. Clive was able to let Paul know that a child was more or less ready to play something new, and Paul could change the music accordingly. Conversely, if Paul was inspired by the child's activity to play something different, Clive could facilitate the child's movement with that new style.

Paul and Clive are held up as the legendary team within the community of Nordoff-Robbins music therapists and music therapy writ large. In teaching, Clive spoke about the importance of primary therapist and co-therapist being partners who share in the creativity, events, challenges, and responsibilities of therapy. While each team member is their own individual, it is essential that their musical-creative abilities combine closely to reach clinical goals for the child. In the training course material it states that for all teams the following is important to the cooperative relationship:

The personal and professional biographies of each member influence the character of their teamwork. So do their genders, their ages, and the extent of their individual experience. Their personal values, attitudes, innate propensities, and their particular personal modes and areas of creative ability will also play into the nature of the team. The relationship between the team members is therefore a dynamic relationship that realizes and evolves its character through clinical practice (Nordoff and Robbins 2007:189-190)

Teamwork is a journey whose outcome is unforeseeable. It is a relationship of mutual attentiveness, support, exploration and caring service toward the client.

Clive has called music therapy “a dual art: the art of music in the service of the art of healing” (Nordoff and Robbins 2007:191). This duality gives music therapy the power to effect change in human relationships and individual existence in the world. The positive influence of an attentive team on a client’s therapeutic process must not be underestimated, nor can it be easily described. The matter of clinical intent, the intention with which the music therapist plays for the child, is paramount to effecting change with a client:

You must approach clinical [music-making] with the intent of a performer...State the music with intention that it be heard, that it may be listened to, that its effects be felt...The language of music will be more effective when you speak it clearly with expressive awareness and communicative intent. (Nordoff and Robbins 2007:191)

Thus, Nordoff-Robbins music therapists are effectively “musician therapists.” The complex role and relationships inherent to the concept of the “musician therapist” as well as the theoretical and logistical problems in teamwork that challenge today’s Nordoff-Robbins music therapists will be considered phenomenologically later in this thesis.

Another early core component of the Nordoff-Robbins approach is the recording of all therapy sessions and the practice of indexing them afterwards. This practice continues today among the therapists with whom I worked. Indexing is considered to be essential by every therapy team at the Nordoff-Robbins Center. Aigen quoted Clive as having once remarked that:

The importance of recording goes back to the first moments I saw Paul playing and improvising with children. When I saw him at work and I heard this music, it was a whole different dynamic of living musical experience... You were living in the now, you were living in the impact of each interval. Each instant of the music was alive. I knew that there was no other musician of this caliber doing what he was doing with the consciousness with which he was doing it. And my first reaction upon seeing Paul work was: we have to record this. It has to be recorded. (cf. Aigen 2005: 11)

When Paul and Clive began, the sessions were audiotaped and the only visuals were photos that Clive had taken. After a session, they would sit down and listen to the tape moment-by-moment, listening for clues about the therapy process either in the child’s response or what

Paul had played on the piano. Clive called this “listening through a microscope.” This was the fundamental stage of what would eventually become called and trained as “deep listening” for all Nordoff-Robbins music therapists. Throughout the development of the approach, their clinical work was underscored by theoretical guideposts like Steiner and Zuckerkandl. From these, they constructed the theoretical foundation for what was to become the Nordoff-Robbins approach.

Core Principles at Work in Contemporary Nordoff-Robbins Practice

Two years have passed since the Nordoff-Robbins community lost Clive Robbins in 2011. When I asked music therapists if they were worried about the future of Nordoff-Robbins they answered with great certainty that they were not. The approach was created to be flexible, without limits, and interested in continuous growth and expansion, just as it desires for its clients. During interviews with the music therapists at Nordoff-Robbins, there was a sense that they had faith the approach would continue to thrive. While contemporary settings and demands upon music therapists were changing, the core principles remained steady anchors around which the approach could continue to be adjusted to meet new needs and answer new questions.

A significant element in the practice of Nordoff-Robbins music therapy that has shifted in recent years is the client population with whom and the contexts in which music therapists work. In the early days, Paul and Clive only worked with children, severely handicapped and multiply disabled children at that. During a conference presentation at the American Music Therapy Association annual conference, Leon, from the Nordoff-Robbins Center, said:

What’s so interesting about Clive is the way he was able to extrapolate from his experience of working with music to a much more general experience. Clive never worked with a normal person in his life. He never worked with an adult, yet he was able to take the experiences that he had and the realizations that he had from those experiences and extrapolate something that would apply much more generally. That’s a step in music therapy as well, that music therapy is now being done with people who are more

approaching normal; they may be under difficult situations or in certain kinds of distress, but it isn't a permanent situation that can't be remedied.

Leon was also critical of conflating Clive's and Maslow's theories, arguing that Maslow's humanism informed some of Clive's work. He continued:

My sense is that Clive would say, What I'm doing is activating something that is beyond all of this and perhaps parallel to it...I'm working to facilitate and strengthen something that I don't think Maslow even would account for because he never dealt with music as did any other psychologist. What we're seeing is something that only working with this kind of a population and only working in this way could bring out.

Today, Nordoff-Robbins music therapists work with clients of all ages from diverse social and health backgrounds. There is a famous case of a Nordoff-Robbins music therapist working with a coma patient with great success; the music was said to have brought him out of his coma. A music therapist at NYU might work with a group of severely handicapped children from the Board of Education program, later someone struggling with psychological problems, and then adults with seizure disorders. When I was doing my fieldwork, the Nordoff-Robbins Center at NYU had just received an award for their collaborative work with occupational therapists, working with rehabilitation groups of stroke patients.

The core principles of individual work and group work have not changed a great deal. Individual work may, however, sound different now than in earlier work when Paul was at the piano because the idioms have changed. There is now more popular music, including jazz, country, and blues genres that frame therapists' clinical improvisation. The approach remains client-centered, and the therapist's improvisations and responses are tailored to the needs of the client. The guiding principle remains that the music therapist's unique abilities and musical sense will shape the therapeutic experience of the client. Further, there is still the belief among music therapists that "the potential has yet to be seen," and that there is always something more to learn

about the client. The ideas of “yet to be seen” potential and the music therapist being tasked with finding a musical key to realize that potential will be a central idea throughout this thesis.

The significance and importance placed on teamwork has not changed at all in the approach. The types of clients that seek Nordoff-Robbins music therapists and professional settings that shape therapists’ experience have changed over the years. At the Center, often only one music therapist would be used if the client was a physically able adult or just did not require someone extra in the room. When trainees left the Center, it was with the understanding that they would be more likely than not working alone, because most facilities could barely afford to hire one music therapist, let alone two, and rarely have filming capacity. Phenomenological consideration of teamwork experience at the Center will be explored in a subsequent chapter, with emphasis on the problem of forming good partnerships between primary and co-therapist that will help the client come into social relationships.

Sociality and Universality of Music

At the core of contemporary Nordoff-Robbins music therapists’ beliefs and practice is the concept of music as a universal social force. This principle has remained constant throughout the development of Nordoff-Robbins. Music therapy sessions have to do with meeting another human being in music. During my fieldwork I asked music therapists whether they believed music had the power to reach people, to establish connections when no other means can. One of the most striking responses I was given came from the music therapist Leon in an interview, who said, “Music spends its time being social; it’s spending its time being interactive. You can understand melody and harmony, but the biggest hint about all this is what’s *not* in music.” He continued:

Here's this amazing communicative interactive medium, what is it communicating and interacting about? What information is it concerned with? Biology, chemistry, physics, mathematics, current events, anything in the great library? Nothing is there... Music, not even there, not even there. No biology, no physics, no chemistry, no anthropology, nothing... And there are certain kinds of discouragements. Well, who can explain it, who can tell you why? Fools give you reasons, wise men never try. Not only is it not there, but we're not interested. It's of no concern to us, all of these material things, all of this trying to understand, understand, understand, understand... not interested; it's a waste of time. What is music spending its time doing? It's spending its time being social. It's spending its time being interactive. Music is all about the part of us that cares about how other people are and what they're doing.

The music therapists with whom I worked at the Nordoff-Robbins Center expressed ideas that music was an effective therapeutic medium because of its versatility and opportunity for people to connect with one another. When I asked Nancy how she felt music worked, she said:

That's the central question. I think it works because music is such a versatile medium of expression. It's dynamic, it has multiple elements that can be operating, changing simultaneously or separately. It works because people can participate either simultaneously or sequentially. We can't talk at the same time and be understood, but we can play together and be connected.

Though music and verbal psychotherapy share some common healing components, there are, as Nancy's account highlights, some fundamental differences. Verbal communication demands a kind of holding back action and then acting in turn with another, but in music, social communication is not necessarily so rigidly structured. In verbal therapy, for example, it is always a pattern of 'talk, listen, talk, listen,' but in music therapy, as Nancy remarked, "you can join together in something and it can be meaningful, or you can cultivate reciprocity." Harmony and polyphony were great musical advances, expanding the possibilities for musical expression. Scholars who are concerned with aesthetics and society, like Alfred Schutz (1976), have remarked on the creation of polyphony in music as a powerful vehicle for creating community and relationships among people who play music together .

In music therapy the music can reflect a social agreement to communicate with one another, to meet in music, or it can reflect an effort not to agree, to reject and resist the invitations of the music therapist to join in the music-making. This rejection can happen musically or it can happen through silent gesture. This thesis suggests that music, like the living body, is multi-modal and multisensory within itself. There is a vitality shared between live music and lived existence, the expression of one brings the other into being. Albert, a music therapist at the Center said:

Immediately, you're tapping to a different kind of relating, different way of being when music is being created and heard. So all of a sudden this potential for things to emerge, to unfold in a way that if you're just talking doesn't happen. I think you're tapping into certain sensitivities, certain strengths, and certain core essences of the person's make-up.

While music therapists were interested in the neurological effects of music, how the brain works and in which ways, they remained certain that there was something else, non-material that music worked through. Lynn, another music therapist, said in an interview, "I've always been fascinated with how [music] works, what part of it has to do with the brain, what part is something less concrete, like the soul. But I think we're naturally musical beings, we're naturally melodic and rhythmic and we respond to harmony and intervals and all elements of music."

Nordoff-Robbins music therapists define sociality in a wider sense, in terms of engagement and relatedness to another. Music is a relational aesthetic medium that creates social connection when people play together. When people stop playing together, or the music stops, the medium for this special relationship is lost, and with it goes the milieu in which clients can express themselves. "When the music stops," says Leon, "everything disappears and goes back to as it was before." Without music as an option for self-expression, the client who cannot communicate any other way loses his or her chance to be social. As therapy progresses, the client may find ways to communicate without music, however, playing music will always be its own

modality for expression that is different from the everyday world of social communication. “There’s always that feeling,” said Albert, “that if you breathe, if you’ve heard your mother’s heartbeat in the womb, if you’re a human being, then there’s something about tone or rhythm that you could somehow respond to... There’s something about being in music, the *homo musicus* thing, that is special.” This belief in the universality of music and human sociality underscores the work of the Nordoff-Robbins approach.

The following chapter, “A Phenomenological Approach to Understanding Music as Therapy,” will describe and explain the theoretical perspective by which the ethnographic data will be analyzed. Central to the theory are Merleau-Ponty’s concepts of indeterminacy, pre-objectivity, pre-reflexivity, and synaesthetic perception as structures that govern the human experience of perception and the world. A short vignette of a music therapy session will be offered as an opportunity for the reader to relate the material in this chapter about the Nordoff-Robbins approach with the theory that is to come, and the subsequent ethnographic chapters on listening to, improvising with, and meeting the client in music.

Chapter Three

A Phenomenological Approach to Understanding Music as Therapy

The ethnographic material in the following chapters will be analyzed according to phenomenological theories about the body and its experience in the world. The principles of indeterminacy, pre-objectivity and pre-reflectivity, and synaesthetic perception which govern our lived experience will be articulated in relation to music therapists' concrete experiences of training for and performing music therapy with "hard to reach" clients. The goal of music therapy is to restore mutuality and reciprocity in the relationships between the "hard to reach" client and other people in the world. Accordingly, the following topics will require phenomenological inquiry: the way music therapists learn to perceive a client, the way music therapists respond creatively through improvisation to their client, and music therapists' perception of the transformational, or curative effect these responses have on the "hard to reach" client. The music therapist's primary tool is music, thus, the power of music as a sense modality (a phenomenology of music) will be explored as well. The associated problem of finding a language to talk about what music does in the context of therapy will be taken up in this thesis. The theoretical perspective of this thesis will be explained after the following vignette.

An Example of a Music Therapy Session

In order to give the reader a mental picture of how the performance of a music therapy session plays out, a vignette of a session will be presented below. From the music therapist's perspective, therapy is a process of listening and responding to the client musically in a way that will capture the client's attention and engage them in music-making. Playing music together in a creative and spontaneous way is inherently a form of play, and, thus, the therapeutic process

takes on an experiential freedom for exploring new ways of being with another person. Through the mutuality and reciprocity of music-making, a social relationship is created in which therapeutic work takes place on a transpersonal, being-to-being level. As discussed in the Introduction and Chapter One, the Nordoff-Robbins approach to music therapy is a form of improvisational music therapy (Bruscia 1987), and as will be seen, it shares significant healing components with evocative therapies (Frank and Frank 1993). Throughout the vignette, I will refer briefly to additional components of evocative therapy that are relevant to the Nordoff-Robbins approach to enrich the reader's understanding.

The session I will describe took place on November 9th, 2012, with a client named Sam.⁵ It was my second session with this client, but Sam had been participating in music therapy at Nordoff-Robbins for about one month. Sam is a three-year-old boy who exhibits behaviours like those one would expect to find in a child diagnosed with an autism spectrum disorder. He is delayed in his language skills, prone to self-stimulating behaviour, and has trouble relating to others socially. Music therapy is hoping to restore his social communication in terms of his language acquisition and social relationships. This session was thirty minutes long. Joan was the primary therapist and I was the co-therapist.

When Sam entered the music therapy room, he went straight to the bass end of the upright piano where Joan was already playing and singing. He looked at Joan as she played and sang a "Hello" song to him. The "Hello" song is played at the beginning of each session. Joan had not transcribed the song from previous sessions, but seemed to remember the core melody and pulse of the song and added improvised material to the song in order to match Sam's mood in the session. Often times the "Hello" song is approximately the same each session to create a

⁵ The therapist's and client's names have been changed for anonymity.

routine at the beginning of therapy. The song may also contain the word “Hello” and the names of the therapists and the client in the room which invites people into the musical space. While Joan played piano, Sam played clusters of notes and single tones on the piano, too. It was difficult to tell whether he was copying Joan or if Joan was copying him. Seeing that Sam was intrigued, Joan played a glissando on the piano, running her finger along the keys. Sam tried to copy, jumping as he played, but could not make the same sound. He and Joan shared the keyboard, Sam repeating notes in the piano’s bass end.

When Sam dropped to the floor to investigate the piano pedals, Joan improvised a song with the theme “Where, oh where, is Sam?” Joan’s intention was to encourage him to come away from the pedals. When the song was unable to distract him, Joan and I got two drums and tried playing them to attract his attention. When Joan returned to play the piano, Sam went over to her and played at the treble end of the keyboard, creating a lovely melody, slow with some moments of faster playing that began with a C minor arpeggio. Sam stopped to listen to the piano as Joan continued to play. He ventured over briefly to try the drum with me and then returned to the piano with Joan. As Joan played strong tonal segments with him, Sam began to play triplets to her duple-meter melody. The music came to a stop and Joan asked Sam if he wanted more, making the sign language gesture for “more.” When Sam copied Joan’s sign, she began to play again and he turned to me, smiling and jumping happily. He continued to jump in place, playing the high treble notes in time with Joan’s melody.

Ten minutes had passed in the session and Joan had already modeled for Sam how to participate in music-making by demonstrating glissandi on the piano for him and playing with the drum. Later in the session, Joan and Sam played a game at the wind chimes, where Joan again modeled for Sam how to participate in the game with her. It was not always clear when

Joan was following Sam and when Sam was following Joan. It was also ambiguous because there were an infinite number of ways that Sam could have joined in making music. Even when Sam was not engaged in music but in his own fixations, Joan supported Sam's gestures, playing music for him instead of reprimanding him, as she did with the song "Where is Sam?", where the improvisation is as explorative as Sam's investigation of the pedals. In this way, we made Sam aware that we acknowledged what he is doing without judging it. Nordoff-Robbins shares the perspective of evocative therapies that the client's own work and integration of new skill is at the root of their positive development, increased self-awareness, and improved relationships and ability to communicate with others (Frank and Frank 1993).

The session continued when I offered Sam a mallet to play the drum, and he took it briefly and allowed me to guide his hand in beating the drum a few times. He then dropped the mallet and Joan began to sing "Uh, oh," improvising on the piano to reflect the tumbling of the mallet. Sam moved toward the piano and focused his eyes on his fingers pressing down the keys. Soon after, he vocalized and looked directly at Joan as she sang. Sam ran to the back of the piano out of sight, and then returned to play at the treble end of the piano while running in place. Joan began to play *Twinkle Twinkle Little Star* and Sam listened to Joan while staring at me as I sang on "La" and beat the drum in time with the music. Sam stood very still, listening. Then he moved from the high treble end of the piano to the bass end and played the tonic note of the song. Noticing Sam's engagement with the music, Joan continued playing, and added a rhythmic activity, where she played a sequence of notes and left a pause of silence in which Sam could fill in the missing beat. Her silence evoked a response from Sam which matched the rhythm of the music Joan was playing. Sam's striking of the tonic note was interpreted as a high level of

relatedness and for music therapists this is an exciting moment because it indicates that the therapy process is progressing and Sam is engaging in reciprocal coactivity.

As Frank and Frank note, interpretation is the therapist's main way to communicate to the client that she or he empathizes with the client's situation and re-affirms the client's confidence in the therapist's ability to help. To effectively express an understanding of the client's experience confirms the client's confidence that the therapy works. Interpretations can also offer a positive sense to a habitual behaviour, giving the client a better self-image (Frank and Frank 1993:204). Turning Sam's drop of the mallet into a song rather than a moment of motor failure and reprimand, created a new meaning and dimension for his experience.

The trajectory of therapeutic progress is ambiguous. Within itself the session proceeds according to the client's engagement in an activity. There is a desire to move with the client, but this gives a false impression that there is no structure to the therapy performance; there is structure, but it is a flexible structure that bends with artistic expression. In the example at hand, we were now twenty minutes into the session and Sam had left the piano and began to wander around the room. Moments of transition are difficult for all clients, so the therapist strives to move seamlessly from one activity to the next. Here, Joan went to the wind chimes that were in place and initiated a game called "Play and Stop." In this game, Joan played the chimes as she sang "Play", moving in long melodic lines from the tonic to dominant of the scale. She did this over and over until she suddenly wound up to "And stop!", where she clasped the chimes between her hands quickly to silence them. Sam was elated with this game, smiling, vocalizing, and moving his fingers near the chimes, copying Joan's movements. For about five minutes Sam continued to play with Joan, and finally he helped her catch the wind chimes to stop them, vocalizing when Joan said "Stop!"

With about five minutes left to go in the session, Sam lost interest in the wind chimes, so Joan got her guitar and sat on the floor with him. Joan strummed the guitar improvising a “Goodbye” song. We sang goodbye to everyone as Sam laid on the floor moving his mouth to form the word “Bye.” Like the “Hello” song, the “Goodbye” song can be pre-composed or improvised, but what is important are the words “Goodbye” and the names of the people participating in the session. The “Hello” and “Goodbye” songs offer a clear bracket and ritual that demarcates the beginning and end of therapy, setting it off from the flow of everyday life.

Like evocative therapies, described in the previous chapter, music therapists aim to promote the clients’ self-actualization, minimizing their symptoms and restoring their social relationships. Therapists approach the client as someone with infinite potential which music can help them realize. The performance of therapy is a complex lived experience for therapists, for whom certain structures of experience are especially salient in the creative clinical milieu. The experiences of the Nordoff-Robbins therapists will be considered in light of the following paradigm, drawing upon key concepts from phenomenology.

Indeterminacy and Pre-Objectivity of the World, and Synaesthetic Perception

Merleau-Ponty describes human existence as being governed by the principle of indeterminacy. There is an ambiguity about being-in-the-world, in terms of the things and people that surround us, our body, and the space and time within which it operates:

The world is always already constituted, but also never completely constituted. In the first relation we are solicited, in the second we are open to an infinity of possibilities... We exist in both ways *simultaneously*. Thus there is never determinism and never an absolute choice; I am never a mere thing and never a bare consciousness (Merleau-Ponty 2012:480).

The structure of our social life is indeterminate. Within every interaction there are infinite possibilities for action available to us, as the world is never fully constituted and our perception is never complete, nor our actions determinate of other actions (Merleau-Ponty 2012:80-82).

Some of these possibilities are recognizable to us as choices that we have learned through experience, while others remain unknown and surprise us, as creative action often does.

For phenomenologists, the body is the starting point from which a person experiences the world. The body simultaneously has a world and belongs to a world; one's own experience and embodied knowledge construct a personal world drawn out of the broader social world. The body is open and ambiguous, thus, it can never fully be either an object or a subject to itself (Merleau-Ponty 2012:242). This is the paradox of the body that limits the totality of my experience; I cannot touch myself touching, nor can I see myself seeing. So, while the body can be perceived as a living subject through which I experience the world and the body can be examined by me as something separate from myself, I can never do either of these things completely, yet I take for granted that I can.

All perception is taken for granted as complete and total; if it were not we would have to pause at every moment to consciously deliberate about what to do next or what we can count on being present. The body is one's locus through which we engage the world; it is the Center to which objects turn their faces to meet us. With the body we engage objects in an existential movement, demanding responses from the objects around us, and in turn, responding to the demands the objects place on us:

By carrying myself toward a world, I throw my perceptual and practical intentions against objects that appear to me. (Merleau-Ponty 2012:84)

For example, I assume that the back of the house is there and I do not go around to the back to check my assumption. Of course, I would be shocked to find that a house did not have a back,

but it remains a possibility for me whether I acknowledge this consciously or not in the context of the indeterminate world and my ever-partial perspective.

In existence, we take up an indeterminate relationship to our world, and in transcendence we transform the situation into something meaningful (Merleau-Ponty 2012:174). The Nordoff-Robbins approach seems to capitalize on existential indeterminacy: the music therapist is poised and ready to spontaneously create new music from their pre-objective experience of the client as best they can using their embodied clinical skills of listening and responding. The objective musical expression of the pre-objective is intended to speak to the client, drawing the client into the musical relationship. The music therapist, however, has no more complete perspective of the client than they do of themselves or any other object in the world. Phenomenologically, nothing shows itself to us completely, be it object or person. Moreover, the perception of a house (an object) is different from the perception of a client (a living being): one can walk around the house and see for oneself the different aspects of the house, but a client does not show all of his or her personal aspects to the therapist. With a living being one must wait for the other person to reveal different aspects of himself or herself or one must find a way to evoke these aspects, as the music therapist does with music during each moment of therapy.

The idea of spontaneous expression is central to creative clinical improvisation. The lived experience of creative work can be understood in relation to the ambiguity of time and space that the body inhabits. Merleau-Ponty argues that each present moment grounds our existence:

In so far as [the present] presents itself as the totality of being and fills up an instant of consciousness, we never actually break free of it. (2012:86)

The present grasps and condenses within itself the specific past and the near future, but it only possesses past and future in intention, not in actuality (Merleau-Ponty 2012:72). The present is lived by me, but never fully, because the present moment is never complete in itself.

My present is always in the process of becoming my past and being filled by my future. The present is not a static state in itself; it is only ever experienced by me in so far as I throw myself into it and engage with the flow of time:

I never have an absolute possession of myself by myself, since the hollow of the future is always filled with a new present...The alternative between created and creating is thus transformed into a dialectic of constituted time and constituting time...I put my confidence in the world. To perceive is suddenly to commit to an entire future of experiences in a present that never...guarantees that future; to perceive is to believe in a world. (Merleau-Ponty 2012:250, 310-311)

The flow of melody interlocks temporal experience, carrying its listener away through a near past and present toward an anticipated future. The person who makes music throws himself or herself into the flow of time, engaging with the present as it transforms over and over again into each new future. Just as I put confidence in the assumption that there will be a back on the house and I can safely enter without the house collapsing, the listener anticipates that the melody will rise and fall or come to an end as the music suggests, yet the expectation only portends a future, it does not ensure it. In their pre-objective, pre-reflective perception of the world, music therapists trust that their musical skills will be there for them to draw upon and play music and that they will be able to spontaneously create something meaningful between themselves and the client. In the case of the “hard to reach” client, the music therapist must also have confidence that while the client has not been engaging in the therapy process, he or she may do so at any moment. This follows the principle that the present is always in the process of becoming and that experience is indeterminate.

The fundamental pre-objectivity of our engagement with the world can also be illustrated by the concept of habits which constitute the first relationship of the body to the world:

The body is the vehicle of being-in-the-world, and for a living being, having a body means being united with a definite milieu, merging with certain projects and being perpetually engaged therein. (Merleau-Ponty 2012:84)

Habits are taken up and incorporated in one's style of being-in-the-world; without our conscious awareness, which is to say pre-objectively and pre-reflectively, habits guide our actions.

Experientially, habits make consciousness a matter of "I can," not "I think" (Merleau-Ponty 2012:139). The pianist can state with certainty that he will be able to reach out and manipulate the keys on the piano because the piano is manipulable to him, and specifically to his hand. He has the embodied skill that he can consistently perform; his ability to manipulate the keys is a bodily habit.

We are our habits, for they give us our manner of being-in-the-world; to change our habit is to change our very existence in the world. The pianist who acquires more advanced skill, experiences a new relationship to their instrument, to other players, and to their performance milieu. By changing a music therapist's habitual way of listening, one changes their perception of the therapeutic milieu, just as changing a client's habit of withdrawal from social relationships changes their perception of the world. Both of these are existential shifts in modes of being that open new possibilities for action and response. Through habit we dilate our experience of being-in-the-world (Merleau-Ponty 2012:145). In everyday lived experience, we navigate the world, interact with others, and take up new projects and activities through our phenomenal body and the habits it embodies. Thus, each new experience is articulated in relation to experiences I have already had and things that I already know, yet it is always open to new meanings.

Our body creates for itself expressive spaces, with its movements of thought and expression as unified gestures of being (Merleau-Ponty 2012:106). In music, expressive gesture is possible for the music therapist and the client alike. The versatility of music as a playful and artistic medium allows the smallest utterance to speak about the emotional life of the client in a way that words cannot. The music therapist is able to signify the pre-objective experience of the

world through music giving it an objective expression, structure, and form that can exist and be built upon by the therapist and the client. As the client becomes increasingly capable of musical expression, drawing upon their ability to play and be imaginative, they extend their existence outward to engage with the world. Indeed, experience is a modality of our total existence, a synchronization of our body with the thing we are experiencing, and to change our way of being with something is to change ourselves existentially. Playing music and synchronizing with the client changes everyone's experience of being-in-the-world.

Our body engages with the world through a variety of sensory modalities. Our pre-objective experience of the world is through synaesthetic perception, where our senses are undifferentiated and objects we perceive speak to all of our senses at once. The phenomenal or living body does not "hear" or "see" in this first pre-objective, pre-reflective instance of sensing; rather, it experiences the world as a unified impression, before any objectifications about particular qualities are made. Synaesthetic perception is the rule, not the exception in sense experience. Under the influence of mescaline intoxication which compromises rationality, Merleau-Ponty describes the experience of perception for the phenomenal living body:

...The sound of the flute gives rise to a blue-green colour, the sound of a metronome in the dark is expressed by gray patches, spatial intervals for vision corresponding to the temporal intervals of the sounds, the size of the patch to the intensity of the sound, and its height in space to the pitch of the sound...Everything happens as if he were seeing 'the barriers between the senses, established in the course of evolution, occasionally falling down'...The form of objects is not their geometrical shape: the form has a certain relation with their very nature and it speaks to all of our senses at the same time as it speaks to vision. (2012:238)

It is because of empiricism's dismissal of experience in favour of scientific knowledge that we have "unlearned seeing, hearing, and sensing in general in order to deduce what we ought to see, hear, or sense from our bodily organization and from the world as it is conceived by the physicist" (Merleau-Ponty 2012:238). What we take up in existence and transcend to render

it meaningful to us, thus, remains undetermined in our sensing experience, yet we only take up and signify that which our living body grasps.

Perception is an immediate, pre-objective and pre-reflective experience that belongs to the phenomenal body and is guided by intentionality. Merleau-Ponty argues that intentionality is the first way the body experiences the world before thought intervenes. Through experience, we interpret our world and make it meaningful; consciousness facilitates this interpretation. In the case of music therapy that is so much about the corporeal lived experience of sound, it is especially important to note that our experience and interpretation of something does not have to be a matter of objectification; it can happen solely within the body and its gesture:

In perception, we do not think the object and we do not think the thinking, we are directed toward the object and we merge with this body that knows more than we do about the world, about motives, and about the means available for accomplishing synthesis. (Merleau-Ponty 2012:248)

The phenomenal body relates to the world directly from its embodied position; this is our personal style of approaching the world. As will be discussed in Chapters Four and Five, the therapists' ostensible embodied clinical intentionality is about listening and responding to the client in helpful ways. Clinical intentionality shapes therapists' perception of therapy, just as phenomenological intentionality shapes experience; clients are approached with the goal to heal, and with a positive attitude of openness, receptivity, and faith in their potential.

Like bodily intentionality that moves the body of the music therapist in space, affective intentionality can also affect the therapist's perspective of a situation:

For example, love and desire are inner operations; they create their objects and it is clear that by doing so they can turn away from the real and, in this sense, they can trick us. And yet it seems impossible that they trick us with regard to themselves: from the moment I experience [éprouve] love, joy, or sadness, it is true that I love, that I am joyous, or that I am sad, even if the object does not in fact have the value that I currently invest it with... Within me, appearance is reality, and the being of consciousness consists in appearing to itself. (Merleau-Ponty 2012:396)

Unlike everyday life where we take for granted that our perception is complete and total, what is taken for granted in creative music therapy is that the therapist's perception is incomplete and that the world is indeterminate; there is always potential for something new to emerge.

A client's musical expression is at first felt synaesthetically, and through a subsequent secondary step of interpretation based upon the therapist's clinical intentionality they grasp what he or she "heard" or "saw" from the client. One must step out of the phenomenal experience, out of the flow of the present with the Other, for experience to become objective data that can be articulated in language (Merleau-Ponty 2012:230). Indeed, each person will agree on the objective object of the experience (*i.e.*, "the what": the client, the music), but each will have his or her own experience, given to him or her through their own embodied position and intention in the world.

"Hard to Reach" as a Disorder of Communication and the We-Relation

The ultimate goal of the music therapist is to restore social relationships and communication to the experience of the "hard to reach" client, yet this is a struggle when the client communicates so little about what their world is like. For the purposes of this study, "hard to reach" was used broadly to connote a type of client who had limited capability to express their thoughts, feelings, or experiences. These clients often were those who were locked in their own world because of neurological, behavioural, or emotional conditions that affected their ability to engage in a reciprocal social relationship with another human being, including parents, friends, and the music therapist. Music therapists use musical techniques to respond to what they sense about the client's mood, engagement in music, and capabilities. It is an integral part of the

therapeutic enterprise to expand their client's world by working at the "developmental threshold" or upper limits of their emotional, social, and physical capabilities.

The music therapist responds to what they perceive in that moment. In the clinical encounter, the music therapist may respond to the style (the totality of expression) of the client, given through their gestures, energy level, or physical appearance. However, the therapist's interpretation of the client's style is a product of the therapist's habitual body and consciousness; thrown forward into the present, the therapist takes up their client's gesture and attributes meaning or significance using a creative musical response.

The "hard to reach" client is not completely described by any one of Merleau-Ponty's cases of pathology that he presents in *Phenomenology of Perception* (2012), but there are general structures of experience that are important to highlight. The "hard to reach" client has a particular temporal and spatial structure to the world that is far narrower than that of the music therapist. The client lives in a narrow milieu, his or her present is affected by a "shriveled past and future" (Merleau-Ponty 2012:137). In so far as we have a body, we reserve the power to withdraw from the world at any time. The "hard to reach" client may be withdrawn from social relationships because symptoms limit expressive capabilities or the client might have withdrawn by choice and have embodied this as a habitual way of being-in-the-world.

As mentioned above, habits of movement for the normal person are lived through the phenomenal body, not the objective body, and these movements are performed unconsciously and naturally. Merleau-Ponty offers the case example of Schneider, a brain-damaged adult man whose communicative gesturing became disordered. Schneider's gestures lack melodic character because he must stop each time to command his body to do something as if it were a manipulable object before him. In order to perform a directed movement, he must acknowledge the location

of his arm and prepare for the gesture by assuming the entirety of the affective situation. For example, to perform a salute, Schneider must role-play being a soldier, adopting the persona as if he were one himself. To the patient, this is not make-believe acting, as it would be for the normal person; rather, it constitutes an existential shift, “within the affective situation of the world...the movement flows from this whole, just as in life” (Merleau-Ponty 2012:107).

In music therapy, the clients need the flow of music in order to create a new reality into which they can throw themselves and experiment with new expressions of communication. For the clients, these “concrete” movements take up their entire being; they are not reduced to their most significant elements as when a normal person performs them because they do not place themselves fully in the spirit of the situation. The normal individual can salute without having to “become” a soldier and he can imagine possibilities beyond that which is actually given:

The normal subject immediately has several ‘holds’ on his body. He does not have his body available merely as implicated in a concrete milieu, he is not merely open to real situations...The normal subject’s body is not merely ready to be mobilized by real situations that draw it toward themselves, it can also turn away from the world...Because the patient is enclosed in the actual, the pathological sense of touch needs its own movements in order to localize the stimuli and...the patient substitutes for recognition and tactile perception the laborious decoding of stimuli and the deduction from objects. For example, for a key to appear in my tactile experience as a key, touch must have a sort of fullness, a tactile field where isolated impressions can be integrated into a configuration, just as notes are no longer the points of passage of a melody; and the same viscosity of tactile givens that subjects the body to actual situations also reduces the object to a sum of successive ‘characteristics,’ reduces perception to an abstract signaling, reduces recognition to a rational synthesis or a probable conjecture, and strips the object of its carnal presence and its facticity. (Merleau-Ponty 2012:111)

The body delimits their world and has the power to create for itself new and different worlds (Merleau-Ponty 2012:109). In music, the client can adopt a world which provides a background for more creative gesture. Music’s flow connects the past, present, and future in such a way that it reintroduces melodic gesture into the client’s communication, linking together otherwise dislocated abstract movements which patients like Schneider experience as events in

themselves. The “hard to reach” client in music therapy has withdrawn from social relationships in his or her own way. Such people, Merleau-Ponty says, have made an existential choice, but reserve the right to act otherwise as per the indeterminacy of the world. When I lose the ability to use speech, the other person no longer exists as an interlocutor in my world: “The entire field of possibilities collapses, and I even cut myself off from the mode of communication and signification that is silence” (Merleau-Ponty 2012:165). Note that not speaking may be related to more factors in a person’s lived experience than language faculties alone.

The case example Merleau-Ponty uses to describe the body’s withdrawal from the social world is about a young woman with aphonia, who involuntarily lost her ability to speak yet regained it upon seeing the young man she loved. Her aphonia was not a mere refusal to speak; rather, it was a refusal of others, of the future, of her own situation:

By losing her voice, she does not express an ‘inner state’ on the outside, nor does she put on a ‘show’...To have lost one’s voice is not to keep quiet: one only keeps quiet when one can speak...The young woman never *stops* speaking; rather, she ‘loses’ her voice as one loses a memory... Through this generality we still “have” [memories], but just enough to hold them off at a distance from ourselves. For the patient...movement toward the future, the living present, or the past, and the power to learn, to mature, and to enter into communication with others are all somehow blocked by a bodily symptom; existence has become entangled and the body has become ‘life’s hiding place.’ For the patient, nothing ever happens, nothing takes on a sense and a form in his life – or, more precisely, nothing comes to pass but always identical ‘nows’; life flows back upon itself and history is dissolved into natural time. Even when the subject is normal and engaged in inter-human situations, insofar as he has a body, he continuously preserves the power to withdraw from it...But precisely because it can shut itself off from the world, my body is also what opens me up to the world and puts me into a situation there. The movement of existence toward others, toward the future, and toward the world can begin again, as a river thaws. The patient will rediscover her voice, not through an intellectual effort or through an abstract decree of the will, but through a conversion that gathers her entire body together, through a genuine gesture. Memory or voice are rediscovered when the body again opens to others or to the past, when it allows itself to be shot through by coexistence and when it again signifies (in the active sense) beyond itself. (Merleau-Ponty 2012:164-168)

The therapeutic alliance between the client and therapist aims at restoring the client's speech and expressive gesture. From the girl above who lost her voice, it is clear that this restoration must approach the entirety of the client's being-in-the-world from the point of his or her body as the thing that opens the client back into coexistence. The therapy session creates its own reality that is different from everyday life and allows the client to change his or her environment sufficiently that the stimuli which initially motivated the client to repress his or her capabilities disappear and all that remains is music as a social force. Phenomenal bodies are always in relation to the social, an aspect of the intersubjective world that is constant.

Phenomenologically, one can only escape the experience being-in-the-world into alternate forms of being, but never escape being completely. This is seen in the partial withdrawal of the "hard to reach" client from the world. Indeed, the body never folds back completely on itself, and the music therapist can play music that coaxes the client's body to respond and engage outwardly with the social:

I find in the sensible the proposition of a certain existential rhythm...and taking up this proposition and slipping into the existence that is thus suggested to me, I relate myself to an external being, whether it be to open myself up to it or to shut myself off from it.
(Merleau-Ponty 2012:221)

People are never fully alone because they have sensory faculties; they can perceive the world and also be perceived by the world around them. Solitude and communication are two aspects of a single phenomenon. Thus, even the rejection of communication is a form of communication, situated in relation to the social and projecting what is visible as well as what is concealed (Merleau-Ponty 2012:376). The reflected carries with it the unreflected in so far as a music therapist can take up and experience only that which is accessible to his or her body.

According to Schutz and Luckmann (1973), each of us lives in a shared life-world through which we relate to people and things in the world. The structure of the life-world has

gradations of possible intersubjective relationships that are often taken for granted. Other people appear to me in real-time, sharing with me a spatial and temporal community in a mutual “thou-orientation.” The other person’s body is perceivable and his or her gestures and expression are intelligible in such a way that the other’s thoughts, feelings, and meanings are accessible to me. When the other person’s body cannot verbally or physically communicate with me, as in the case of “hard to reach” clients, the thou-orientation is one sided.

The more desirable form of the thou-orientation is the “we-relation,” a reciprocal thou-orientation in which people meet face-to-face and understand one another. As I turn to you and you turn to me, our worlds become immediately meaningful to the other in a way that we can share in a flow of lived experience, and the life-world becomes one of common experience (Schutz and Luckmann 1973:63). Schutz and Luckmann argue that the we-relation is the fundamental relationship between human beings, the precondition for social existence. This relationship characterizes the therapeutic alliance. People whose bodies prevent them from entering we-relations become trapped in an anonymous form of the thou-orientation, a “they-relation,” with contemporaries, people who live in the same space and time, but whose consciousness is inaccessible. The “hard to reach” client’s limited bodily expression ensures that their life-world will only ever be populated by contemporaries. In turn, they will only ever be a contemporary to other people in the world, denying them the enrichment of the we-relation.

The Power of Sound: The Role of Music in Restoring Communication and the We-Relation

Communication is an event, just as each tone is an event (Berger and Luckmann 1991:161). Music’s unique phenomenological qualities have the power to change habits and to expand the world of the “hard to reach” client because playing music with another person is a

social relationship. Music is sensation and, as Merleau-Ponty says, sensation is coexistence. As social communion, musical expression speaks figuratively beyond its own theoretical structure of melody and harmony, giving objective form to emotions and experiences that belong to the pre-objective, pre-reflective experience of the phenomenal body.

The phenomenology of music uses the term “music” broadly to describe sound that follows the basic properties of music, such as rhythm and melody. In music therapy, the music need not be complex, nor does it need to be pleasant to the ear, but the client’s musical responses are always supported by an accompanying instrument, either piano or guitar. Making music in therapy can mean combining a variety of tonal expressions and rhythms with the voice and different instruments. It can also refer to a more organized event, where there is a musical framework established by the piano and different players contribute their own musical ideas, taking solos or continuing to play with the piano’s music. Utterances, shouts, cries, and wails are all considered meaningful components of the therapeutic process; they are not “music” as such, but they are a musical response. The smallest expression may follow a rhythmic pattern and the most aggressive wail can be in harmony or consonant with the musical atmosphere. Early in the development of Nordoff-Robbins it was observed that all children cry in the key of the music around them and when the tonality of the music shifts, so does the tonality of their crying.

Silence is an integral part of music as well; it is the rest or space between the notes, defining melodies, harmonies, and rhythmic statements. Sometimes this emptiness is more significant than the tones themselves because silence can make music more “permeable” and more open to a client’s attention and participation (Nordoff and Robbins 2007:193). Silence is as therapeutically effective as sound, particularly “active” silences which alleviate the pressure of continuous sensation, leaving space for the client to “be,” and choose when and how they want to

participate in co-activity. Silence is used cautiously as a clinical tool because it can intimidate; however, it can also reassure the client that the therapist is attentive and willing to wait for them (Nordoff and Robbins 2007:275). Thus, silence is an integral part of the phenomenology of music and the developing social relationship.

From Erwin Straus' essay, "The Forms of Spatiality" (1966), sensory experience is construed for the purposes of this thesis as a mode by which one himself or herself in relation to the world. In this relationship, we do not recognize ourselves and the Other as separate entities; rather, we experience ourselves and the world at the same time, and we do so differently depending on which sense modality we perceive. For Straus, each sense modality has its own set of significant sociological results. For example, sound is inclusive because it can be experienced by more than one person at a time, though necessarily from each person's unique perspective in the world. Further, sound is a pathic phenomenon which is experienced by the entire body, rather than merely heard by the ear (Straus 1966:12). By "pathic," Straus means to say that the sensation is directly and immediately experienced, and cannot easily be escaped; sound and smell are perceived the moment one walks into a space, and no matter where one moves in that space, one cannot shut out the sound or smell from perception. Moreover, sound and smell can be disconnected from their source and perceived at a distance from the site of production; an improvisation can be played and taken up, or "played off of" by anyone else in the room (as described in Chapter Two).

At the other end of the spectrum are more gnostic senses. By "gnostic," Straus means that the sensation is experienced more indirectly and one must turn their attention toward the source in order to perceive it. For example, sight requires that onlookers cast their eyes on the picture in order to seize the colours. When they are finished looking they can turn away from the picture,

but the colours cannot be disconnected from the painting, they stay there and wait for my gaze to return.

Thus, music is pathic and it fills the space, reaching out and including everyone therein.

While each person may experience the music somewhat differently, they can all agree that music is present. Further, the music's melody will simultaneously connect the flow of past, present, and future for everyone. Linking this to the earlier discussion about experiential structures, the phenomenology of music offers everyone a sense of inclusivity and temporal flow at the pre-objective level within the context of the world's indeterminacy.

Schutz (1976) argues that music is a social relationship, thus the reciprocal music-making constitutes a restoration of social communication as a face-to-face we-relation. When playing music with another person, Schutz says, there is a shared flux of experience (1976:175). During the creative process, a vivid present exists for both people who "tune in" to one another; they grow older together as long as the music lasts. The social relationship is presupposed whenever collective music-making happens. Schutz points to Western polyphonic music as possessing "the magic power of realizing by its specific musical means the possibility of living simultaneously in two or more fluxes of events" (1976:173).

In music-making, one can share in the present of the Other's stream of consciousness, anticipating the Other's music by reading co-performers' facial expressions, gestures with the instrument, and personal style expressed as their gait and posture (Schutz 1976:178). Music therapy seeks this level of relationship to effect therapeutic change. The freedom to synchronize with the client and spontaneously create music together is a powerful therapeutic tool. This aesthetic power to forge social relationships is important in the exploration of music therapists' experiences of working with "hard to reach" clients.

Thomas Clifton described the phenomenological properties of sound and the association of music to social relationships. In *Music as Heard* (1983), Clifton argues that musical meaning is immediately taken up by the body, expressing things about the Other and about ourselves (47, 65). He positions music as fundamentally play, wherein everyday dualisms like stimulus and response or spontaneity and order are blurred and transcended. While playing music, the nuance of words (e.g., lyrics) is subordinated to the connection of music and movement, which makes its own meaning through creative gesture (Clifton 1983:70-73). Echoing Clive's belief in the spiritual, being-to-being connection that affects therapeutic change (Chapter Two), and Frank and Frank's (1993) emphasis on the therapeutic relationship (Chapter One), it makes sense that the therapeutic milieu would rely on the experiential aspects of play and human connection. This basic connection between music and expression permits a new reality to be created in music, so that the therapist and client interact on the pre-objective, indeterminate level of experience.

In therapy, the element of play and musical frame switching by means of musical gesture and expression can be used to direct the client toward a reciprocal relationship. Within games like the "Play and Stop" described above, music therapists can define a moment of success, for example, when the client stops the chimes and vocalizes with the therapist. However, the entire session is play and the reality of the session knows only temporal and spatial boundaries that are indeterminate and ambiguous, allowing for connection in music. "Play," for Clifton, "is an irreducible element in the meaning of musical being" (1983:74). The world's indeterminate structure and infinite possibilities for action that we have available to us make this possible.

Bateson (1985) argues that for therapy to be successful, it must have a characteristic of play. He suggests that setting a psychological frame, explicitly or implicitly, offers the participant instructions for how to behave and how to interpret the actions of other people. When

the therapist alters these frames they adjust the client's possibilities for experiencing the world (1985:141). It is a clever and subtle move that allows enough ambiguity for the client to try out new behaviours. Through experimental action, or play, the rules are switched and new actions can be explored without fear of reprisal, as one might receive in the rule-bound everyday world (Bateson 1985:142). Therapy's co-activity is a shared project of establishing communication. The music therapist works in the pre-objective realm and switches between structured music and free-form improvisation to negotiate the indeterminacy of social communication and give an objective form to that which is felt pre-objectively.

The work of creativity relies upon openness. The world of positivism obviates the creative act, spontaneous expression, and play that guides therapy: its insistence on determinism and completeness chokes out any possibility of the unexpected, particularly the potential for therapeutic growth and development (Merleau-Ponty 2012:73). In music therapy, the therapist must interrupt the client's habitual actions that shut out social relationships, encouraging them instead to find new actions that restore mutuality and reciprocity. Just as the senses pose particular demands upon us and solicit ways of being-in-the-world, so, too, does the therapist's music evoke creative response from the client and vice versa.

An experiential milieu is created through music. The therapeutic relationship is supportive and promotes new possibilities for the client to express his or her existence in the world. As previously discussed, isolation and communication are two aspects of one phenomenon, and like the girl who lost her voice, it is possible to return to participating in social life; the body never folds back completely, it never completely withdraws, and with music the body can once again be shot through with coexistence (Merleau-Ponty 2012:369). In cases where the client immediately categorizes new objects as something to exclude from their world, music

is the only novel object from the outside that stands a chance of being integrated because sound does not allow itself to be ignored (Schutz and Luckmann 1973:11). Music includes the client in the atmosphere, changing their lived experience of the world, from their sense of time, to their mood and their relationship with other people. Without words, the therapist's expressions draw the client into the experience of making music, and the act of reaching out toward the world.

Music therapists enter the subjective world of the client using expressions that communicate their intention to understand the client's emotions and experiences in music. As will be discussed in Chapter Six, this finding clients in music and meeting them there is a process of approach and withdrawal, often with a great deal of resistance on the part of the client toward the music therapist's invitations. As the music therapy continues and improvisations engage the client, the musical relationship builds and the therapist and client begin to be able to work at the horizon of the client's world. The music is created to challenge the upper limits of the client's physical, emotional, and social capabilities. The therapist must creatively discern the horizon, where to go beyond it, and motivate the client to go there with them.

With regard to creativity and the phenomenology of music, it is important to consider the principles of indeterminacy and pre-objectivity and their relationship to spontaneous musical expression. The musical gesture or expression enables the therapist to make tangible the world of the possible, playful, and imaginative with the client. The world is open and indeterminate, thus, there are many possible ways that musical expression can be created and improvised. "The world," for Merleau-Ponty, "is mysterious, it has fissures and lacunae through which subjectivities are lodged" (2012:349). The figurative gesture is an expression of existence whereby the therapist or the client can capture an infinite number of ways of being-in-the-world and make them his or her own:

Bodily existence...is but the sketch of a genuine presence in the world...We might say that the body is the ‘hidden form of self-being’, or, reciprocally, that personal existence is the taking up and the manifestation of a being in a given situation...The body expresses total existence in this way, not that it is an external accompaniment of it, but because existence accomplishes itself in the body. (Merleau-Ponty 2012:169)

Gesture is indeed the manner of meeting the situation and living it, and musical expression of the body is an existential statement of one’s own position in the world (Merleau-Ponty 2012:195). Music is able to express different tonalities, idioms, moods, and energies; it can take up a factual situation and give it a style that means something to its listener beyond the objective space and time (Merleau-Ponty 2012:184). The experiential synchronization of the therapist with the client is an existential step for the therapist (later, the client develops the ability to synchronize with the therapist as his or her disorder is overcome). From years of training as musicians and as Nordoff-Robbins therapists, therapists have a personal embodied “know-how” that they draw on to meet the client’s needs. These clinical musical resources are present to the therapist to reckon with or count upon, posing as one of an infinite number of possible uses of his or her body and possible modulations of existence (Merleau-Ponty 2012:186-188).

The music therapist’s expression is successful if it opens a new field or new dimension of experience for the client (Merleau-Ponty 2012:188). Through the genuine gesture of speech (or musical expression, I argue), Merleau-Ponty states that we are able to transform our own being and deliver our meaning to another person who may not share our experience of the world; this is the power of expressive gesture between phenomenal bodies. Our existence shifts in order to coexist with the Other and make ourselves understood. The therapist shares the subjective world of the client (attunes to him or her), grasping an aspect of the client’s perspective to foster a therapeutic relationship; it is a modulation of existence, not an abdication of one’s position in the world. It is this reciprocity of gesture, a meeting in the middle and taking up the sense of the

Other's expression without giving up one's own position that is fundamental to communication. While the music therapist cannot live the experience of the client, and the client cannot live the experience of the therapist, the phenomenology of music connects everyone to a common social world. We will always find ourselves in relation to the social (Merleau-Ponty 2012:379).

This theoretical perspective will guide the analysis of the following ethnographic chapters which track the process of learning to become a music therapist and the performance of healing. The analyses will take up phenomenology's concepts of indeterminacy, pre-objectivity and pre-reflectivity, and synaesthetic perception to give insight into music therapists' experiences of training to listen deeply to clients and respond to them with creative clinical improvisation. Central to these discussions will be the phenomenology of music that is integral to therapists' creative use of musical resources to resolve disorders of communication and restore social relationships for clients. In the last chapter of this thesis, the problem of finding language to speak about the lived experience, the performance of healing, will be addressed alongside therapists' practice of documenting and reviewing therapy sessions.

Chapter Four

Musical Portraits: Learning to be a Music Therapist by Listening to the Other

The Nordoff-Robbins approach emphasizes that therapists' personal development and breadth of experience and skill are the primary means through which they will become most sensitive and responsive to their client's needs. Beth, a senior music therapist, confided that it is often difficult to train musicians because of their previous training that emphasized a self-critical attitude toward music. This seems to run counter to what one might expect to hear: that because of previous training a musician is more skilled than anyone else to do music therapy. Beth went on to explain that music therapy students are encouraged to take private music therapy as a way to connect with the process and understand it from the client's perspective. Musicians are very good at technical playing, but reaching someone in music in a clinical context requires another set of skills entirely, demanding a reversal of the usual inward focus to an extension outward to meet a client. In general, standard music education before music therapy does not involve learning to transform oneself through music. Beth explained, "I believe you can't take a person further than you can go yourself in the world...I don't think it's fair to ask a person to do something with you that you would never think of doing, which is revealing yourself in music to someone."

While I was in the field, I was encouraged by music therapists to try music therapy as a client, to experience it from the inside and gain a true experiential understanding. Being a trained musician, I wondered how I would have felt. Would I have been able to free myself from my musical training and experience the transformative power of music from within, as Beth believed was possible? Shelley, a music therapist, understood the great personal challenge of the Nordoff-Robbins approach, remarking, "It's a limited number of people, even music therapists, that can

do this particular kind of work; talk about a sub-sub-sub-specialty, right?” Unfortunately, the limits of my fieldwork schedule did not allow me to try music therapy sessions as a client, but I did get to experience the transformative power of music from the perspective of the music therapist. About a month and a half into my fieldwork I got the chance to work as a co-therapist.

During my fieldwork at Nordoff-Robbins Center for Music Therapy, I also had the opportunity to transcribe Clive Robbins’ fourteen-lecture series, “Introduction to Clinical Improvisational Music Therapy,” that he had delivered in the late 1990s to certification students at the Center. This chapter and the next will refer periodically to material presented in Clive’s lectures, not only because it is foundational to the Nordoff-Robbins approach, but also because it is an example of the training the music therapists with whom I worked received from Clive. Thus, these lectures explicate the therapeutic milieu which my informants embodied, however articulated through their particular lived experience of learning to listen as music therapists.

Listening is the first step in getting to know the needs of the client and listening therapeutically is a skill that is acquired with training and clinical experience. As musicians, music therapists listened one way, but as Nordoff-Robbins music therapists they often had to learn to listen in another way and with different goals in mind. Training their ears to hear therapeutic process and emotional states had to be added and integrated to their existing listening skills as musicians. Listening “deeply” with clinical intention is their responsibility as clinicians and also becomes a habit for them as people so much so that their perception is changed.

Within the context of the indeterminacy of the world, listening and responding to the client are so closely related that it may seem artificial to separate them; their division into two chapters must not be taken as a sign of experiential difference, rather as a distinction between training clinical listening skills and training clinical improvisation skills. Thus, listening in the

therapy session is addressed in this thesis before learning to respond to clients, which will be addressed in the following chapter. The current chapter will investigate the phenomenology of listening in music therapy in terms of pre-objective and objective experience, synaesthetic perception, and phenomenological intentionality. These concepts will be articulated in experiential narratives about the synaesthetic and pre-objective foundations of listening deeply, in the Creative Now, and with clinical intention. Finally, the role of silence (described in Chapter Two) will be discussed as a form of listening and active witnessing, and the intimate connection between listening and response will be highlighted.

Deep Listening as a Synaesthetic Practice

Phenomenologically, the concept of “deep listening” presents an interesting intersection of the structures of human experience. As described in Chapter Three, in the first instance, our experience is synaesthetic, meaning that we experience the world pre-objectively and pre-reflectively with our whole bodies, prior to differentiation into our senses. When the Other is perceived and experienced by the music therapist, they are perceived in their totality, in what Merleau-Ponty calls their “style.” The style of another person is grasped in the pre-objective; it is a general impression, or sense of someone that does not yet include the details about them:

A style is a certain way of handling situations that I identify or understand in an individual or for a writer by taking up the style for myself through a sort of mimicry, even if I am incapable of defining it; and the definition of a style, as accurate as it might be, never presents the exact equivalent and is only of interest to those who have already experienced the style. I experience the unity of the world just as I recognize a style. Moreover, the style of a person or of a town does not remain constant for me... Yet this is only the knowledge of things that varies. Almost unnoticeable upon my first glance, this knowledge is transformed through the unfolding of perception. (Merleau-Ponty 2012:342)

The music therapist learns to listen to the client, recognize his or her style, and translate that pre-objective impression of the client into music, or into the objective realm. The nature of perception is that it is always partial; grasping the entirety of someone's being is not possible phenomenologically. An important part of the therapists' listening training is learning to perceive and translate the client's essence in music. Deep listening and reflection of the client, as I will discuss, is a synaesthetic practice and requires the translation of pre-objective and pre-reflective experience into the objective and reflected. This practice also creates a shared experience where music therapists demonstrate their desire to understand and relate to the client through music.

The Nordoff-Robbins approach emphasizes listening deeply to the client in order to respond to them in the moment in a manner that will facilitate their social, emotional, and physical development. The "musical portrait" is a musical reflection of the client's personal essence or style of being-in-the-world, created by the music therapist from what they have perceived. The client's first session is called the intake session and it is unique because the music therapist is gathering information about the client that is not on the medical charts. These perceptions, as information, convey clients' style of being-in-the-world, how they approach their world and relate to other people and objects therein.

Shelley presented the concept of the "musical portrait" at the American Music Therapy Association conference to a group of music therapists, the majority of whom were not Nordoff-Robbins-trained music therapists. When she queried the group about what they thought the musical portrait was, they responded in terms of technique or creating an atmosphere or environment. She asserted that the musical portrait is bigger than technique and that it is even bigger than finding a way to meet someone who is limited in their responses. The class did an activity where they looked at someone and based on their perception of the other's personality

(energy and style), found music that reflected this essence. Shelley remarked, “Now that sounds a little crazy, doesn’t it? How can I put into music what I’m sensing about somebody, especially when I’m trying to go beyond activity?” She continued with an example of a session:

Okay, so they come in and they beat the drum right away, so I go with their beating because they’re giving me something to beat with. But we’re going bigger than that. I’m not just going for behaviours, I’m trying to develop a relationship and a way to develop a relationship with somebody is try to understand who they are. So, who are you? My goal is to send a message that I am trying to understand you, to understand who you are. If I can make that happen, everything else happens.

Synaesthetic perception is the rule in sensing experience, in everyday life and in music therapy. Phenomenologically, Shelley’s experience is not the result of an absence of sanity because existence is a totality that expresses itself as a style. The therapist has his or her own style which the client perceives, but it is the therapist’s task to express the client’s style in sound. Music therapists are always searching for the right sign to capture and objectively reflect aspects of the client. This technique treats the client’s style as if it were something tangible that could be handled like an object, cut out of a horizon of indeterminacy and given an independent existence. This approach is not entirely at odds with Merleau-Ponty, because the technique of music therapy does not espouse a method of existential dissection and packaging; rather, it is built upon uncertainty, searching, and finding only some of what is present for that moment. It is, of course, impossible to fully objectify the pre-objective, which will be addressed in Chapter Seven regarding language and therapy.

The problem of indeterminacy and determinacy can be located at the fundamental experiential paradox of being a body and having a body. As explained in Chapter Three, we are able to switch between synaesthetic, pre-objective experience of our lived body, and the objective and reflective experience because we can reflect upon our body as separate from us. In music therapy, the therapist listens with a lived body and relates to the client as a lived body.

This means that rather than inferring a separate, closed consciousness of the other, they look to their behaviours to interpret the world their client inhabits. After experiencing the client pre-objectively, the therapist reflects upon what the client has been doing and figures out not only what that means about the client's relationship to the music, but also where to go next to bring about a social relationship. I asked one music therapist if listening deeply was a psychic phenomenon, or a sort of sixth sense. Could they hear the client and know exactly what was happening in the client's world? Nancy's response surprised me. She said:

It's not a sixth sense. The five are enough as they are if they're used in an integrative way. It has to do with integration and integrating some subtle shift in someone's facial expression that you've seen with a shift in the music that you've heard. Being able to do this makes you better informed about the significance of these changes that you observe. You don't need a sixth sense...It is not only hearing, but perceiving more broadly. In some cases like working with the stroke clients listening to them may involve really feeling what they are trying to do, feeling the subtle impulses that are emanating from their attempts to move a part of the body that is not functioning.

The "hard to reach" client may give very little or no feedback whatsoever for the music therapist to perceive, yet there remains something that can be felt in the pre-objective moment of experience. Isolation and communication are bound together in experience, where one is always the shadow of the other as a potential on the horizon of existence; in one moment the Other is accessible to me and in the next moment they may not be accessible in the same way. The music therapist's task is, as Merleau-Ponty said, "To know how I can reach a point outside of myself and live the unreflected as such" (2012:376). For music therapists, this knowing may come from an embodied listening skill to carefully perceive and give meaning to the most subtle of responses from the client and musically amplifying the smallest expressions of being.

A few of the music therapists with whom I spoke said they had perfect pitch. Perfect pitch is taken in this thesis as an example of the phenomenon of synaesthetic perception that is well known in the music and science worlds. People with perfect pitch perceive sounds in

tandem with other senses, such as colours or textures, marking for the listener which specific tone they have heard. Other people have relative pitch, which is the ability to identify tones in relation to a known tone and can be developed through training. People with either ability report synaesthetic experience of music, such as hearing a particular musical key as warm and sunny, or dark and unsettling. These experiences of music are immediate and unified phenomenal relations to the world. I asked Albert if his perfect pitch made a difference in his work as a music therapist. He responded:

I think it's what do you do to build on it. I think you can be very effective with relative pitch. Sensitivity to sound is a good thing to have as a therapist. You know, it's interesting because I think a lot of therapists who are sensitive to sound are hypersensitive to sound. It comes not from a state of relaxation, but a state of arousal... There's the whole concept called the wounded healer and through this you can be much more sensitive and attuned to somebody when you are aware of your own damage, your own things that make you who you are, not just healthy things, but also not so healthy things.

In response to Albert's explanation, I thought that I needed new ears. Albert disagreed with me, saying, "I always had the ears. It's about which focus do I bring to the forefront." The relationship between hypersensitivity to sound, the medium through which the music therapist expresses understanding of the client's being, and the notion of being a "wounded healer" have a phenomenological association to one another. Each characterization constitutes a manner of being-in-the-world, a mode of experiencing the world with particular personal filters. As Frank and Frank (1993) note, an otherwise ambiguous situation may bring out a pre-reflective, personal reaction from the therapist if they identify with the client, over-empathizing with the client's wounds because of the therapist's own:

Personal vulnerability may motivate and enable a person to heal others, an insight embodied in the Greek myth of the centaur Chiron: Chiron, the teacher of Aesculapius, suffered from a wound that never healed... A person's own wounds may enhance the ability to empathize with the sufferings of others. In addition, the healer who has been cured may serve as a model and a source of hope to the sufferer... [Ultimately], a

psychotherapist's success depends on his or her genuine concern for the patient's welfare... The therapist should be willing to risk his own existence in the struggle for the freedom of his partner's. (165)

Listening to the client is the therapist's own project, so while the therapist cannot live the experience of the client exactly, he or she can give up enough of his or her own position to share in the experience of the client. Frank and Frank also noted that in healing rituals, shamans risk their own souls to find and recover those of the people they are trying to heal (1993:166). While music therapists did not speak of self-sacrifice or risking their souls, per se, they did talk about using empathy techniques to synchronize themselves with the client. This practice included pacing of one's energy and rhythm to match the energy and rhythm of the client. Nancy, a music therapist, described how she creates a musical portrait of the client by capturing the client's style:

The way they move, the way they breathe. It's a way of really sharing in their experience at a very visceral level. If you're improvising music that is reflecting these vital signs, all these aspects of their presence, then you're really sharing in those qualities yourself because you're in the musical experience of them.

Merleau-Ponty argues that our experience is a modality of our existence; it is a synchronization of our body with the thing we are experiencing. In the moment of pre-objective experience, the music therapist slips into the existence of the client, sympathizing with his or her condition in the world. Listening deeply to a client draws upon all of the music therapist's faculties and draws upon their personal background and training. It is a means through which the therapist can build a relationship with the client by expressing understanding of, and empathy for, the client in music, and in so doing, disclose the intersubjective relationship.

Learning to listen in music therapy does not come from classroom experience, but from the client. The client often will express what he or she needs from the therapist and it is incumbent upon the therapist to learn how to best treat this particular person. Lynn commented that getting to know a client reminded her of getting to know a new baby, "Which cry is about

hunger? Which is about discomfort? When somebody walks in and there's a tone that they're bringing in, that's their habitual pitch. I would want to find that, that's really important. That's a place to start." There is no method in this approach to music therapy that diagnoses the clients' expressions systematically. The theory of intervals makes a move toward determinacy, but remains situated in the indeterminate and the creative. The music therapist learns to discern what the client is saying in even the most foreign expressions, including the absence of expression.

For Nancy, the therapist is always learning to discern the client's communicative intent. In this regard history helps to contextualize the client's response and make more accurate inferences:

Sometimes they're vocalizing in an existing context, so they're trying to match what we're putting out. There's already a context. But also the emotional state is conveyed through the voice [by] the degree of tension in it. And you develop a baseline when you've been with a client for a while about how their voice sounds across a variety of conditions. It's like a built-in experiment. Sometimes the tension is due more to their physical state than their emotional state, you know, but if you've heard them under a number of conditions you can kind of filter through that.

Listening deeply puts the therapist in a position of using his or her whole body, clinical sensibilities, and any past experience with the client to decipher what the client is trying to communicate. The idea of therapy as being an ongoing set of experiments in interpretation speaks to the continuous interaction between the pre-reflective and reflective experience: in the former, the music therapist listens fully to what the client is expressing; in the latter, they evaluate and judge meaning and relationships between therapeutic events in retrospect. To "filter through" possible meaning is a reflective process that moves the therapist out of the synaesthetic, pre-objective perception toward an analysis of the client objectively. Engaging with the client pre-objectively entails an immediate experience in which the client's expression is taken as a full expression of their being. As mentioned above, the problem of finding the words to describe

objectively that which is experienced pre-objectively is an ongoing challenge for music therapists, and one that will be taken up in Chapter Seven.

The synaesthetic experience of listening is an immediate experience of the Other's style of being-in-the-world. It is not just the ear that hears the Other, it is the whole body. Music therapists train their bodies to be open and receptive to the client in a way they had not necessarily trained their bodies as they perfected themselves as musicians. Lynn described her own experience of being trained in a new way to hear the client:

I was already a music therapist and when I studied the Nordoff-Robbins approach in more depth my listening *definitely* changed; my listening, and observing, and seeing things as *potential* ways to meet in music, this can be movement, as well as musical response. It's so important, because some of our clients do not speak, right? He doesn't come in and say, 'I had a hard week,' he [vocalizes]...Okay, I'm going to take that as a deep expression from you, and see how I can make music with you and be with you.

Lynn's experience points to the synaesthetic nature of listening deeply to a client. It is not simply about using the ears to hear; rather, it is a complex experience of the client in the moment that opens a point of access between herself and the client. The word "depth" in itself is a visual idea that describes an increased perceptual field, suggesting a greater experience in terms of amount and refinement, as well as significance of that experience. The idea of listening deeply to someone else calls to mind a more intimate and meaningful experience, in which their hidden feelings and motivations are shared. Lynn's experience also reveals that listening deeply is an experience of possibilities. The change in how she listens is not a shift that assures greater diagnostic accuracy; rather, it is a shift that assures greater ambiguity and indeterminacy. Listening in this way opens the field to finding social relationship and taking new existential steps toward communication in the therapeutic relationship.

Poised in the Creative Now: Training Habits of Preparation and Perception

Nordoff-Robbins trainees embark on their certification training with existing embodied knowledge of how to play their instrument and how music works, but they must learn new habits of preparation and perception that best suit their work in the therapeutic milieu. Years of intensive technical musical training have been absorbed by musician's bodies; they have learned to attend to music in a certain way and judge it with a particular goal in mind. The trained musician's habits allow them to "just know" how to do something, be it playing or listening. However, no matter how much technical facility one acquires, one's perspective on the world is necessarily partial and incomplete, and our usual way of doing things (our habits) may even occlude other perspectives. Music therapists must augment their habits or learn new habits in order to incorporate the therapeutic way of listening into their approach to the world.

Habits are our vehicles of being-in-the-world and our means for uniting with a milieu and engaging with our projects therein (Merleau-Ponty 2012:84). Musicians can train their ears to identify ascending and descending intervals, chordal structures, and polyphonic voices, as described above in cases of relative and perfect pitch, but training the ears to perceive another person's existential experience is different and this skill belongs to the province of the music therapist. Learning to be a music therapist means acquiring new habits that are either supported by existing habits, or are in conflict with already embodied habits. As mentioned earlier in the chapter, musicians' constant critical self-examination, self-admonition, and interminable quest for perfection pushed them toward exceptional technical facility, but for therapeutic purposes these habits interfere with reaching out to someone else in music creatively. Learning to listen deeply requires training and ultimately shifts the therapist's relation to their own music, the client's music, and the therapist's embodied experience of the world.

Where listening deeply is a mode of being-in-the-world, the therapist learns to be open to the horizon of possibilities, and entrains an embodied knowledge that “just knows it may not know.” Listening deeply is learned in classes and then the skill is mobilized during the therapy session in what is called being “poised in the Creative Now.” This constitutes a trained skill that music therapists must practice repeatedly. Being poised, for Clive, did not mean passively balanced; rather, poised meant being ready to act, like a batter at the plate or a tennis player at the baseline. Clive spoke about this in the following way:

There is this energy, this life, this vitality that belongs to music. Music's got to be exciting, it's living! It's not something you churn out like ground beef. It's alive, it's colourful! It's going to change you emotionally. It's going to change you as an individual. It's going to make you feel differently about being alive... You have to develop faith in the power of music. If you don't have it, you're going to get it, or you're going to go into another profession.

The perspective of music as life force that is existentially transformative, and the importance of this perspective to the work of the therapist are made clear in this statement. In lectures, Clive taught that there are six aspects of clinical musicianship that music therapists train their bodies to perform: intuition, sensitivity, and creative spontaneity which they already have as inner gifts as living human beings; to these gifts they add the acquired habits of controlled intention, clinical responsibility, and musical technique. Learning to listen deeply trains a new habit of perception, a particular application of the music therapist’s existing capacity for intuition, sensitivity, and creativity.

The Nordoff-Robbins approach focuses on learning to be aware of the elements and structures of music in terms of their meaning for one’s relation to the world. These become essential tools for listening to the client and creating a musical environment, and offering musical stimuli that engage the client and encourage him or her toward establishing a

relationship with the music therapist. Lynn recalled an exercise that she taught to Nordoff-Robbins trainees:

In classes, we do an exercise in which we play and listen carefully to intervals and ask people to write down any impressions. Often there are so many overlaps. And then often there are particular reactions, there's something that's particular to that personality that's different for each person. So, people would say "tense" or "shuttering" for a minor second, but someone might also add "exciting," while someone else might say "scary." The response is both archetypal and particular to the person, that's my belief.

Music appears to create a common milieu, a shared world in which one body can slip into another's perception and understand what they intend to communicate. Sharing and reciprocity within a milieu in this way are foundational to social communication. Lynn's training exercise highlights the synaesthetic nature of listening deeply and the relationship people have to the world through music. Objectifications such as "shuttering" and "exciting" metaphorically describe the pre-objective immediate experience of individuals when a musical environment is created. Music has the power to colour one's experience of one's self, of other people, and of an ambiguous situation. Like movies that use a particular soundtrack to amplify the emotional quality of the visual scene, the audience reacts to the music in a shared way, but articulated through their own lived experience. Everyone may feel tense, but each person will have their own visceral reaction; one may find their palms sweaty, while another may feel cold. The therapist learns to listen to the client and to recognize personal reactions as indicators of the client's experience. Nancy described what listening to different modes is like for her:

What's interesting about the modes is that I feel like each one has a different flavor. That's very vague...But, it's not even conscious analysis: Oh, this is a minor scale with a raised sixth, so it must be Dorian, or a scale with a flat second, so it must be Phrygian. It's more the atmosphere that's created.

Training the body to listen deeply and recognize its responses to what is experienced conditions an embodied knowledge base from which the therapist works in the session. The

training includes a great deal of objective and reflective work, much like training as a musician, and the performance of therapy comes from this absorbed training in the body. In session, music therapists do not actively think about what specific tones or intervals do in the way they thought about them in lecture or practice; instead, they trust in their internalized sense of what to do and when to do it. The spontaneous and improvised nature of the sessions makes specific preparation for each moment of the session impossible: therapists must go with the flow and trust themselves to listen and respond to the client in a helpful way. Shelley explained that she must trust herself to do what is needed in the session because preparation was not an option:

There's no way I can prepare for this, except to be present with my own feeling and to be aware of that and to know that and to do some self-acknowledging, self-affirming: 'I can do this, I have the tools, I can make this happen.' Inner calming. It doesn't get any easier. Because I'm humbled by it, it keeps me caring, that's important. I'll never master this, with each new person it's a new adventure. I learn more about myself and about the other person. It's hard for me, maybe it's not hard for other people, but it's hard for me.

Embodied knowledge from habit is not "I think that"; it is "I can" (Merleau-Ponty 2012:139). The music therapist knows that they cannot know what is to come in the session or what skills they will need to draw upon to meet the client's needs, but their training has conditioned them to be present and poised in the Creative Now. Their certainty in uncertainty lends the therapist a confidence in their healing performance. Regarding her listening and response to a client in session, Lynn said:

There's no disputing that an octave, or a unison, or a third sounds different than a tri-tone, and what that is to each person in each context I can't say, and I can't say there's a formula that this interval is going to do that. But I have enough experience with music to say, 'this is probably a better choice than that' or 'this fifth is going to give a sense of grounding to the music for this person who's out of control, rather than playing minor seconds.'

As described previously, the early Nordoff-Robbins approach was based on theories about intervals that described particular relationships between the Self and the world. These

accounts of the intervals suggested that each interval had a particular and determinate association to the client's world. Theory is often different from practice, and in Paul and Clive's early work these intervals were used creatively without constant attention to their meaning. What was important was that the therapist understood that the perceived or played tones were powerful and each one could be more or less significant for an individual client's process; therapists have to train their ears (inculcate a habit) to identify intervals as effortlessly as they create them on their instrument, but to do so creatively with clinical goals in mind (Nordoff and Robbins 2007:488). Habit, for Merleau-Ponty, is not a reflex; there is always distance and freedom to choose one's response to the world (2012:89). Lynn's account shows that the therapy performance is more indeterminate and open than one might expect from a musicological standpoint. Creative clinical improvisation habits are a matter of technical fluency and awareness of therapeutic meaning.

In the Creative Now, embodied knowledge about music trains a particular perception of the client's style and response. For example, a client's response is interpreted as one of relating to the music therapist when the client sings a tone, often the tonic (the first) or the dominant (the fifth) of the mode's scale. Nancy observed that even in a fairly trained system of interpretation, there remains indeterminacy about what the client is really doing. “[If the] therapist switches to Dorian, [the client will] notice that the total center has moved. This could mean a level of awareness and contact, or nothing and the client is still in their own world.” In session, the technical seems to be forgotten or to disappear, but it does not disappear in the sense that it is lost or not used; rather, it disappears in the sense that it is absorbed into the music therapist's body and way of performing music therapy. In the pre-objective, pre-reflective experience of the Creative Now, training is embodied and becomes the background from which the therapist listens and responds creatively to the client.

Clinical Intentionality as a Form of Phenomenological Intentionality

When I explained my frustration with not being able to hear as therapists heard, music therapists introduced me to the concept of clinical intention. Like phenomenological intentionality, discussed in Chapter Three, clinical intentionality expresses a general orientation and approach to the world and one's relation to the clients they encounter; therapists listen and respond to clients with the aim to heal. The practice of clinical intentionality is a defining feature of the therapeutic milieu, without which the healing prerogative would not be present. Referring back to Bateson's concept of framing (1985), clinical intentionality sets up the context of the therapy session for the music therapist and shapes his or her perception of the music. This affects how the therapist listens, responds, and interprets the client's music: as process, rather than as aesthetic musical ability. As part of clinical musicianship and responsibility, this intention to help the client differentiates the improvising music therapist from the improvising jazz musician. Music therapy is not a concert experience, it is a healing experience driven by goals and the therapist's responsibility to meet the client's needs in the moment. Clive addressed clinical responsibility in his lectures to students, asserting:

We're not just going to enjoy ourselves, indulge ourselves, get carried away with how clever we are, or what a great time we're having, or how nicely I can play this music. We're putting it at the service of our client.

Thus, while the client in music therapy may enjoy a playful experience of music-making, the music therapist is always working to ensure clinical goals are realized. Their performance is more often than not spontaneous and creative; anything can happen, but that anything is guided by their fundamental intention to heal.

The culture of therapy sets certain norms that condition responses to and interpretations of the milieu. Since I was not habituated in the milieu of music therapy, I felt as though I was not

able to “hear” as the music therapists “heard,” to listen as they listened. Albert explained the difference between just listening and listening with clinical intention:

I think that our perceptions of sound change as we hear the intention in the sound. So, my whole reaction to the aesthetic of something is different when I consider the meaning of somebody’s sound. This becomes part of how I listen. So when I hear somebody’s process in the music, when I hear a breakthrough for somebody, or if I hear something expressive in a way. The Edward material, same thing, people have strong reactions to that. So, if I listen to that, if I went to a concert hall and I heard [the client] singing, and he cries and sings that way, I would feel, ‘Oh my god, he’s hurting my ears,’ but when I’m in the session creating music with him and knowing that not only am I witnessing that, I’m facilitating it, I am stimulating him, I am consoling him with the music, I’m asking her to go further with the music. So, I’m not listening to it as a concert as I’m sitting there as a musician thinking, oh that sounds terrible, that’s not a part of my experience. I’m in it, trying to see what can I, how could I respond to this that makes it even more powerful, or bringing it to a close, or whatever I think needs to happen. I’m listening to it clinically, and with those ears I’m not judging it...So, when I’m hearing him sing one note that’s kind of flat, I’m not responding to that like ‘Oh my God that sounds so bad,’ I’m thinking, ‘How can I move her from this? Where can I go? Which note can I bring in that will stimulate [the client] to move in one direction or the other?’

The clinical thought that arises during the music therapist’s experience of listening is a sort of living thought, according to Merleau-Ponty. It is neither categorization, nor judgment; rather, it is a thought in the moment that reflects the dimensions of the therapist’s experience of the client and what they need to do next to guide the client closer to engagement and social relationship. The thought is a conscious reflective action and interpretation of perception, thus it constitutes a secondary existential step for the music therapist. According to Merleau-Ponty, acquired thoughts are cut out of a primordial world from which experience is taken up and signified in the synaesthetic moment (2012:131). Interestingly, the clinical thought seems to occur as the music is flowing, almost as part of the flow itself. The performance of the experienced music therapist is not disrupted by a clinical thought that arises during the session.

The acquired thought is part of a “world of thoughts,” for Merleau-Ponty. Said otherwise, the clinical thought is part of the clinical intention and trained knowledge about music therapy.

During the session, the therapist attributes meaning to the client's gestures and intuits where to direct the session musically based on their embodied knowledge gained in their training. From training, a world of thoughts is accessible in any clinical moment, working as an internalized resource that is always grounded in clinical intention: music in service of the client.

Consciousness is always *of* something, and it is always ambiguous. Where I heard noise, the music therapists heard process because of their training. When I filmed sessions at the Center or reviewed old session tapes from the early work of Paul and Clive, I did not hear the therapeutic work. In the early "Edward" case, for example, I heard only noise, not the communicative "singing-crying" of the emerging Music Child that was in tune with Paul's piano music. Paul and Clive each experienced clients through their own particular embodied knowledge of anthroposophy and beliefs about the potential of music to heal children with special needs. This perspective about music and relation to the world guided their clinical work; however, their work as lecturers may have required a different intentionality. Our consciousness provides itself with one or many worlds within which the acquired is taken up in a new movement of thought at the same time as it reaffirms its own situatedness in a milieu (Merleau-Ponty 2012:132). The music therapy session is a unique enclave of lived experience that lasts half an hour to an hour. The intentionality one has in a session is likely unique to that enclave but does not guide behaviour in routine everyday life.

It would be an error to assume that clinical intentionality is a homogeneous screen through which music therapists view the world. The therapeutic milieu is special and its nuances and variegations of clinical intentionality may vary depending on whether the music therapist is relating to the client, the other therapist in the room, or something else about the clinical situation. This is, unfortunately, beyond the scope of this thesis. It is sufficient to argue that

clinical intentionality is an embodied perspective that music therapists inhabit in order to heal their clients and that clinical thought derived from this intentionality should not interrupt the flow of therapy, but maintain it.

Silence in Music Therapy: Learning to Listen and to Keep Listening

It may be surprising that there are times when the creative improvisational music therapist chooses to remain silent and keep listening. The music therapist has committed to living in an “inter-world” with the client, but this remains a project. Coexistence must be lived by each person in his or her phenomenal body, and there must be a common world established in order for communication to exist. For the music therapist, the Other’s behaviour and utterances belong to the Other and are not lived by the music therapist. The music-making combines the backgrounds of the two subjectivities and projects a “single” world (Merleau-Ponty 2012:373). Music helps to establish a common ground.

Thus, when music therapists choose to remain silent they are not withdrawing completely; they remain situated in the primordial atmosphere of the social. They escape being into more being, just as the “hard to reach” client does in their own silence, bound to the social. The experience of the other living being continues, and in silence, therapists offer the client as much room as they have made for themselves (Merleau-Ponty 2012:373).

Music therapists spoke of many types of silences: silences of expectation, silences of resolution, and silences of reflection. As discussed in Chapter Two, silence is an important part of music therapy: different from sound, but just as therapeutically effective. Each silence is different and has a unique quality that contributes differently to the sense of the healing project. Therapeutically effective silences, whether brief or prolonged, are hardly moments of passivity;

they create anticipation and evoke new response from the client. In Nordoff-Robbins, an approach that believes the potential has yet to be seen, silence is a powerful tool that therapists use to invite mutuality and learn more about the client. Silence gives clients space to enter into the musical relationship in their own time or to process their experience in therapy. When I spoke with Albert, he described learning to hold the tension of a moment, trusting something would emerge:

As you get more experience you're able to hold the tension of nothing happening and kind of trusting the moment that something will emerge. And early on you try to do things and you think the best thing is *to do* [rather than not do]. So I think that's true and it's not bad, it's just the way it is.

Training and experience of performing therapy gave music therapists an internalized sense of when to play and when to remain silent. There is an embodied knowledge that comes from training as well as an embodied faith that one can make sense of what is perceived through interpretation. Listening is a form of active gesture, playing a sort of witness to the client's process in music. Sometimes longer moments of silence or simply not playing music is a way for the therapist to withdraw and give the client an opportunity to approach, which is an important part of building reciprocity (discussed in Chapter Six). Music that is too full of the therapist's sound pushes out opportunity for the client to participate and for mutuality and intersubjectivity to be achieved. Lynn described how she has used silence in her therapy sessions:

Over the years I have developed the ability to not play every moment, as Clive would say, music becomes like wallpaper, there's no room for the client. Silence is often the thing that's going to spur a response... So after a short phrase, 'Ba ba ba,' or 'Wel-come,' you may hear an 'Oh' or a 'Hih' or something... You may have someone who plays every beat like this [motioning] and they're putting their all into it, they're trying to engage, but there's no space. There's no place for the person to answer.

Silence in music therapy is a way to evoke response, to demand reciprocal engagement, and it is also a way to ensure that a response is given the space to come through on its own. The

client is seen in a partial view, indeterminate, and reflecting only the faces the music therapist is attuned to see. Even synaesthetic experience is partial and indeterminate. Silence can pose a question to the client that they must answer in sound, or it can give the client space to ask the therapist questions of their own. Like in the case of the young woman with aphonia, described in Chapter Three, silence in music therapy is a mode of being-in-the-world, an existential step away from the other and social communication. By waiting to answer, the therapist withdraws from the client, giving the client space to approach the world in an existential step. Albert described a session in which his premature interruption disrupted the therapeutic process for the client:

Remember when I was talking about Jerry, and the first time he had this very emotional experience he said, ‘Look, I don’t have feelings, I analyze things, I want to be more integrated, I want to have emotional experiences that mean something to me,’ and so we’re going to and all of a sudden he has it, and right afterwards, instead of being silent, I said, ‘Tell me more.’ And he said, ‘That was heavy stuff,’ right, he said ‘that was heavy stuff.’ Now, of course I had to respond because he’s talking to me, so it wasn’t like it was a big mistake, but in retrospect I wish I wouldn’t have said anything. You know, I could have not verbally communicated ‘Yah,’ or ‘I’m with you.’ Instead I said, ‘Say more’ and when I said, ‘Say more’ it got him thinking and then it was no longer about his experience, but his trying to figure out if this is what humankind feels when they play the horn. It became more of an intellectual discourse about what’s the effect of blowing a horn for people? And so the next time after he had an experience, I purposely left the sounds out and I didn’t say anything. So, I think silence is very important.

Although the music therapist is in some ways conditioned to live experience with clinical thoughts, the client, as in Jerry’s case, is concerned more with staying in the phenomenal lived experience of therapy. The “hard to reach” client who has emerged from isolation and taken the existential step to open back up onto the social world has made great therapeutic strides. This client must be allowed to hold the tension of the indeterminacy of their existence as long as he or she needs. It is as though the music therapist’s sound can close the indeterminacy in the very moment the client is searching and expanding the horizons of their world.

Therapeutic change occurs as an existential shift, and thus takes place within the pre-objective, indeterminate experience. Music therapists experience the client first as a synaesthetic phenomenon shaped by their clinical intention to heal. They express their sense of the client musically, shifting with combinations of tones and silences between the pre-objective and objective realms. Listening is natural for all humans, but for music therapists listening deeply is a skill they must learn and practice. Clinical intention shapes the music therapist's perception of sound such that therapeutic process is perceived, rather than pure aesthetics. This way of listening becomes a habit of fluency in music and therapeutic interpretation. Silence has a very special role in music therapy, where it expresses most poignantly the unity of experience, where active listening and silent response intertwine. With experience, music therapists learn to use silence for best therapeutic effect and evoke more information from their client that will help them respond to their client musically. In the next chapter, the experience of learning the skills of creative clinical improvisation will be discussed.

Chapter Five

Creative Clinical Improvisation: Learning to Respond to the Other

Music therapists use improvisation to connect with “hard to reach” clients and restore communication and social relationship. Learning to practice clinical musicianship, as discussed in the previous chapter, entails learning the art and craft of music in the healing performance. For Clive, music therapy constituted a double art: *It is the art of music applied to the art of bringing the healing transformation to clients. Isn’t that wonderful? It’s a double whammy!* Clinical improvisation is a skill that is learned in Nordoff-Robbins training. The therapist must develop a technical facility on their instrument to play a variety of musical resources while maintaining the awareness to use these resources to best clinical effect. Improvisation skills are mastered outside the clinical space (until they are a habit for the hands), then used creatively in the session. Phenomenologically, listening deeply and responding are unique active experiences – related, but distinct. When responding, the therapist actively creates a musical environment and a present into which the therapist and client throw themselves. From Bruscia’s (1987) description of Nordoff-Robbins as “creative” music therapy in the Introduction, recall that the therapist is fully engaged, creating and improvising new musical resources and directing the client’s progress.

In this chapter, as in the previous one, Clive’s lecture material will be brought to the fore as a way to elucidate the background and training of music therapists with whom I worked, all of whom had trained with Clive. One of the aspects of clinical musicianship that Clive taught was about intuition and inspiration and their relationship to the creative act; the moment of spontaneous musical expression in response to the client which could then be developed through improvisation to work toward clinical goals. Clive explained:

You cannot have an artistic creation without this intuitive force working in you that says, ‘I must go this way here, I must do that, or I can balance that with that, or bring this

back... [This] comes from your musical self, nowhere else; the place where authentic spontaneity arises. If you choose someone else's music, you've made that choice; that's a form of spontaneity; but the creative spontaneity has to come out of how you're reacting to the situation, out of your personal responsiveness...you could not have conceived of [the musical expression] ahead of the moment of creation in the clinical moment.

Clive believed that music therapists needed to not only recognize their intuition, but also be brave enough to follow it. Synaesthetic perception combined with an embodied knowledge of how to respond in the moment is the foundation for the therapist's creative spontaneous expression. "It's not magic," said Beth, a senior music therapist, "but I would say an intuitive ability to reach the child with the music. It's like some people just have that instinctive intuition of what to play and when." From intuitive creative spontaneity emerges inspiration, the ability to perceive the client's essence and create music to reflect it. The emphasis on versatility, flexibility, and creative client-centered music-making underscores Nordoff-Robbins as an approach, rather than a method. Creativity and spontaneous expression cannot be pre-planned, nor prescribed. The creative process is intersubjective: the therapists may introduce musical material, but the client's response will develop the expression into something new between them.

Therapeutic change takes place at the existential level through the musical transformation of pre-objective experience into something objective. In addition to the different instruments used to offer a variety of listening and playing experience to myriad timbres, the therapist's use of melody, chordal progressions and inversions, tempi, and dynamics to meet the client's need is profoundly important. Clive taught that the therapist's ability to respond well to the client comes from their musical sensitivity, training, and understanding of the healing power of music: *How you live in music and how music lives in you.*

In addition to creative spontaneity, the therapist uses expressive spontaneity. This is related to the type of creative act where the therapist does not create brand new material, but

“plays off of,” or improvises upon, existing material; it is a process of trial and error where some improvisations will mean more to the client than others. As the basis for improvisation, some therapists at the Center brought in popular songs to which they added musical layers to engage the client. The therapist chooses how much structure versus creative freedom they want to bring to a session. They may improvise a song for the client that fits the relationship so well that the song is brought back multiple times in the session and transcribed for future use. Effective improvisations become “clinical themes.” As will be discussed in this chapter, themes provide structure without inhibiting creative expression. Inherent in the therapeutic work between pre-objective and objective is a negotiation between structure and freedom; a dance between musicological structure and spontaneous expression that fits the clinical moment.

This chapter will consider the concept of creativity in therapy and music therapists’ experiences of creative clinical improvisation. Phenomenologically, the creative musical response to the Other brings to the fore the issue of how therapists use their creativity to spontaneously produce new music out of conventional musical resources. Like listening to the Other, responding to the Other is a synaesthetic experience; the creative act draws from the whole body as an undifferentiated perception of the world. Accordingly, this chapter will investigate the embodied experience of intuition and creativity, and the negotiation of musical structure and freedom. The conversation among therapists regarding the universality and subjectivity of music will be considered in relation to pre-objective creative experience.

The Creative Act: Expression and Flow between Pre-Objective and Objective

Clinical improvisation is a unified expression that gives objective form to that which is felt pre-objectively, including experiences of intuition and inspiration. Creativity is experienced

by music therapists as both an independent skill that requires training and practice, and as a co-creative act with the client; the latter will be discussed further on in this section in terms of its relation to empathy. In one of my first meetings with Albert, a senior music therapist, I recall the moment in our conversation about creativity as a learned skill where he asked me with great excitement, “How do you teach someone to be creative?!” I was unsure whether he was referring to the client or the music therapy trainee, nor was I sure what “being creative” meant for therapy. To contextualize Albert’s question I will present what Clive taught students about creativity, and the concept of the creative act as an immediate, unified flow of thought and expression.

In the eighth lecture of his series, Clive placed an interesting diagram on the overhead projector that looked like two upright footballs next to each other. In the center stood the words “Creative Now,” on the far edge of the right football was written the word “Creative,” on the far edge of the left football the word “Created.” The Creative, he said, is the unknown, the unpredictable, what *may* become (the non-physical). The Created is everything that is known, that is realized, predictable, and that *has* become (the physical). The words “intuition” and “inspiration” belonged to the Creative side of the diagram, while the words “expression” and “form” belonged to that which has been Created. The therapist is poised in the Creative Now, at the point where the creative and the created make contact. Clive described:

You’re living right there in the now. You’re mediating between what is unknown and potential and what is going to be formed, made factual and realized... You go through intuition, then you pass into inspiration. Your intuition is going to say, I must do this, I want to do this. I’ve got a hunch to go in this direction. Then your music comes in to meet that situation. You have that inspiration. Immediately, it becomes an expression – becomes an expression of your presence, your message to your client, your reflection, your moving of the client, and that takes form. And as such it’s now got stability that the creativity can move in and work in and change it and develop it... [Clasping his hands together, with his fingers interlocked] The creative act goes from the intuition, to the inspiration, to the expression.... It doesn’t go click, click, click. It’s one flow of energy, one flow of will.... You think and you act.

Ever-poised in the Creative Now, the creative process operates all the time: intuition is acted upon before you can think of it. Clive's explanation of the creative act, from intuition and inspiration through expression, supports Merleau-Ponty's assertion that in human experience, thought and expression are inseparable. For the music therapist, the simultaneity of the "creative" and "created" is a manner of meeting the situation and living it (Merleau-Ponty 2012:195). The therapist suffers the same existential experience as the orator described by Merleau-Ponty: the orator does not think prior to speaking, nor while he is speaking, for his speech is his thought. The listener does not think while listening either; if the orator's expression is successful it will be all that the listener grasps in that moment:

[Speech] fulfill[s] our expectation exactly...but we would not have been capable of predicting it, and we are possessed by it. The end of the speech or of the text will be the lifting of a spell. It is then that thoughts about the speech or text will be able to arise. (Merleau-Ponty 2012:185)

Like speech, music is a genuine gesture that bears a style and transforms one's own existence. For the music therapist in the Creative Now, the moment of creation is a genuine expression of being-in-the-world.

Music is flexible and less bounded by representational and syntactic conventions than language. This is important for clients with extremely limited linguistic capacities. Musical tones and rhythms can be formed and reformed in improvisation to meet the moment and the client in his or her particular style without adherence to an ordained set of grammatical rules. Therapists have a host of embodied musical resources with which they create new, sometimes unconventional expressions. The resources are part of them, just like their vocabulary:

Like the objects behind my back or like the horizon of the village surrounding my house; I reckon with them or I count upon them, but I have no 'verbal image' of them. If they persist in me...[they do so] as a very precise and very general emotional essence detached from its empirical origins. (Merleau-Ponty 2012:186)

Scales, modes, and rhythmic patterns entrained in their body, represent many possible uses of their body and modulations of existence in a given moment. Each present is formed from an ambiguous temporality that is always an interwoven unity of a past, present, and future (Merleau-Ponty 2012:250). Perception and movement also unite as a single experience in the creative act. In the first instance, our world is spatial, and in a second, deeper instant, it is temporal. As music erodes visual space, the world is given as time inhabited. Albert observed:

The great thing about music is that when you're playing it you're referencing where you came from, so there's the past, and then you're in the moment, but you're also anticipating what's going to happen next. It's a real way of linking together past, present, and future.

Music structures a past, present, and intended future; it enriches the present and changes one's experience of being-in-the-world, particularly for creative music therapists who throw themselves into the flow of music-making.

Music therapists described creativity as an experience of flow that happens when they are in a certain existential space. As therapists reckon with ambiguous situations, they create explicit spontaneous acts from the “here” and “now” of their body; from their embodied position, they rise up to meet a client’s demand (*e.g.*, a cry, a rhythmic pattern, a melodic utterance). Their musical response is an immediate experience that moves out from them as an aesthetic expression. Shelley described her experience of being creative with visual metaphor that located the practice of creativity within her body, saying:

It's a hard thing to talk about [laughing]. I'm deriving my creative juices from a couple different strands and it could be how they [the client] look, how they're acting, what emotional state I'm perceiving. I'm not saying, ‘Oh they seem sad, let's play this.’ It's not like that. For me, it could be about what they're doing, and those are some of the strands. For me in order to get into that space of a creative flow, I have to do a real letting go. I kind of let go and my fingers go in a certain direction, now I might be guided by a scale or a progression to start, but sometimes I'm not. Sometimes I just let my fingers land and I go for a sound rather than an actual structure, and then the sound might move in a direction that might become a musical structure. I really can't teach how to do it. I

just feel like I'm inspired and I want to let my total creative possibilities happen, and I can only do that in music therapy when there's another individual there who I'm responding to. I feel like I'm getting all my juice from that individual and then I'm going to filter it through my fingers and I'm going to let my fingers go.

Shelley's description highlights the importance of the embodied experience in the creative act and emphasizes that creativity is a unified expression of pre-objectively being-in-the-world with another human being. As described in Chapter Three, existence is indeterminate and the body is the mediator between a person and the world, creating for itself an expressive space with each gesture (Merleau-Ponty 2012:146). Creative expression is an existential activity that belongs to the pre-objective and pre-reflective social realm. Music therapists described the sense of creative flow as an experience of being with the client, not by themselves, in a different space. Thus, if "flow" is an expression of pre-objective experience that is felt in relation to another person, then creativity is a cooperative, or co-creative, expression of a social existence.

Returning to my meeting with Albert, he elaborated on his question about how to teach someone to be creative, pointing to the inherent reciprocity of the creative act:

I think what you can do to help somebody to really trust their authentic expression. I don't think you can teach somebody here's the method to be creative, but I think you can help them to discover that they have something to create. And I think certain clients can bring out the creative aspect of the therapists, and therapists help the creative aspects of the clients...we both build on each other's creative interest.

Albert's statement reflects the need to train music therapists to trust their embodied knowledge, their musical skills and intuition, and acknowledge that their creativity is supported and influenced by the client's presence. Creativity is an individual skill of expression (the creative act itself), and it is also a social phenomenon, an expression of sociality.

Merleau-Ponty describes gesture as a manner of meeting the situation before us and living it through our bodies. The reciprocity of gesture is foundational to communication: in understanding another's gesture, one is able to understand emotional expression as well. Genuine

gesture communicates not just a style of being-in-the-world, but can truly transform one's actual existence, or lived experience (Merleau-Ponty 2012:190). Authentic expression arises through genuine gesture. For Merleau-Ponty, there are two kinds of speech: authentic speech, which creates something new out of the grammatical rules of one's culture; and secondary expression, which is uncreative and reproduces the language and meanings of others; he insists, however, that the latter could not exist without the capacity for the former. What is important is that humans have the innate capacity to create something new from within the boundaries given by convention, and that this "for the first time" expression is fundamental to discourse. Further, like creative spontaneous musical expression, authentic speech only exists objectively for others while it is being performed (Merleau-Ponty 2012:530).

Further, there are two categories of expressive gesture, both of which are authentic: the literal (or concrete) gesture, which is not playful or imaginative, but purely functional in response to its surroundings; and the abstract (or figurative) gesture, which is playful and takes up the surroundings to support the new context for movement (Merleau-Ponty 2012:234). The musical gesture is a figurative, aesthetic, gesture that intends beyond the literal and creates for itself a background that is dynamic, playful, and free-form. Intuition and inspiration are essential to the figurative gesture, for without them, the gesture would not be related to the clinical moment with the client. With the creative act, the music therapist shifts between the pre-objective realm in which the therapist and client are in an unspoken relationship and the objective realm where the music becomes objective representation of the therapeutic work. Indeed, "the operation of expression is successful when it opens a new field or new dimension to our experience" (Merleau-Ponty 2012:188). For clients, this existential shift changes their priorities, including their experience of other people, of who they are, and who they can be.

The music facilitates transformation and also becomes an object to grasp and explore the change. To understand how music can engage us so completely in its flow and do therapeutic work, I refer back to the phenomenology of music described in Chapter Three. Rhythm and musical form give improvisation structure, harmony provides atmosphere, and within this melody connects and orders tones in a predictable way. Clients participate in making music by throwing themselves into the present and expressing their existence. Schutz (1976) argued that music is a social relationship, a connection to another person that opens a new world of possibilities for self-expression. According to Straus (1958), music directs a person's attention towards it, so even if the client resists joining the flow of music, they are part of the flow by simply being in the room. Finally, play, inherent to making music and music therapy, offers new frames for existential exploration, as Bateson (1985) and Clifton (1983) suggest.

For therapy to have a transformational effect on the client, the therapeutic relationship must be strong. The therapist builds the relationship by expressing empathy towards the client with each creative musical act. The pre-objective space contains the therapist's empathetic intentions toward the client, thus any co-creative expression draws with it this empathy. Once again, the experience of synaesthetic perception from Chapter Four, and the power of intuition are essential. In one lecture, Clive attempted to clarify the meaning of intuition as it applied generally, and specifically to music therapy. With regards to the former, he said that intuition was the direct perception of truth or fact and an immediate apprehension. Clive focused on the word "apprehension," explaining that it meant to grasp the sense of a situation, or have keen insight into it. Building on this, he explained intuition in the context of music therapy:

It's like when you hear someone's voice and you wonder if something has happened, or you have the hunch to call someone at just the right moment...It is a natural human faculty in everyone. It can be a catalyst toward clinical action that does not depend on an explicit process of conscious consideration. So, you don't have to be conscious of an

intuition and it could be clinically warranted. An intuition arises in the context of a clinical situation and from a combination of musical and personal sensitivities and maturities...As a person and as a professional, as any artist would have to be. In the creative therapist, professional background is incredibly important, but so are such subjective capacities as insight, clinical instinct, empathy, determination, sense of timing, and personal communicative style... I think if you're on the piano bench and you're faced with it, the intuitions come. I think you can't sit there and prescribe what it will be and how you will do it. You just need to know all you need to know from this class is that there are these possibilities and that music can have all this variety, and you have to have that freedom.

Clive illustrated the creative act, from intuition and inspiration to spontaneous expression, using a case example from his early work with Paul:

The crying child comes into the classroom and Paul looks at him and creates a vocal song, 'Oh, When You Feel like Crying.' There's the intuition: the child's grief must be accepted, we've got to do something about this, before we can get into anything else, we have to heal this. So that's the intuition. Out comes the inspiration...The descending octave is so consoling. It becomes an expression; first of all, an expression of Paul's sympathy and empathy. An expression of consolation, not just acceptance, and that it's okay to cry! And this takes the form so we can all remember it and [Paul] can carry it around in his mind.

Even though the child above could not discern which musical intervals he was feeling, as Paul could, the child understood their meaning. When the child's teacher verbally reprimanded him, the immanent sense of her words was clear, but the child could not relate to her words; words could not penetrate his isolation. Out of a bodily knowing of what to express and how, Paul created music and sung words that communicated more to the pre-verbal child than did merely spoken words. Aesthetic expression is powerful: like the sonata, it is accessible to everyone; like a foreign language, one does not need to know the meaning of words to grasp the speaker's expression. Expression opens new experience for everyone (Merleau-Ponty 2012:188).

At Albert and Joan's AMTA conference presentation, the attendees sang "Oh, When You Feel Like Crying." Afterwards, a therapist in the audience raised her hand and remarked that she felt singing "encourages me to open up emotionally." None of us had been present in the original classroom with Paul and the child, nor had we been there for the creation of this song, yet, its

power to move us emotionally was strong. The song's structure contains the interval of the descending octave which sounds and feels like a human sigh; the octave and the sighing expression it connotes is believed to be universally relatable for people from all cultures, authentic and profoundly human. Through the two notes that form the octave interval, the sound speaks not to the literal distance between these notes, but to compassion, to consoling, to lived bodily experience that persists beyond time and space. It is a secondary elaboration to objectify the interval as an octave, but it is a phenomenal experience to sigh. Even as imitation or an anticipated element of the song, for the singer it is an authentic expression of being-in-the-world.

There is an inherent intersubjectivity between people who play music together, synchronizing with each other's experience:

Here there is a being-shared-by-two, and the other person is no longer for me a simple behaviour in my transcendental field, nor for that matter am I a simple behaviour in his. We are, for each other, collaborators in perfect reciprocity: our perspectives slip into each other, we coexist through a single world. (Merleau-Ponty 2012:370)

This collaboration of experience and creation is evident in participating in music as well. Schutz argues that playing music together with another person is itself a social relationship, and entails understanding and synchronizing with the gestures of another person in music. This mutual "tuning-in" is the foundation of all communication (1976:173). Clive recounted one of the sessions with Edward, reading from Paul's session notes and adding his own commentary:

[In Paul's words]: I felt it necessary to create music that met the qualities of his personality as these were expressed. For these I wanted music that was formed, yet stimulating and active; music that derived its stability from definite music ideas, and its vitality and immediacy from extensions and variations of those ideas...[Later, when Edward was more playful, Paul said]: I was also responding to the dancing quality in the way that Edward moved. He was quick and light on his feet and his head movements were so free and responsive that making music for him, music that reflected him, often spontaneously called out a dancing quality in my singing and playing. [In Clive's words] Paul took Edward's dramatic protest and jumping and screaming and said, 'Here's music to jump to, here's music to scream to.' This was his intuition about what Edward needed and at once he was inspired to make this music to match the perception and meet

Edward's needs. Isn't it lovely? Your inspiration is right out there running around the room and responding to what you are doing.

Paul took up Edward's behaviours and signified them in a social context, as dramatic protest communicated from one person to another. He created something between himself and Edward that was meaningful to both of them because it was drawn from the pre-objective experience they both shared in that moment. Paul's empathy for Edward was his clinical intention, and he experienced Edward's needs as part of the creative process, not as obstacles to progress. The improvisations brought Edward into relation with music and with Paul and Clive.

The music therapist's act is free, and can take up a factual situation by giving it a figurative sense (Merleau-Ponty 2012:195). Paul's gesture met Edward and lived the co-created situation. Paul's perception of Edward's style was a synaesthetic experience, in the realm of the pre-objective, which he expressed musically through the creative act. Creativity requires drawing upon musical resources to create the song's musical form and also requires that one's own bodily experience attune to the Other's: Edward sighed, Paul sighed, and in music they sighed together.

Improvisation is a form of search, an existential search for the expression that will say something to the client, and at the same time it is a synchronization of the music therapist's own manner of being-in-the-world. Clive remarked:

When you're improvising, every second you could be exploring, you're living in this exploration. And if you're thinking of the flow of this music, sometimes the flow is a torrent, this is a gently meandering stream; sunny like a sunny afternoon, light coming through trees.

The recording of Edward in this session brought to Clive's mind the image of a landscape he associated with the key of D major, a very light, yellow, and sunny key. This exemplifies synaesthetic perception. Improvisation is a multi-sensory experience of thought and expression as a unified movement outward into intersubjective space.

Music therapists use music to effect therapeutic change at the pre-objective level, bringing feelings and experiences that are inchoate into something objectified in sound but with words. The first step for drawing them into the intersubjective space is engaging them and pulling them out of a state of pre-engagement. Searching for meaningful sounds and shifting one's own embodied experience toward the client, as Paul did with "Oh, When You Feel Like Crying," are ways therapists relate to and engage clients in the co-creative experience of music. By tuning into clients and letting their intuition and inspiration guide the creative expression they open themselves and the intersubjective space to the possibilities of communication.

Negotiating the Indeterminacy of Communication through Structure and Improvisation

Music therapists use creative techniques to shape and adapt their musical expression to meet the client's needs in each moment of therapy. Among their technical resources are the skills of improvisation and playing pre-composed music from a score; it is up to the music therapist to decide which technique at what moment will be most effective. Improvisation is a play on the musical form that is first created through the flow of intuition and inspiration, to expression in the creative act. To negotiate the pre-objectivity of therapeutic work and establish communication with the client, the therapist alternates between structure and free improvisation.

For the restoration of the reciprocal communication from disordered communication, music must frame the experience of therapy as play. As I presented in Chapter Three, Bateson argues that setting a psychological frame, explicitly or implicitly, offers the participant instructions for how to behave and how to interpret the actions of other people. When therapists alter the frames, they adjust the client's possibilities for experiencing the world (1985:141); experimental action, or play, changes the rules (Bateson 1985:142). Music is play and musical

gesture and expression adjust frames to orient the client toward mutuality, for the world's indeterminacy allows infinite possibilities of response no matter how the demand is framed. The co-activity of therapy is a shared project of establishing communication by switching between structured music and free improvisation.

The practice of clinical improvisation and clinical musicianship is a complex undertaking that involves mastering particular musical structures and forms (modes, pieces, and songs), while also learning how to use musical resources freely and spontaneously. Music therapy trainees at the Center envied Paul and aspired to play music with his technical facility and sensitivity that reached clients. Paul used music from Broadway to Bach and Gospel to Prokofiev as the basis for his improvisations with children; sometimes he improvised from a structure, other times he composed music on the spot which later took on structure. As discussed in the chapter on the history of Nordoff-Robbins, Paul had specific ideas about how musical elements like intervals and chords worked therapeutically. Clive shared some of Paul's secrets in his lecture:

Root position chords are like nouns, and the melody that's made of a root position chord is also like a noun. The moment you invert a chord you're not sitting so firmly on the base, it's an inversion, things can happen, things can move. The secret of a lot of the movement in Paul's music is his use of inversions.

Music therapists were familiar with Paul's famous advice to take the chord that will be most effective for the client, not the one that falls most easily under the fingers or is conventional. Using unconventional harmonic structures and particularly dissonances with children was frowned upon when Paul and Clive were practicing, but because it was effective with the children they were not afraid to go there. Thus, in this ongoing discussion about clinical efficacy and negotiations between structure and creative freedom, the advice about the "right chord" liberates therapists so they can invent new material and break conventional rules of composition. However, the freedom to do anything can be a burden; if it is possible to do

anything, why not always do the best thing? The belief that each tone could potentially make or ruin an opportunity to connect with a client was an underlying concern among music therapists at the Center, despite their understanding that this approach is fundamentally one of trial and error.

Shelley said:

The elements of music are studied in such detail. There is a book out there called, *Every Note Counts* [Laughing]. The single tone and every note that you play matter; there are no throw away notes, there are no throw away chords. Now it can make you nuts worrying about every chord that you're playing. We can't do that. We have to play in a phrase, we have to play in response to the situation, but the idea is to have a hypersensitivity and awareness that each note does make a difference and that changing that interval could do something. This is paired with your clinical sensibility, your goals, and your understanding of who this person is.

Shelley's description echoes the phenomenological approach to experience that states every experience, no matter how insignificant and fleeting, is meaningful. Recognizing the power of a single tone to signify and give objective meaning to a constellation of inchoate feelings is important in the music therapist's work.

As mentioned in the introduction to this chapter, sometimes a song or melodic passage emerges that fits the client and has meaning in the session. The therapists refer to this as a "clinical theme." The clinical theme is a musical idea that arises spontaneously, but through repetition assumes an anticipatable form. When it comes back in a session it is predictable and familiar for the client which can have therapeutic value. Unlike improvisation, the clinical theme, like a familiar song, can be anticipated, remembered, and played with by creating variations upon it. Recalling the musical portrait, this improvisation is not a clinical theme itself, but may generate a theme in the creative process. Clive took very seriously the importance of repeating the clinical theme exactly as it was first given in order to serve the client's needs, saying:

When you improvise significant clinical themes for children, don't take it off in a haphazard way, to get it as the child got it. Get it off accurately. You can always extend it, change it, but bring it back to the child in the form in which he's become involved in it,

otherwise, you're giving him something and taking it away. You have that responsibility to get your music formed. Not rigidly, but as a basis for new developments out of the child's response. But the basic form has to be there. It's very important. Otherwise, you're kind of touching something and then going away from it, and not really committing yourself to what that song can mean.

The clinical theme is a co-created musical form that does clinical work in the relationship between the therapist and client. The clinical theme is a mark of intersubjective understanding; it signifies a reciprocal gesture fundamental to communication. Indeed, we must understand others' gestures and their emotional expression to communicate with them (Merleau-Ponty 2012:190). When presented consistently, improvising upon the theme increases the depth of therapy's work. Arbitrarily altering the theme is problematic because changing the theme is akin to changing existence, confusing the movement between pre-objective and objective realms.

In Nordoff-Robbins music therapy, the empathy Clive described is being-to-being, where empathy discloses the relationship between two phenomenal bodies whose worlds are open and indeterminate. The therapist must understand the client's gesture, and the client must, in turn, understand the gesture of the music therapist, as Nancy remarked:

I feel like skilled therapists in this approach are fluent in musical communication. What does fluency mean, right? There's no Rosetta Stone for saying that you're conforming to these rules of grammar or semantics or whatever, I think it has to do with flow. Fluency and flow between two people....The flow has to do with whether you're all connected somehow through music.

There is a grasping and a taking up within a shared project that mutually enriches our respective worlds. Understanding the Other, I have stated, is indeterminate; there is a sort of agreement that must take place, a compromise, where it is not entirely mine, nor entirely yours, yet it is of both of us, and has meaning for each of us.

When I asked music therapists how they knew what to play when in sessions, they were quick to correct me if it was implied that creativity was a conscious thought process. Very often, like Shelley, they would say that when doing a particular session they were not thinking in a

premeditated way about what to do next. Thoughts were like sense impressions; they were aware of but not judging or evaluating in sessions in an objective sense. Recalling the discussion about clinical intention and clinical thought from the previous chapter, there are moments when music therapists maintain a certain distance from the world and consider their response. In the absolute authentic creative expression there is an enmeshing of perspectives from which responses flow.

In Lynn's description of sessions with a new "hard to reach" client, she touched upon this distinction between intuition as a unified unconscious process and the articulation of an expression, a physical form, that involves clinical thought. She explained:

When playing, I'm thinking about creating melody and using repetition, it's not a music that just goes on and on and on without structure to it. Improvisation is structured, improvisation is compositional here. Just like a song has form, so, too, can improvisation, and it can develop. We're fortunate to have this art of music to use to communicate our intention.... I am being creative in the sense of creating in the moment something for him out of my assessment of what's happening. Some of that is thought, I would say through intention, and then some of it just takes off into something more intuitive. I don't decide every note I'm going to play. For example, I'm told right before he comes that he's been agitated and aggressive. I'm thinking, I'm not going to play something that's atonal and arhythmic, I'm going to start with pentatonic that has less dissonance and maybe I'm going to choose $\frac{3}{4}$ meter. So within that clinical musical thought, I create something for which I don't think out every note. To me, it's a very interesting back and forth of thought and intuition. I think those would be the words: clinical thought and then creative intuition.

The taking up of one possibility among an infinite number of possibilities creates an artistic expression, but its success is never guaranteed. Joan said, "You're setting up the situation, you're going to do something and you're hoping to get a response back. If it doesn't work, you try something else. We train in these different kinds of music, idioms, modes and scales, so when one doesn't work, you try another one." Recognizing the trial and error nature of communication, therapists do not know if clients will respond at all, let alone as they expect. Only the present is known, for the future is only intended, but never assured: a horizon of infinite potential responses is present for the client just as it is for the music therapist. Albert recounted a

session where he worked with an adult client who felt emotionally disconnected from the world and sought music therapy to move from a purely intellectual relationship to a more empathic relationship with the people around him. In the session, Albert's client's response to an idiom of music was surprising, and the reason for the client's reaction was not known until a later session:

I remember one time I was playing the blues at the end of the session, and I didn't feel connected, it didn't feel right, and to me it was not right, it was not the right music, it was wrong. [The client] didn't seem right, we didn't seem together. Afterwards, he just kind of walked out. At the next session, he came in and said, 'You know, I really didn't like that blues music,' and that was great! That he could come in and say that was actually a step in his development. That rather than sitting on something resentful and putting it somewhere else, he could come and say that to me. So, even though it was a mistake, even though it was music that was not right for the situation, it actually led to a fuller development.

The experience of trial and error exemplifies therapy's reliance on the indeterminacy of communication and the horizon of potentialities. Creativity is a co-operative activity that is guided by the therapist, but influenced significantly by the client, as described earlier in this chapter. In Albert's case, it is evident that there can still be miscommunication in the creative process and the therapist may not support the intersubjectivity in the way the client needs in that moment. It is this opacity of experience, a partial perspective on the self and the Other, which makes therapy a search for the right key, where one or many right keys may exist at any given time. Phenomenologically, the creative taking up and expression of musical resources (the potential keys), are objectifications of pre-objective experience that sympathize with the client's perspective as a shared project. As clients respond creatively to each new demand, they enrich their life-world for themselves and draw nearer to social communication.

Universality of Music?: Creativity as Objectively and Subjectively Experienced

There is an ongoing debate in the Nordoff-Robbins community about whether it is the music therapist's subjectivity within the music to which the client responds or if it is the music

itself that catches their attention and works upon them. It ought to be clear by now that the lived experience of music is a unified, embodied experience that occurs pre-objectively, before the artificial categories of subjective and objective qualities. Nevertheless, this debate may benefit from a phenomenological remark; thus, I will briefly present the two facets of this issue and offer a phenomenological perspective with regard to improvisation and form.

The Nordoff-Robbins training capitalizes upon music as a universally social expressive force. Upon examining the Center's approach to teaching music therapists about Western clinical musical resources, like modes and intervals, it appears as if music is being treated as an aesthetic object as much as it is considered an existential thread between beings. It is as if music, not the therapist, which does the work of therapy because it is universally understood, transcending generations and geographies. Shelley explained:

Clive would speak about music itself as an objective entity. I mean we study these scales and these idioms because they have certain qualities that 99% of the population will respond to in a certain way, and that's where the objective quality of music comes in to play....Why would we study the qualities of the pentatonic or the Middle Eastern scale? There must be something about that that we're all as a human community responding to. There's something in those intervals. But I may play it a certain way that's different [from another music therapist] but still the unique tones, the way the tones are organized, convey something that we all can agree upon....For example, the pentatonic Children's Tune can be found across cultures. They're doing that in India, they're doing that in Israel, they're doing that in the United States, they're doing that in Mexico. How is every child taunting with that sound? What is that? How are we all doing that? There is some kind of objectivity to music, but it's in the personal use of these things that are somewhat objective that makes it into a therapeutic relationship.

The Nordoff-Robbins approach refers to these modes that speak to people universally as "archetypal," a term borrowed from Jungian psychology. The idea of universal musical patterns might recall for the reader Lévi-Strauss' (1963) and Dow's (1986) assertion that general cultural mythic worlds have the power to be transformed by the therapist to explain and modify the particular experience of the patient. In their work, Paul and Clive found that American children

could relate to, for example, the Middle Eastern, or Arabian, idiom and be moved by its tonalities even though they had not grown up with these sounds or been exposed to them during their life because through the use of authentic instruments and clinical improvisation the idioms expressive character can be made to speak to clients (Nordoff and Robbins 2007:481).

Anthropologically, this argues that in terms of music as a relational aesthetic in the context music as therapy, there is a universality about the way human beings relate to music from other cultures.

In the immediate moment of synaesthetic perception what matters is that the constellation of melody, harmony, and rhythm speak to the client's lived experience. The treatment of music as a universal object is also found in therapists' training in how to use the church modes with clients. Clive and Paul believed that each modes expressive character had the potential to speak to any client. A mode is a set of given notes that form a scale; there are seven modes and each has its own unique tonality: Iolian, Dorian, Phrygian, Lydian, Mixolydian, Aeolian, and Locrian (Feldstein 1994).⁶ Albert said, "We try to emphasize not the theory of it, but instead on the practical tonal center of each mode. You have to hear it. Is it a major or a minor mode? If it is a major mode, what is the tone that makes it unique compared to a major scale?" The practical use of modes refers to what the tonalities do emotionally for the client. Albert noted it is difficult to discern which developed first, the modes' intrinsic qualities, or people's associations to them because composers employed them so often.

⁶ According to Nordoff and Robbins (2007), the modal scales (or modes) are like scales in the sense that each one has a tonal center and set of harmonic intervals that make each sound distinct from the others (469). Further, in practice, the modes can serve to support a particular idiom. For example, the Spanish uses the Phrygian mode with the Aeolian mode as a contrast, and by raising the third step in the Phrygian mode and creating possibility for major triads the Spanish idiom becomes distinct from Middle Eastern music (2007:483).

During one of my days at the Nordoff-Robbins Center, I found Albert and asked him if he would show me the modes. I said, “I’m curious about all these modes you use, about how they work.” Albert ushered me into a therapy room, sat down at the grand piano, and said:

Did you ever go into a movie theatre, and all of a sudden you hear... [He plays the Lydian mode on piano]. They call this the Disney mode because the songs are about wonder, the possibility of another new place that is going to come to us. In Indian music, the Lydian mode is used to create a reverent atmosphere. The way I relate to it and the way I have used it in my own work, and I’m not saying this is how everyone hears it, it’s not 100% universal, but for me there’s something about hope here...[Albert switched to playing Dorian mode]. This mode is used by composers to say, ‘We’re faced with a big challenge that we’re going to try to overcome!'

The Nordoff-Robbins approach positions modes and idioms as universal therapeutic tools to create emotional atmospheres. As an object, music that speaks to everyone portends a fundamental sociality. Leon remarked that “*nothing* is there in music,” that “music spends its time being social.” Phenomenologically, the social is deep and as people who live in the world we are always related to the social, we are always situated in relation to it (Merleau-Ponty 2012:379). Merleau-Ponty suggests that we make our personal worlds out of the universal and anonymous (2012:341). A universal meaning of a musical expression parallels Straus’ (1958) idea that music is a social agreement, and that we invest in the universal our own meaning (1958:167). Music connects personal worlds as an accessible aesthetic expression. Without knowing a foreign language we can understand the speaker’s meaning through their style and tone (Merleau-Ponty 2012:184). Clifton argues that music expresses things about the Other, ourselves, and the world that affect us on a personal level, as musical meaning is immediately taken up by the whole body (1983:47, 65). We escape into more being, which remains social.

The body inhabits a particular milieu within a world whose indeterminate horizons contain objects for me to grasp and signify, making them my own. The therapist creates out of the pre-objective indeterminacy of experience an objectification in music as a universal aesthetic

object. Phenomenologically, Merleau-Ponty argues that there is the pre-personal world that exists prior to us, but it is from this world that we draw our intentional threads and act creatively in our personal intersubjective space. As described earlier in the chapter, it is out of this anonymous world that the music therapist can create and perform authentic expression of their own for the first time. The world is wrapped in objective determinations, in actual tones and actual chords, yet these are lived by me and they are expressed through me; as with all authentic gesture, it lasts only as long as its performance (Merleau-Ponty 2012:349).

Creative improvisation searches for the right key: the perfect combination of objective tone and personal expression. It is this combined effort of anonymous and personal, the pre-objective and objective, that is at the core of the objectivity and subjectivity debate. Many of the music therapists with whom I spoke believed that music had a universal quality but maintained that personal subjectivity mattered in order to engage the client in social relationship. They felt that their intention was given through the music and that their personal style of playing enriched their expression and communication with the client. Shelley remarked:

I can't separate myself from the music. They are hearing me and I'm exposing who I am when I play. I have a distinct sound to my music as do other music therapists. Everyone has their own touch....It might be in how I harmonize, how I put my intervals together, or how I voice my chords, it could be something like this that they know intellectually, but it's also about touch.

As was discussed previously regarding the choice music therapists make between using structure and relying on free expression, they have a choice about how and what subjectivity they convey through the music. Each expressive style is a modality of their existence which speaks differently to the client and effects change differently in the pre-objective sphere. Lynn said:

I can come in and play in a brittle, loud way, not related to the tempo of the person or it can be legato, lyrical, and sweet. Something about me and my attitude, my feeling, not personal feeling, but feeling I'm trying to put out, I think, can be perceived. Without

words I'm saying, 'I'm here for you, I support you' in music. I think that has to be felt, I believe that.

Lynn and Shelley's words reflect the phenomenological structure of expression and gesture that is a manner of being-in-the-world. One's style is both given and transformed in a unified aesthetic gesture. It is a being-to-being empathy that slips into and shares with the perspective of another, something that happens only between two living bodies.

This chapter addressed a central component to the music therapists' training: creative clinical improvisation. In addition to learning to listen deeply as a synaesthetic experience of the other, music therapists train their bodies to know how to play a variety of musical resources and then, in session, draw freely from them in the Creative Now. Listening and responding are both embodied, pre-objective experiences from which the therapist creates a musical expression as a unified act of their thought and movement. Guided by clinical intention to help the client and draw them closer to communication, the music expresses the therapist's empathy and a genuine desire to understand them and share music with them. All of this training comes to the fore in the experience of the healing performance, otherwise known as the music therapy session.

Chapter Six

“A Hit and a Miss. A Hit and a Stick”: The Performance of Healing

Interweaving ethnographic material, this chapter will focus on the performance of the therapy session. The music therapist’s training and embodied skill of listening deeply, using silence, and responding with creative spontaneous expression, discussed in the previous chapters, are enacted in the therapy session to make it successful. “Things happen in music,” said Albert, “that don’t happen anywhere else,” and the therapy session is a performance, a “show” that must persuade the client to return from isolation to coactivity with the therapist.

According to Schutz and Luckmann (1973) mutuality is the precondition for communication. Clients who are “hard to reach” have severed their communication with the outside world, whether by choice or through the limits imposed by their pathology. “The Music Child,” Leon said, “wants to be social, [but] there is conflict in meeting, in having to be another way in music.” Indeed, for “hard to reach” clients the process of being drawn into a social relationship and relating to another human being is a struggle. Leon observed:

This is a profound situation. You’re seeing an aspect of people that is present in everyone, but it’s something that I think if we had an awareness of it, we’ve lost it. The process of going and coming from music, we don’t get it, we don’t sense it....Everyone seeks out music.

Schutz and Luckmann argue that every person takes part in a shared life-world that includes other people and things in the world. In our everyday lives, we take certain things for granted about our life-world: there are other people in the world to whom I can relate, and who can relate reciprocally to me; the other people in the world share the same consciousness as I do (they see the world the same way); and I may act upon the world and be acted upon to realize my plans or yield to barriers (1973:6). In music therapy, the life-world of the “hard to reach” client is far narrower in scope than that of the music therapist, and it is incumbent upon the music

therapist to interrupt the client's habitual actions and encourage them to find new actions that lead to mutuality and reciprocity. The therapeutic interaction creates an experimental milieu in which the restoration of the "we-relation" is possible. This relationship is, for Schutz and Luckmann (1973), the most fundamental social relationship between human beings, and in therapy, it is what the therapist hopes to achieve with the client.

In this chapter, the following aspects of music therapists' experience of the therapeutic process will be investigated: constructing the therapeutic milieu in music, inviting the client to play with sound, searching for and finding the client in music, dealing with rejection from the client as a form of communication, and finally, establishing a social relationship and restoring the we-relationship with the client in cooperative music-making.

The Therapeutic Milieu and the Musical Invitation to Play

During my fieldwork, I saw the effect of the musical environment on clients. No matter what the client played, the music therapist was able to play music that gave clients' utterances a meaningful place within the flow, providing a background to the client's musical figure. The music seemed to give the client license for free expression, spurring on their creative music-making. The music therapists' music was always alive and responsive to the client's musical impetus; it never came across as boring and unresponsive sound ("musical wallpaper," as music therapists called it). Music seemed to give context and order to the client's playing in a supportive and encouraging way. This sort of music sought out the client and invited him or her to join in no matter what amount of response or lack of response the client was demonstrating in the session, reflecting the core belief that the "potential has yet to be seen" and that there is

always something more to discover if one finds the right key. Each session was seen as an opportunity to learn more about another person and to make a connection with them.

Indeed, the construction of the therapeutic environment is a crucial first step in the music therapy process as it is in any therapeutic approach. Frank and Frank (1993) observed that all therapeutic approaches construct an environment that is perceptibly separate from daily life. It is thought that this offers the client a safe and supportive space in which they can feel free to express forbidden thoughts, release emotions, and experiment with new ways of behaving without fear of consequences (Frank and Frank 1993:188). As long as the music was playing, the shift in environment from the everyday to the therapeutic, Leon observed, was not in the realm of awareness for the client: “The change is unconscious; people don’t know it’s happening.... Silence interrupts the flow and everything goes back to how it was before.”

I was curious about how music worked therapeutically and how the music therapists worked with music. Music therapists spoke to music’s versatility, its dynamic quality in which different parts could play together and separately yet maintain internal coherence and meaning for participants. Ideally, within the musical environment, Nancy observed:

We can’t talk at the same time and be understood, but we can play together and be connected. The therapist and client are responding to each other. It’s not just that the therapist is slavishly following the child with all the musical skill you can muster, but also creates a musical portrait of the child that they’ll recognize, so they can see that someone’s in the room with them and they may begin to follow in his turn and respond. It can become a dialogue. I think that’s one of the primary strengths of music as a therapeutic modality.

The therapy space felt inclusive and inviting in itself. An interesting feature of the Nordoff-Robbins Center was the architectural design of the space. The Center is housed in a small building at the back of the Steinhardt Education building at NYU. Each time I visited the Center I had to pass by a security guard and take a small elevator up to the fourth floor where the

door opened onto the waiting room with about eight chairs facing each other against the walls.

The Center was a small and intimate space. To the right were two administrative offices, each shared by two music therapists who had a variety of directorship roles in addition to their clinical work. To the immediate left, a small picture of Clive hung on the wall. Further on were the doors to the small therapy room, the back room where the instruments were kept and indexing took place, and the bigger therapy room. The therapy rooms were designed to have five walls, following the concept of the Steiner Curative Education movement that believed right angles stifled children's creativity; fewer right angles gave a circular feeling to the room, which is inherently social. Both rooms had a piano and open floor space for a variety of instruments to be arranged and played. The rooms were painted light blue, a very calming colour. Finally, adjacent to each therapy room was a small filming booth from which sessions could be recorded on video.

The therapeutic effect is existential: it takes place at the level of pre-objective and indeterminate experience. One can imagine that the architecture of the therapy space contributes as an important element of the background that is unconsciously felt by clients. Immersed in the musical milieu, the client is surrounded by novelty: new objects, people, sounds, and possibilities for expression. The therapist extends a special musical invitation to them, asking them with music to engage with the milieu differently than they do in everyday life. While the "hard to reach" client may habitually ignore these spoken invitations, the musical invitation they find more difficult to shut out. Shelley explained:

You're creating the musical emotional world for that child or adult, and in that world they can not only beat along because they can hear a tempo or a rhythm, but they feel that they're heard or they're being encouraged or they're being comforted or stimulated. 'I see that you hear me and you're trying to make a connection with me.' 'Come play with me because this is something that you'll love.' 'Whoa, no one ever responded to what I was doing, this perseverative thing, in this way before. It sounds like you're trying to get to know me, and I'm going to come over with you and join you.' Can I create musical structures that might provide room and space for this person to join me in a relationship?

What will those structures be? How am I perceiving the feeling life, the emotional life, in front of me? How am I going to create something that might be reflective of that but also say ‘Join me, come with me and do this with me?’

Creative improvisation, discussed in the previous chapter, is the main therapeutic tool by which the music therapist piques the client’s interest, playing novel sounds and playful rhythms to spur on the client’s response. In the service of guiding the client toward reciprocal music-making and mutuality rather than saying “Come sit down with me” or “Look at me” in words, therapists might play a quick trill on the piano or an interesting musical figure. Lynn explained, “[It is] another way to beckon, to invite, to create a comfortable, safe-feeling environment.” This new beckoning, or question from the environment, is initially unfamiliar. This sound that they hear is peculiar in that it is unfamiliar to them, yet familiar because the music therapist has improvised music that deliberately reflects the mood, style, and essence of the client. Albert said, “I hear this music that has something to do with who I am, and I want to engage with it, I want to respond to it...the music is motivating me, I want to enter into this.”

Indeed, the musical invitation interrupts the structure of the world and surprises them with a new opportunity for communication that is accessible to them. Confronted with this new demand, “typical” ways of acting no longer work because what they are being presented with is atypical. The client has two possible courses of action at this point: they can include the new demand in their schema, thereby adapting the schema and expanding their world, or they can try to ignore the demand and maintain their world as-is (Schutz and Luckmann 1973:12). Since our life-world is governed by pragmatic motivations, solutions to problems are only sought in so far as they practically need to be. In early stages, the client may encounter the sound, recognize it as atypical, but very likely choose to exclude it from their reference schema, or stock of knowledge, and reproduce their narrow world. The goal of music therapy is to guide clients away from this

decision, and entice them to be curious and explore musical demands in greater depth through creative musical self-expression.

The unique qualities of music create a new milieu in which new relationships and experiences become possible. People are pragmatically driven to find solutions to environmental problems. This was evident in therapists' observations that the therapeutic milieu constitutes a space that orders the client's disordered world, changing their priorities. The depth to which they seek new understanding and experiment with new ways of coping with demands in music is much greater than in their everyday life. This may be because music, as sound, is a less complicated and more intriguing object to explore than other objects in the world. In our interview, Leon explained his perspective that, in music, social categories like age, gender, and expertise are suspended or erased; everyone is on a level playing field where neither is playing something beyond their range of ability, they are simply playing music as two beings.

Each musical invitation interrupts the client's withdrawal from the world and insists that the client find an increasingly related way to respond. Through trial and error, music therapists search for the "right chord" that will compel the client to move closer to the person behind the sound object to which they are responding. Music is social and invites the client into a musical relationship. With the development of a new reference schema and a new pattern of self-expressive actions upon the world, the client's horizon of their life-world begins to expand in the direction of a social relation, a "we-relation" that opens the door to deep therapeutic change.

Music is Inclusive: The Team and the Client

One of the core principles of the Nordoff-Robbins approach is teamwork, the presence of a primary therapist and a co-therapist in therapy sessions to facilitate the client's engagement in

music. It was described to me that the primary therapist is responsible for creating the musical framework for the session and it is this music that guides the therapeutic work. The music is the modality of the therapeutic relationship. The primary therapist usually played the piano or guitar (the main harmonic instruments in the Nordoff-Robbins approach), but they also led activities with the client on other instruments (*e.g.*, wind chimes or drums). The co-therapist's role is to physically or emotionally facilitate and support the client's musical relationship to the primary therapist by assisting the client with playing instruments and singing.

Music therapists acknowledge that music is an inclusive force, it is "hard to get away from," and this lends music the unique ability to extend an invitation to clients and direct the client's responses toward engagement. As a co-therapist, I was not creating music at the piano, yet I was essential to the session. When I asked therapists about the role of the co-therapist, they asserted that the co-therapist lives the experience and responds to the music just as much as the primary therapist and the client: everybody is reached at once by the music. Nancy said:

It's not just the piano exclusive of the co-therapist, but rather the music embraces everyone in the room. You are participating in the music as well, along with the child. You're modeling participation in the music, you're facilitating it and the primary therapist is creating the environment.

When I participated in music therapy sessions as a co-therapist, I often did not make much sound at all. I was an "active witness" who responded with positive interest toward the client's musical responses. My responses toward the client, whether musical (in singing) or physical (in action), were an effort to facilitate the client's musical response and relationship to the primary therapist. At the end of the chapter, I will describe a session wherein Joan supported Sam and me playing horns together and we met in a face-to-face *we*-relation.

Frank and Frank (1993) argue that all therapy can be seen as group therapy, even if it is just a group of two. Thus, where there are two therapists and a client, the group of three

represents a communal healing setting, like those described by anthropologists Kapferer (1979) and Friedson (1996) where many people participated in the performance of healing. In the case of music therapy discussed in this thesis, harmonic music-making can be seen to function as a particularly mutual and reciprocal moment in music that restructures the client's life-world and engagement with the Other.

To lead the client increasingly toward mutuality, the music therapist must continue to present new challenges that the client feels motivated to explore and solve. They work with the client at their "developmental threshold" and move beyond it with each successful creative action upon a novel musical invitation (*e.g.*, a trill, filling in a beat, or playing in time). The developmental threshold is a concept developed by Clive and Paul to describe the client's upper limits of physical, emotional, and social capability. Phenomenologically, this represents the edge of the client's experiential horizon, or the edge of what they have experienced as possible. Frank and Frank (1993) observed that such directed exploration had important therapeutic effects. "[Healing ceremonies]", for example, "supply the patient with a conceptual framework for making sense out of chaotic and mysterious feelings, and suggest a plan of action...[helping them] regain a sense of direction and mastery and resolve inner conflicts" (Frank and Frank 1993:99). The challenge with "hard to reach" clients is that they offer very little response, making it more difficult to locate their developmental threshold. Albert observed, "You have to value what you're doing not based on the response, but on how you're approaching the person."

The musical approach to the client is crucial in Nordoff-Robbins, as discussed in the previous chapter. The therapist's response to the client is based on the meaning they are able to interpret from the client's music, gestures, or withdrawals. Often the perspective of one music therapist alone does not gather enough information about the client to gauge the next musical

invitation to play. As primary therapist who plays at the piano, Albert described his reliance on his co-therapist in music therapy with a severely handicapped client:

[My co-therapist] was always giving me clues, giving me cues, giving me ideas....The person who's holding [the client] has so much more information. [The client is] not doing anything, they're not saying anything. At least the person holding them can feel are they tight? Are they loose? What do they sense?

From a phenomenological perspective, we can understand the therapists' difficulty in sensing aspects of their client when responses are limited. Straus (1958) and Merleau-Ponty (2012) have argued that perception of the Other is partial and located within a world of indeterminacy. Experience of another person's style is taken for granted as total, yet it is ever-changing (Merleau-Ponty 2012:342). Albert's account reveals his awareness that the therapist cannot know everything about the client's experience of the therapeutic approach from their singular vantage point. The music therapist at the piano cannot know, for example, how the client's muscles are reacting, and the co-therapist who is physically facilitating the client's arm cannot experience the client's music through responsive repartee. Frustration, or "hitting a block," with clients who offer little aural or visual response to the primary therapist is remedied by adding a third sensible-sentient being to the musical relationship.

It is important to note that the partial view that each therapist gains in the clinical moment is dependent upon their own phase of existence. For example, if the therapists are alert one day, they will experience the client's physical sensations and musical responses differently than on a day when they are feeling fatigued. In his lectures, Clive Robbins notes the importance of the therapist's attitude toward the client. If the therapist finds the client off-putting, or if the therapist is in a poor mood, it will necessarily affect their ability to meet their client's needs.

Indeed, the client has a certain style that each therapist perceives, but the view from which the client is perceived and the interpretation they make about the client is unique to each

therapist. This view depends on the life-world within which the music therapist is acting at that moment and the particular sense one has access to when interpreting the client. As described in Chapter Three, Straus (1958) argues that sensing experience for different senses can be more or less pathic and gnostic, though it is always some of each as a unified whole. The experience of touch is more exclusive than sound, where only those touching and being touched have access to that experience. The therapist at the piano relies completely upon the co-therapist who handles the client to accurately convey their experience. The experience of sound is more inclusive, where everyone hears the sound in the music therapy room and can share in the experience.

In practice, the provinces of the different senses can lead to interesting divisions of labour within the music therapy team. Primary therapists, for example, often felt that co-therapists were outside the musical relationship, but that this was a vantage point from which to learn how the music affects the client. Co-therapists, on the other hand, acknowledged the different relationship they shared with the client, but did not seem to share a sense of being “outside the music.” Nancy recalled that as a co-therapist her goal was to “go with” the client and facilitate the client’s creativity: “That’s my desire, that’s always my main intention, so that it could be truly said to be [the client’s] music in response to the music that was being played around [the client] at the piano and also by the other members.”

The structure of their sense perceptions, where everyone can hear what is played, but only one person can feel what is touched, may lead primary therapists to view the co-therapist as standing outside the musical relationship. Co-therapists, on the other hand, feel as though they are integral to the musical relationship, but that they also have a physical relationship that does not obviate the musical relationship. Each person has his or her own unique position on and

perspective of what is taking place, making consensus of therapeutic interpretation difficult to achieve. This jeopardizes the therapist's ability to sense and work at a client's limits.

Nancy described a group therapy session in which miscommunication had detrimental effects for the client and the participating therapists. She explained that during the session, the primary therapist at the piano did not understand the information that she, as co-therapist, was communicating about the client's playing, knowledge of which only she had access to because she was holding the client's arm. The primary therapist could not know that the client's arm had very limited mobility and a spasticity that was making smooth playing difficult for him.

Miscommunication, Nancy argued, influenced the clinical interpretation and agreement among therapists in the group. She observed that therapists in the flow of music-making had difficulty discerning whether a client's response was a loud sound, or a loud feeling:

I want to emphasize, and this can't be stressed enough, that people in different parts of the room have different perceptions and experiences of sound. So to [the primary therapist] at the piano it may have come across as a wall of sound because of the way vibrations built on each other, but because I was behind the instrument and very close to the instrument, I could see how he was playing it and hear the other people playing around. This guy was definitely hostile. There was a lot of spewing going on. On the big hanging chimes, because he couldn't hold a mallet, he was just brushing his arm across them.

The primary therapist at the piano controlled the authoritative therapeutic response to the client's needs, but Nancy, the co-therapist, was located in relation to the client in such a way that she was the only therapist in the room who could see the physical reason the client was making loud sounds. While each therapist can be said to inhabit a different space in the room, each one also has their own project within the milieu and a unique perception and clinical intention toward the client. It is for themselves that they perceive and interpret what is taking place. The milieu's indeterminacy is controlled for by having many lived perspectives from which to simultaneously evaluate the session. However, the different perceptions make the milieu open to myriad

interpretations which are just as likely to miss the mark as they are to speak to the client. This is consistent with Frank and Frank's (1993) description of the role of interpretation in therapy:

As the therapist's chief means of demonstrating understanding of the patient and command of technique and theory, skillful interpretations arouse and maintain the patient's confidence in the therapist as a master of a special healing art, thereby enhancing the patient's hopes for help. (202)

Music and its social qualities reach out and connect with the "hard to reach" client, but this does not guarantee the client will engage further with the music. In practice, facilitating the client's engagement is dependent upon the communication between therapists. Music therapists have noticed that their own disconnection is sensed by the client who responds by withdrawing physically, emotionally, and cognitively from the emerging social relationship. Such miscommunication usually happens between less experienced music therapists or teams that have not been working together for a long time. The shared history between Paul and Clive let them anticipate each other's response, bringing their "hard to reach" clients out of isolation and into the musical we-relations now legendary in the field. Close teamwork was important to Nancy, but she recognized that there was no set method for performing music therapy, including short-cuts to good working relationships among therapists. Skilled music therapists are those who are fluent in musical communication with everyone in the room, but even they need time to build relationships. Efforts to engage the client musically is a process of trial and error, approach and withdrawal, that is successful only when, as Nancy said, "[the primary therapist] and the client, and by extension the co-therapist...are all connected somehow through the music."

"A Hit and a Miss, A Hit and a Stick"

When discussing the experience of meeting a client in music, music therapists were often at a loss for words. They acknowledge a language problem. "Especially things in music," Shelley

said, “there’s just no language for it. We try to find it, Clive was the best at it, but no one else really comes close, but it’s really hard to put into words the experience of music.” Metaphors such as “musical portrait” and “Music Child” are constructs music therapists use to try to explain what is happening in music. When I attended the American Music Therapy Association (AMTA) Conference in Illinois, I heard Nordoff-Robbins music therapist, Shelley, describe the musical encounter in a way that surprised me. Back in New York, we sat down at the Center for our interview and I made sure to ask her about her perspective on the musical encounter once again. With hand gestures that seemed to simulate two arrows or darts heading towards and away from one another, she told me the following:

There’s in this work, whether it’s an intake or a regular session, it’s always about a finding, it’s about a looking for, and I tell my students that especially in Nordoff-Robbins that ‘here I am improvising and here you are in your world, and now I’m going to try to find you – oops missed – and ooh oops missed and sometimes a hit! A hit but a move away! And another hit and a move away! I’ve got their attention, they look at me or they do something to indicate to me without looking at me that they’ve heard me. Hit and move away. And then at some point hopefully, a hit and a stick, and then we begin to play together. And then we need to separate because it’s too close, right? It would be unrealistic for a person who’s been hitting and missing for 15 minutes to stick with me. But at some point we do stick and we stay for a little while in our own little universe and then we need to leave it. The whole beauty of the work is about one person trying to find another person. I don’t mean one therapist trying to find a client, but one person trying to find another person. The client, in the client role, is trying to find something, they might not know what it is that they’re trying to find, but they’re here in the world and they’re looking around and they’re touching some instruments, or they’re crying. There’s something that’s happening with them, so now I’m really going to do my best to try to find them, and they’re probably if I hit the right note or something they might stick with me. They might like that and stay with me.

To the outside observer, the Nordoff-Robbins approach of finding the client in music can appear somewhat chaotic. This issue is reminiscent of my problem of not being able to hear what the music therapists could hear. At the AMTA conference, I was sitting in my chair waiting for the talk to begin when two young music therapy students from Ohio sat down and started chatting about their impressions of the field. I expected to hear them singing the praises of the

Nordoff-Robbins approach, but instead I heard them talking to each other about wanting to go into something more behavioural, perhaps neurologic music therapy, because they felt it was more structured and had clear goals. They seemed unsure about how Nordoff-Robbins worked, but also certain that however it worked, it was not for them. The schism in the music therapy field between structure and freedom represents a divide between professionals who rely on empirical method as practice, and those who work through an approach, or non-method; in the former indeterminacy is rejected, in the latter it is embraced. One of the great leaps in Nordoff-Robbins is the reconceptualization of rejection as a form of communication. This ideological pivot serves the indeterminacy of their milieu well because it recasts rejection from a moment of closure and discontinuation into an opportunity for dialogue.

Rejection as Resistiveness, Degrees of Relatedness

The Nordoff-Robbins approach characterizes rejection from clients as resistiveness; in other words, as varying degrees of relatedness to the music and the music therapist, rather than as an outright refusal. Early on, Paul and Clive reframed rejection in terms of seven graduated levels of resistiveness and relatedness which they assembled in the “Child-Therapist Relationship in Coactive Musical Experience” scale (Nordoff and Robbins 2007:375). During my fieldwork as co-therapist, I did not use this scale to evaluate the client with whom I worked, but other music therapists at the Center referred to the scale often. They agreed that a client’s resistance indicated a step toward social relationship. Shelley commented that “seasoned therapists” view resistiveness as “the healthy part of the self. When you see someone reject an experience it means they’re aware that something is in effect, something is going on. You can’t reject something unless you’ve acknowledged that it’s there.”

The client may resist playing music with the therapist for many reasons, including feeling overwhelmed or uncertain. Often, the “hard to reach” client’s resistiveness takes the form of treating people as objects, as they have done before in the world, to push away social relationship. Lynn recalled a session with a resistive client who approached her aggressively in their session:

Whenever you know that someone could potentially hurt you, it’s challenging...the more experienced you are probably it’s easier. It would have been much scarier when I was younger and starting out. It’s a funny position you have to be in. You’re still trying to call to the person and say, ‘This is another moment and we can be together,’ but I have to watch, ‘Okay, he’s close to me now, am I safe, am I ready to protect myself or him if he’s doing something?’ He takes my hands off the piano sometimes. I don’t know if I would call it uncomfortable but it’s a moment where there you are ready to relate, are communicating, ‘Here, let’s be together,’ and someone’s rejecting that. You do get a lot of rejection as a music therapist with this population. Sometimes there are amazing moments, but other times, no, they want to shut you out. Not to generalize, but maybe the music is too much at times, or it’s too close a contact, or the client feels, ‘I want to play that myself,’ and it’s not like they can express that, as in, ‘Can I have a turn?’ Instead, they may just pull your hand off... You can tell by his face he’s listening to the sound, he’s reacting, but it’s rare that it’s one on one, ‘I’m with another human being.’ He’s somebody who will, and he was doing it to [the co-therapist] too, if he wants to play the piano, he goes right in front of me like I’m an object and he may push me away, that’s typical.

While filming Lynn’s session with this client, I witnessed startling instances where the client hit or pinched her, acting upon her aggressively to push her out of his world. He was directed toward the instruments, curious and willing to interact with objects that were familiar enough to him, but people, on the other hand, fit into categories of things to move out of the way. In this session, the client treated the music therapist and sound as separate objects, both dislocated from their human source, thereby posing no challenge to the client’s existing reference schema (Schutz and Luckmann 1973). Though the client approached sound, he continued to associate Lynn with the category of objects to resist, excluding her from any of the new objects with which the client was becoming familiar and comfortable relating (*e.g.*, the piano).

It could be argued that the client had not yet had enough actual experience of the music therapy environment, nor had he yet fully explored solutions to the new demands generated by it. At the early stage of music therapy, the horizons of the life-world are beginning to expand to include new objects in the reference schema, but with the musical demands posed by the therapist, the client is being challenged to interpret and act upon that which is foreign and does not fit into existing reference schemas. By taking up an action from the horizon of possible actions, we transcend our existence and take an existential step towards the Other, re-opening ourselves like Merleau-Ponty's aphonia patient. Schutz and Luckmann remark, "The core of my experience...has become problematic to me. I must now turn my attention to it...I must again take up the explication of the horizon" (1973:11). Indeed, when old reference schemas offer no ready solution, no "until further notice" to cope with the demands of music therapy, the taken-for-granted nature of one's experience "explodes," and crisis ensues.

Music is able to evoke resistiveness because it is relentless in demanding the listener's attention. When music is clinically applied it can challenge expectations and re-organize lived experiences, by mirroring a person's feeling of isolation or moving them from this isolation into a more social space. Shelley remarked on the qualities of music that make its demands so different from those encountered in the rest of everyday life, including the invitations to relate from the most familiar beings in the client's life, saying:

I'm not saying their parents haven't tried or all their parents having tried and looked them in the eye and played with them and got a response, because I'm sure it's happened. But there's something about the quality of *music* that touches a *soul*, you know that reaches in, it's *fast*, and it cuts through everything, all those barriers or all those conditions, and it's there, and that can be very scary for a person to have sensed that 'How did you do that?' and they move away.

It is as if music can make demands in every language, upon every life-world, and the music therapist accomplishes this by playing music with clinical intention, discussed in Chapter

Five. With the skill of creative improvisation that is always aimed at helping the client and the skill of listening deeply, the music therapist is better able to make something useful out of rejection. By interpreting rejection as a meaningful expression of communication, the therapist can take what is now the client's resistiveness and manage it musically to bring the client closer to social relationship. Nancy observed:

You have to be attuned to a client's process as a whole. Does this rejection stem from a greater development, a new awareness and self-expression? How can you capitalize on the new levels of relationship that are being expressed through the rejection and monitor your own feelings about it?

Dealing with a client's resistiveness in a therapeutically constructive way can be difficult for music therapists because of their own emotional lived experience. In the pre-objective experience, resistiveness can be hurtful, scary, or off-putting for the therapist who is trying to reach out to the client and make a connection. The embodied skill of clinical intention helps the therapists to re-direct their emotional energy from their own world back outward to the subjective world of the client. Using music to frame new demands that call for the client to respond, the music therapist can change the client's possibilities for new lived experiences without the client realizing what is happening; the music flows and the clients throw themselves into the experience, their bodies expanding into new realms of existence. Directing a client's explorations with music encourages them to build their repertoire of actions upon the world (Schutz and Luckmann 1973:14). Since music is pathic and inescapable, the client must eventually yield to it; their aggressive resistiveness can become a more reciprocal activity. Indeed, music is social and clients engage with it, coexisting in a reciprocal relationship with the music therapist.

These processes do not happen immediately, but over a series of approaches and withdrawals by both client and therapist. Clinical intention and embodied knowledge (what to

play and when) contributes to the therapist's authentic musical expression of empathy toward the client. If the therapist has been successful then resistiveness begins to be overcome and in its place the client begins to interact in a positive social way. Referring back to Chapter Two, this is like saying that the Music Child has been nurtured and evoked to the point that it overtakes the Conditioned Child that keeps the client locked in isolation. This constitutes an existential shift for the client's manner of being-in-the-world. Leon explained that the Music Child is a being who wants to be social, but that there is internal conflict in trying to be a different way in music for the first time. As a music therapist, he said, it is his job to facilitate the expression of the Music Child and keep the client from running away from social engagement:

This is a musical being. It wants to interact with you. What would it be like to play music with you? What would it be like to play the drums? And then there's this other part that's not interested, 'That's not what I do, that's not who I'm going to be, that's not it, that's not me.' So, in practice, there can be internal conflicts that are stimulated, that are initiated by the therapist: 'I'm going to nurture something in you that will actually kind of overcome [the condition]. It's not just a condition, but it's also an accommodation to the condition.' [The client responds,] 'Not only do I have these deficits, but that's who I am, I am these deficits. You're telling me you want me to be another way?' That doesn't go over very well with anybody...For some children, what are initial choices, 'No I'm not going to do this, I don't like this, it doesn't feel good, I don't want to,' becomes just kind of instinct, there isn't choice any more. They're automatic perceptions and automatic neurological responses that say, 'I'm just not, I'm not going to be involved, I'm not reaching out'...I often feel like I'm intervening in that process and saying, 'Here is something that it will pay you to relate to another person, you will enjoy this. It's very easy, and it doesn't take any skill or any ability.' I'm here representing engagement to say, 'This is something you don't want to turn your back on. Let's not get to the point where we don't have a choice anymore. Let's choose and see what our choice brings us.'

It can be problematic for clients to find a new way of being that is at odds with their established relationship to the world. Merleau-Ponty's young woman who lost her voice, her social existence as a totality was distanced from herself, and to be shot through again with co-existence meant she had to make drastic life changes. Although isolation and social relationship remain choices as long as we have a body, according to music therapists, the ability to make a

different choice becomes more difficult the longer a habit of being persists. Thus, it is imperative that the music therapist recognize and handle expressions of rejection as resistiveness and work with these existential statements musically to orient the client toward social relationship.

In my experience filming sessions at the Center and working as a co-therapist, the clients' frustrations with failed habitual actions upon the world and having to yield to the demands of the musical environment resulted in great crying and physical temper tantrums. Children's crying is tonal: it can be reflected and supported musically, treating it as an expression of the child's lived experience. In a difficult session with the client I was assisting, Sam wandered about the room wailing in frustration as if he was looking for something. He seemed to have moved out of his solitary existence, but then was no longer sure what to do in the new social space. He appeared to be in a worse realm of existential limbo; he was outside his solitude, but resisting sociality. I recall feeling as if our music was bombarding him as it never had done before in any other session, driving him into the corner and pinning him there. The therapeutic interpretation at the time was that we were supporting his self-expression and letting him know it was alright to cry in this space.

Phenomenologically, one could say that our music shared his existential drama with him and supported it in a way that kept the expression as communication, rather than letting it act as a wall against social relationship. Referring to Plessner's (1970) writing about the nature of crying offers insight about my client's reaction and other clients' resistive expressions. Plessner argues that in situations where our past experience is not sufficient to answer a new demand, man finds the answer (the last card to play) by withdrawing from the situation as himself and leaving his body to answer as only a body can. Though man loses control of his body in abdicating his relation to it, he maintains his "sovereign understanding of what cannot be understood" (Plessner

1970:67). Here, for Sam, the act of crying is a giving way to the affecting moment, the demands of a situation for which he had no linguistic or behavioural response (Plessner 1970:65-68). Once again, by playing music that supported Sam's crying, he could not completely abdicate his relationship to his body or his relationship to us.

For therapy to progress, clients must feel motivated and comfortable enough to find new ways to relate well with others and expand their world of experiences even though these clients may still express resistiveness. If music therapists approach the client too much, the client has no space to find their role in the music-making. In her experience as a music therapist and supervisor of trainees, Shelley found that it is easy to approach too much, musically chasing the client. She suggested that an alternative approach would be that the music therapist could withdraw and find an indirect "back door" strategy to invite the client to play:

[This is the client who] absolutely hands you back the mallet, knocks the drum over, walks away. They've decided you have put this in front of them and they are just not going to do it. You roll your eyes like, 'Now what?' It can be very frustrating, but on the other hand, you can take a step back and say, 'Wow, they know that something is here, they've just changed the field' and now I have to try and convert them in a way to let them know that this isn't dangerous, that this is fun, this is something they might like and that might help them too. Then I have to find the bridge. It's my job to say...and it might even be a back door, just leaving an instrument there and walking away, rather than directly trying to engage them.

Music therapists found that silence could also be way to withdraw and give the client space to respond and meet the therapist in music. For example, a child with a neurological impairment can move around so fast that it is impossible to stay with them, and if the music therapist follows, then they will also be everywhere. For Shelley, there is the paradoxical need to be fully engaged, but grounded and independent from the whims of the client:

I'm definitely drawn down the rabbit hole, but I'm careful, I know my boundaries and I know when something isn't taking me in a direction. So, say somebody is playing really fast on a cymbal and they're playing and I'm playing with them, and they're playing faster and faster and it's getting really loud and I'm reflecting that on the piano. At some point I realize they're not hearing me and they're just getting some kind of stimulation

from this, self-stimulation, I'm not really part of this, but I was drawn into this because I thought, 'Oh, they're playing and they're in a beat, they're in a tempo. I can do that, I can reflect that'....I'm kind of chasing them to try to see if I can meet them, but in doing that I realize I'm just kind of exacerbating this self-stimulatory behaviour. What might be better is if I stopped playing and they realize that I'm not with them. Or they're playing like this [hits table really fast], and now I play on the offbeat [taps] so that they might know that I'm there or I try to break up that pattern in some way so they know that I'm there. Or if I try to sing and hold a long tone over them while they're busy moving: I'm not going to move, I'm just going to be "Ahhhh" [singing a long arching note], and sing over what they're doing so that they realize they're not alone in this. How do you learn not to chase, not to go there? You go there!

The idea that the music therapist is the one to withdraw through silence, indirect invitation, or literally stepping back from the situation, can work with the client's resistiveness. Resistiveness is a form of communication that the trained music therapist can recognize and navigate with clinical improvisation techniques. Objective behaviour of aggression and temper tantrums can mask the expression of the client's pre-objective phenomenal experience. The therapist's clinical intention and intuition help direct the client to musically express his or her pre-objective experience. Grounded in the world's indeterminacy, the therapist must remain open to the possibilities and dynamics of resistive expressions, for they mark the existential transition between isolation and new-found sociality.

A Hit and a Stick: Experiencing the Other in “The Real Thing”

Through trial and error, the dance of finding and deflecting can come to a moment of true co-active activity, wherein the therapist and the client create music together. In *Being in Music*, Aigen (2005) stated that Paul and Clive were always thinking of ways to discuss the unexplored realm of human experience, looking for “vocabulary to articulate and differentiate its various aspects...[in a way that] preserved the lived, felt experience of both parties” (20). Aigen cited an interview with Clive when they discussed the improvisational nature of their vocabulary: Clive

believed therapists felt uncomfortable with terms like “the real thing,” and “the next best thing,” because they did not fully understand their origins in the clinical work. “No therapist,” he said, “can live with a child in the real thing all the time, nor can the child withstand the dynamic transformational state of the real thing for long. The real thing is that supreme moment in therapy when the child and therapist are living in the Creative Now together. The moments of the real thing cannot be predicted nor sustained beyond [their] realization” (Aigen 2005:20).

Clive was later quoted as saying, “You heard in that wonderful moment with the minor seconds, where his attention was caught and something really effective happened. We call that the *real thing*, in colloquial words. When that happens it’s unique, you cannot predict it; it is the creative clinical work” (Aigen 2005:21). In the Creative Now (as discussed in Chapter Two) the “healing musical instincts come to the fore...born spontaneously out of the dynamics of the client-therapist gestalt” (Aigen 2005:23). Within this moment, the therapist has a prime opportunity to intervene, and it is their intuitive awareness and skillful clinical intent that can bring healing. The majority of the session time is spent in pursuit of the “real thing,” in the dance of hit and miss.

For the present discussion, it is the moments of “the real thing” with which I am concerned. Albert explained, “There’s a moment of expression that feels authentic, that feels... [pause], and that could be very subtle if their pathology is severe.” Other music therapists described the experience of meeting the client in music in terms of “jamming” together as a co-creative musical relationship with another person. The ability to communicate through music, Lynn said, “is so important, because some of our clients do not speak. He doesn’t come in and say, ‘I had a hard week,’ he’s [vocalizes].” In turn, she must relate to that musically with, “Okay, I’m going to take that as a deep expression from you, and how can I make music with

you and be with you?"’ Indeed, music is social and is about being in positive social relationships; however, clients can become aggressive during the process of approach and withdrawal. This aggression can be a form of self-expression, though not a desirable one from the perspective of the therapist. In another session with the same client, she described a surprise “stick” or meeting in music:

You can sense as a music therapist, ‘there’s something important that seems to be happening. I can hear it, I can see it, I can sense it.’ Instead of being agitated as he was at home. He was going from instrument to instrument, he was jumping happily at times, he was vocalizing with a smile, you know, he was engaged....When he was standing behind the piano, looking over at me and tapping in that unpredictable moment when that happened, I could feel that and my co-therapist could feel that, maybe he could as well. We could all feel that moment when we were together. We were connecting over something. He was connecting with a human being, I was connecting with him through what I chose to do I think you can feel it by the response of the person to you.” Initially, though, the client was in a nether land, his engagement had been sporadic, fleeting: “He would come to the drum, touch it three times, then walk away. He might look up, you know, and then come back to making sounds. That was a quality of his contact. But then there were literally ‘moments’ of real back and forth repartee.... Is he being creative?” Sort of. ‘He’s being communicative and he’s being responsive. It’s very exciting to have him do this [taps on table], I do it back [claps hands], and he looks at me with a smile and does it back [claps hands]. He’s being musical, and that will be a good thing to look for. Is he just imitating me? I don’t think so. He’s expressing something spontaneously. The music is evoking something from him, and maybe his responses can become more intentional, he can develop *awareness*, as in, ‘I’m coming in to sing today.’

Reciprocal music-making and contact are important defining features of the phenomenon of meeting in music. Engagement in music-making, or the therapy performance, is a difficult state for music therapists to define. Research projects and measurement tools used by therapists at Nordoff-Robbins tended to categorize clients as being in a state of either pre-engagement or engagement during each session, where being the latter is preferable over the former. A state of “disengaged” was not a categorical option, revealing the approach’s dedication to the idea of a client’s potential being realized at any moment. Pre-engagement and engagement were considered to last a few minutes to the majority of the session. It is not always foreseeable in the

session when the client will engage with the process or withdraw from it. Shelley described for me one such surprising meeting in music:

I just recently did an intake and it was very tough, the kid was very strong big kid who played in a certain way and was not interested in interacting. When I played with him he didn't really respond like he heard me, so even though I was trying to meet him, I felt like there was a wall there. He finally got on the xylophone and when I started to add a lot more of my voice he started to make sounds. Then, all of a sudden, and this has never happened, he came up to me and he put his hands on my cheeks. He got in really, really close and he was trying to see where the sound was coming from and he sang with me! We'd go "Ahhh" we matched tone together....I let it happen because I just wanted to see, 'Wow, there's something about the tone or the vibration that has made a connection with him' Nothing like that in all the millions of intakes I've done has ever happened....I got his attention and I think it was music and because I'm a person and not a TV that was making that sound, I was able to modify my pitch and go up and down a little so he was staying on the "Ah" and I was going "Ahhh" [modulating up and down pitch], so we created all these overtones because we were face to face. I'm now this object that's doing more than an object would do. I was smiling and looking at him and trying to make him feel comfortable.

A music therapy trainee, Drew, said to me after a session in which he felt he met the client in music: "It's like I was in his world, right there with him." In the dance between the client and the music therapist, there were moments when the relationship was unilateral, where the therapist turned to the client, but the client turned away, or when the therapist withdrew in silence, in a sense turning away from the approaching client. From the therapist's perspective being together in music happens when they can play together with the client and feel that the client is communicating with them. This joining in with the co-creative process is evidence of therapeutic change for the client. By turning toward the social, they have taken an existential step in restoring communication.

As described earlier, during my work as co-therapist I had several sessions with the therapist, Joan, and our client, Sam. In another session (separate from the session I outlined in Chapter Three), I experienced what it felt like meeting Sam in music, where he and I formed a we-relation. This session was Sam's seventh, but my third. According to the indexing notes, the

session began as usual: Sam ran into the room and went right to the bass end of the piano. He started playing immediately, pausing when Joan sang to him. He did his usual jumping in place and tapping at the keys, vocalizing in the pitch Joan was playing on the piano. After about five minutes, Sam went to the wind chimes and he and Joan played their “Play and Stop” game, where Joan sings the phrase “Play and stop” and Sam has to mimic stopping the wind chimes with her. He and I had great fun playing with the wind chimes in later sessions. About midway through the session, Sam seemed to need a change of activity, so Joan and I brought out the reed horns from the cabinet. The reed horns are very simple horns, one pitched to a C, the other to a G, and the player only needs to blow into the mouth piece to make a strong sound.

I showed Sam the horns and he vocalized and walked away. Then he came back to watch me blow the horns, modeling how it could be done. I held out the C horn to Sam and he blew into it. As Joan began to play *Frère Jacques*, on the piano, Sam approached me, explored the horn I held for him, ran to the other end of the room listening to Joan singing and playing, then ran back to me and the horns, blowing the horn I held for him. His music was strong and forceful, playing staccato tones. After three minutes of this withdrawal and approach, Sam held his own horn and walked around the room with it. The indexing note reads: “Goes back to Megan and faces her, then goes briefly to Joan. Joan sings about his horn.” Standing with his back to the wall, Sam continued to blow the horn, coming in on the downbeat of Joan’s music. Sam laughed as he tried to separate the sounds but was not able, laughing and blowing harder as he stood near Joan. Minutes later the indexing notes read, “Sam looks at Megan and gestures – does he want her to blow her horn? Sing? He faces Megan and they blow together.” When it was time to end the session, Sam said “Goodbye.” This was his first spoken word in our session.

Needless to say, this session left me feeling elated and as if I had done what a music therapist was meant to do: I had met a client in music and it was fun for both of us. Sam was happy and giggling through the session, and truly enjoyed playing the horn. I enjoyed playing the horn with him. In our early experimental horn playing, the only thing I was aware of was encouraging Sam to play the horn. I am not sure how long Joan was playing *Frère Jacques*, but in our improvisation together, Sam and I created meaningful music: I blew my horn and he answered, he blew his and I answered. In those moments, the only sounds I could hear were the sounds of our horns and Joan's piano music that gave shape and consistency to our music.

Unfortunately, the we-relation ("the real thing") does not last forever. "The immediacy is preserved only as long as I live in the we-relationship, that is, as long as I continue to participate in the joint flow of *our* experiences. When I turn *reflectively* to our experience, then I have...placed myself outside of the we-relation" (Schutz and Luckmann 1973:64). Indeed, in the moments where I knew what Joan was playing and I was concerned with what to play when Sam gestured to me, I certainly left the we-relation. However, in the first moments of horn blowing, before I, as a new co-therapist, could reflect upon what I was doing or not doing, I was fully engaged in making music with Sam. I know this, because I remember the moment when I "came to" and realized that I had forgotten that anyone other than Sam and I were in the room.

Clive often spoke of the love and compassion that characterized the therapist's regard for the child – the kind of emotion that *does* something to help the client. It is possible that in the experience of music therapy, the client is presented as more "alive" and "immediate" than the music therapist is to him or herself. In the musical relationship there is coexistence with another being. The "unconditional positive regard" that Frank and Frank (1993) argue characterize humanistic therapies, like the Nordoff-Robbins approach, is felt in the therapists' expression

toward the clients; their desire to understand them, meet them, and help them is communicated in the aesthetic expression.

To meet the client in music and experience “the real thing” is a process of listening, responding, and searching through improvisation, and it depends on the therapists’ ability to express their intention musically. This therapeutic process highlights fundamental structures of human experience as a phenomenal lived body, particularly the role of pre-objective experience, synaesthetic perception, and intuition in building the therapeutic relationship. Empathy is communicated to the client in the moment of authentic musical expression. Therapy is a performance that enacts the therapist’s skills of listening and responding (discussed in Chapters Four and Five). After their performance, therapists “index,” which is the practice of reviewing filmed sessions and writing notes about what transpired. Here, therapists shift their living gaze from the phenomenal body to the objective body. In this objectifying mode, music therapists are able to find words to describe what was objectively “seen” and “heard,” yet still struggle to find language for their lived experience. Indexing, and the language problem it exposes, highlights a paradox in phenomenology. It is this matter to which I will now turn my attention.

Chapter Seven

Lived and Objective Bodies: The Problem of Language

Throughout this thesis, there have been references to the fact that finding language to describe what happens in music is an ongoing challenge for music therapists. This is particularly the case for describing experiences of the phenomenal, or lived, body. Whether music therapists are retrospectively and prospectively addressing the processes of music as therapy, the discussion inevitably resorted to visual metaphor. It was easier for music therapists to assign language to the video recording of the session when writing indexing notes than it was to give language to the pre-objective creative process of music therapy.

When music therapists index, they review a therapy session video and document what happened one minute at a time. Indexing notes have a column of time cues on the left of the page, next to which is a brief description of an important moment of the session. Therapists can clearly articulate that they heard a particular tone, arpeggio, or rhythmic pattern, that they saw a certain response from the client, such as a gesture or a wavering of attention, but they are objectifications of experience that do not capture the moment's lived experience. In lieu of recording the experience of their phenomenal body, which is difficult to capture, music therapists evaluate their objective bodies on screen, adopting a scientific attitude for indexing while they are still a lived body that is doing the indexing.

This highlights the paradox of being-in-the-world as a person who can at one time be a phenomenal body, and at another time have an objective body in front of them to examine, yet never fully abdicate the position of either. For Merleau-Ponty, we have a body and we are a body, and thus we can never become fully an object or a subject for ourselves, nor can Others become fully objects or subjects for us. We cannot touch ourselves touching, just as we cannot

catch our living gaze. As I have described, our experience of ourselves and of others in the world remains only partial to us and opaque. It is never transparent, nor complete. The camera that documents therapy sessions at first seems to offer a reflection of ourselves, but we will see that it is not able to overcome this fundamental structure of experience. In this chapter, I will explore the practice of filming and indexing among music therapists at the Nordoff-Robbins Center. I will also investigate the phenomenological relationship between indexing and language to offer insight into the difficulty of finding language to capture the phenomenal body's lived experience.

The Music Therapist's Dilemma and the Role of Metaphor

From the inception of their work, Clive and Paul struggled to find words to describe what happens between human beings in music. Current music therapists have inherited this challenge. Pavlicevic (1997) called this problem of language the music therapist's dilemma. During interviews, I kept in mind that I was asking for something that was likely very difficult for the music therapists to locate and explain with language. This follows from phenomenology's assertion that the paradox of the body – that we both have a body and are a body – means there is always a lacuna; we cannot see our selves seeing or feel ourselves feeling. In the flow of the creative act, a unified expression of thought and movement in the world, the music therapist cannot simultaneously express. Merleau-Ponty argues that the embodied self can imitate the scientist by seeing his own body as an object, as if it were through the eyes of others and in seeing the bodies of others as mechanisms. With this attitude, the psychologist attempted to adopt a universal thought, where he and those around him were complete and determined entities, rather than open, indeterminate and experiencing beings; however, he could never remain a complete object to himself, for he was always called back.

The psychologist was himself, in principle, that very fact he was investigating. He was in fact this very representation of the body, this magical experience that he was now approaching with such indifference; he lived it at the same time that he thought about it...He *was* everything he was *speaking about*. (Merleau-Ponty 2012:98-99)

Metaphor that called to mind a visual picture of the transpersonal process was one of the ways music therapists spoke about their experiences of learning to listen deeply, to respond with creative clinical improvisation, and to meet the client in the healing performance.⁷ The idea of portrait that is sketched in sound is an example of synaesthetic perception objectively described in language. According to Lakoff and Johnson (1980), metaphor is a central means through which people create and define their reality. Metaphor works to develop understanding of something that is felt beyond words, and asks the audience to imagine experiencing one thing in terms of another. In so doing, metaphor highlights certain aspects of experience and organizes them into a coherent structure (Lakoff and Johnson 1980:5). The “musical portrait” metaphor, the therapist’s artistic interpretation of the client, does not capture the process of creating the portrait. Music therapists never said they “paint” or “draw” the portrait, but that they create it through their music; it is an expression of the process, not a literal description that gives a sense or atmosphere to the clinical work that is done.

Music therapists must train students of music therapy and understand for themselves what it is that they are accomplishing with the client in music. Where language breaks down and cannot fully articulate what we know from our lived embodied experience of the world, metaphor stands in as a next best thing:

Metaphors may create realities for us, especially social realities. A metaphor may thus be a guide for future action. Such actions will, of course, fit the metaphor. This will, in turn,

⁷ For example, the “musical portrait” was discussed in Chapter Four as a way of expressing how therapists synaesthetically perceived a client’s style and responded to an aspect of the client’s being.

reinforce the power of the metaphor to make experience coherent. (Lakoff and Johnson 1980:132)

Metaphor, thus, makes coherent the pre-objective and inchoate, yet never completely; it is a poetic expression of an embodied phenomenon. It can be helpful for sharing experience with other people that could not otherwise be imagined if they had not lived it themselves. With each re-iteration of metaphor, however, the interpretation of experience, and therefore the experience itself is changed. Lakoff and Johnson (1980) suggest that metaphor acts as a self-fulfilling prophecy, where shifts in the way we conceptualize our experience in language can actually change our lived experience itself.

The music therapists were quite eloquent when they spoke about their lived experience in training and the performance of healing. Recalling from Chapter 5, the speaker's authentic expression (or performance) is an embodiment of the speaker's existence, their pre-objective contact with the world (Merleau-Ponty 2012:530). For example, therapists' words and phrases were improvised, just as their music was improvised. Phrases like "a hit and a miss, a hit and a stick" and "filter creative juice through the fingers" were not borrowed from another source, they were creative articulations of each therapist's experience. During an interview, when Leon was speaking about music being social and nothing else, he began to speak lyrics of the songs "Some Enchanted Evening," "I Left my Heart in San Francisco," "I Love Paris," and "Moon over Miami," to express this perspective. The lyrics were so seamlessly interwoven with his speech that they flowed as if they were his own words:

How would it feel to be with you? Well, how would it feel to be with you? How does it feel to be in Texas or Miami or Paris or San Francisco? Is there any song about the buildings in Paris, no. How does it feel to be in Paris? Any songs about the buildings in San Francisco, little cable cars half way to the, no! I left my *heart* in San Francisco. I love Paris. Why do I love Paris? Because my love is there. Moon over Miami. There aren't any places in music. No places, no curiosity, no science, no information, it doesn't

matter, all that's of concern is how I feel, how I might feel, how I feel about music, how I might be involved with you or not.

For Clive, being a music therapist was as much about how you lived in music as how music lived in you. The therapists' use of creative language to talk about their experience shows their existential synthesis with poetics and artistic expression. Therapists did not describe their lived experience of therapy in "scientific" terms, but in creative verse and imagery.

Clive and Paul maintained that music therapy should be taught as close to the clinical experience as possible, if not directly from the experience (*i.e.*, through live clinical demonstration). They wanted people to grasp the healing power of music and knew that language could only approach what was felt and what transpired. At the same time, they recognized that in the moment of the session stepping back and reflecting on the creative process was not an option; the engagement of the therapist was crucial to the process. Clive described indexing as "listening through a microscope" and taught therapists to document sessions in detailed indexing notes. The "microscope" metaphor emphasized the division between the therapy performance as a fully engaged, existential experience, and indexing as an empirical activity; the therapist's use of empirical language makes indexing an objective experience. It is not clear from the interviews whether or not Clive and other therapists considered that the music therapist's dilemma was far deeper than a matter of finding the "right" words; language is actually a matter of existence, our point of contact with the world. In the following sections, I will discuss how sessions are filmed and, later, address the inherent phenomenological dilemma in the practice of indexing.

Documenting Sessions: The View from Behind the Camera Lens

During therapy sessions, both Paul and Clive were so engaged with their work that the only way to accurately recall what had transpired was to have an objective record. They audio

taped the sessions, and upon review of the recordings, they devised therapeutic goals and theory. When Clive presented cases from his early work with Paul, he read from their indexing notes. These notes followed a similar format to the indexing note in Appendix A, detailing to the minute which activities they did with the client, which significant notes and songs were played, and which musical structures were used to what effect. Today, every Nordoff-Robbins therapist at the Center films and indexes their sessions. At the Center, there are row upon row of VHS tapes of every session ever done there. These recordings are referred to for ongoing training of therapists and public presentations and conferences.⁸

Clive designed the layout of the Center so that each of the two music therapy rooms has an adjacent filming booth where two people can work together to film and adjust volume levels during recording. There is a small (2 foot by 3 foot) square hole in the wall that is covered by a black curtain through which the camera's eye protrudes. It is not a perfect system: even some of the younger clients realize that there is someone on the other side of the curtain and play games that are not part of the session. During my fieldwork I was fortunate to have had the opportunity to film many sessions. Usually this role was given to interns and co-op students, but when they were not available, I was there and willing to fill in.

At first this seemed like an easy enough process: just hold the camera steady, lock it in place, and center and zoom as needed. I quickly realized, however, that the filer is the invisible member of the therapy team. The video recording is the only reference for the therapists to see their sessions again. A misdirection of the camera, poorly timed zoom, or unsteady sweeping motion will shape the record and the therapist's impression of the session. Moreover, if the

⁸ As DVD has replaced VHS there is a strong effort at the Nordoff-Robbins Center to convert all of these VHS tapes to electronic technology before the technology becomes obsolete and the recordings inaccessible.

volume is not properly adjusted in the booth, the session's sound could be inaudible. The video thus offered therapists an outsider's view of the same session, but filmed from the wall by someone who is living the session in a physically separated way. If it were representative of the therapist's perspective, the camera would be aimed over the primary therapist's shoulder. Ultimately, the "invisible" team member, the filer, controls what will and will not become historical record.

While filming, I noticed that I had a very different feeling about the session when looking only at the image on the camera's small screen than when the gap in the curtain offered a glimpse of the real people in the room beyond the curtain. The music was the same, as the filming booth was not soundproof, but seeing it on the camcorder was entirely different from seeing it live, as I did as co-therapist. Participating in sessions, one often forgets about the camera; only during moments of self-consciousness is the camera's gaze felt. Filming the session was like watching television with exceptionally good surround sound, but being in the session made me a real social actor; literally, an actor in an improvised drama that was unfolding before a camera. Even though I was not playing the piano, as co-therapist I felt that I was performing, and doing so in a special enclave separate from the outside world.

Each role in the therapy performance is a unique phenomenal experience. Depending on the focus of the music therapists, they may engage with their phenomenal body in the session, but focus more on their objective body on film during indexing. Merleau-Ponty's paradox of being a body and having a body (described in Chapter Three) comes to the fore here, offering insight into how such existential shifts and partial perspectives are possible.

Indexing and the Language of Emotions

I have argued in this thesis that the essential feature of Nordoff-Robbins music therapy as a creative spontaneous healing art is the phenomenal experience in the Creative Now. Therapists throw themselves fully into the present flow of the therapy experience, but in so doing, they cannot step out of the flow to review the session, and thus must rely on the video recording of the session to catch what they feel they missed. Indexing offers the therapist a way to critically review the session from an “objective” perspective. As a source of feedback, music therapists can incorporate the indexing material into their overall sense of their creativity and performance in the session. Knowing what tones, rhythms, and meters are effective with a particular client and noticing aspects of practice like overreliance on certain musical patterns can help therapists continue to monitor and improve upon their skills. However, indexing is a retrospective view of the creative process that belongs to the objective body; it cannot capture the original pre-objective, synaesthetic, phenomenal experience of being in music with the client.

One of the advantages of indexing for the music therapists was the option to take time to process the emotional content of a therapy session. As was discussed, the most effective musical expression is co-created when the therapist slips into the client’s perspective. What happens in the world does not just happen, but happens to me; the continuous searching for and meeting clients in music can be emotionally powerful. Nancy said:

I rarely index right after a session. I want to give that experience room to just continue to unfold because I believe that what happened in the room doesn’t end when the session ends. I believe it continues to have effects on both you and the client even after you’ve gone your separate ways. So if you return to it after a period of time, then the indexing can be more meaningful.

Nancy’s remark that indexing becomes “more meaningful” with time is interesting from the perspective that the lived body that experienced the emotional content of the therapy session

is not the same lived body that indexes later in the week. Over time, therapists withdraw from the original phenomenal experience in order to transform the experience into something objective that they can reflect upon. The interpretation of the retrospective lived experience gains meaning as an objective set of data that can be associated and correlated with other objective data, not because of what was felt phenomenally. As discussed in Chapter Five, secondary speech about lived experience of creativity is not creative because it only repeats established conventions of music and music therapy to analyze what happened in the therapy session (Merleau-Ponty 2012:189,530). Indexing focuses on the objective past, rather than the phenomenal present of indexing; therapists rarely discussed what it felt like to index, only what was objectively happening on the video tape, and had no trouble finding language to describe their observations.

Following from Alfred Schutz, Berger and Luckmann (1991) argue that our experience is grounded in everyday life; among the many realities we inhabit, our everyday life is the paramount reality to which we will always point back and through which we will always translate our non-everyday lived experience (40). This paramount reality envelops other realities. Music therapy is one such enveloped experiential enclave:

The transition between realities is marked by the rising and falling of the curtain. As the curtain rises, the spectator is ‘transported to another world,’ with its own meanings and an order that may or may not have much to do with the order of everyday life. As the curtain falls, the spectator ‘returns to reality,’ that is, to the paramount reality of everyday life. (Berger and Luckmann 1991:39)

As an artistic reality, the session has its own spatial and temporal structure that is different from that of everyday life. Emerging from the session back into everyday lived reality requires a re-orientation of the body with the paramount temporality and spatiality, and translating experience from one reality to another is challenging: “The theoretical physicist tells us that his concept of space cannot be conveyed linguistically, just as the artist does with regard

to the meaning of his creations and the mystic with regard to his encounters with the divine” (Berger and Luckmann 1991:40). Indexing is not a matter of interpreting one reality, but of interpreting the coexistence of realities that are lived and remembered by the therapist, demanding a jockeying between the pre-objective and objective, paramount and enclave.

While music therapists were not always able to articulate their lived experience in words, they communicated that the experience in the therapeutic milieu could be so profound that they needed time and space away from the session before indexing it. Emotional processing requires the translation between one’s everyday role and role of therapist. Lynn commented on this in our interview, “Sometimes you feel like, ‘Wow, that was hard, he told me to shut up,’ or ‘He hit me,’ or whatever. We have to accept this in our roles [as music therapists]. We have to take a bigger perspective. But, still, as a person, you’re affected by this.” When the therapist’s emotions detract from the session’s goals, they must be dealt with in another space and time.

Full translation between realities would require that experience be transparent to the person who lived it. It has been argued that experience is always partial, indeterminate, and never completely constituted. The body, too, is ambiguous and its view of itself is neither whole, nor fully transparent. Albert said that when working with “hard to reach” clients, indexing can be a form of peer supervision; a way for therapists to self-monitor or cross-check with colleagues about what they are communicating to the client during the session.

In my experience of being co-therapist, I had a therapy session with Joan and our client, Sam, that left me feeling upset and in need of time to process the experience; I needed to withdraw and make sense of it in my own everyday reality. The session began well, but about midway through, Sam began crying and would not let himself be comforted by the music. I understood that the point of music therapy was to support the client’s emotional expression, but

in that moment I wanted to play something that stopped his wailing. Nothing seemed to work; Sam cried, we played music, and I felt that our music was actually harming him. A week passed and Joan and I indexed the session together. I was expecting to see a tape full of Sam crying and frustrated, but I was surprised to see that the crying was only in the last ten minutes of the session. There were other elements of the session that I had remembered feeling much more intensely about than were presented on the video. Watching the session video was a completely different experience from the original lived experience. While Joan and I were indexing, Albert joined us and recalled what Clive used to say in such situations:

Clive always used to come away from a session and say ‘Oh, that was the worst session ever,’ then he’d watch the video and realize it wasn’t so awful. Or the reverse would happen, he’d say, ‘Wow! What a great session!’ Then he’d watch the video and think, ‘Oh that wasn’t so great after all.’

The session video is an objective representation of lived experience which therapists used to discuss what happened during a session with discrete, objective terms. Recall Merleau-Ponty’s paradox of being and having a body: we are always partially an object and subject, but never completely one or the other. For example, the lived experience of excitement during the session is recorded in the indexing notes as smiles, gestures, tempi, and tones “seen” or “heard.” The indexing note is like a chemist’s laboratory report. The video is its own world of objects to which therapists ascribe experiences and descriptions, treating these objects as if they were living entities. Objects, be they words or images, only pretend to completely describe that which evades description. This ambiguous condition of phenomenal existence is inescapable, and no matter what mirrors or technology we employ to correct for it, objectifications are never complete representations of phenomenal experience.

Challenging the Notion of Failures in Perception

Another frequently mentioned reason among music therapists for needing indexing was as a back-up reference for things they had missed during the session. Many therapists remarked that it was very difficult to listen while playing with the client. In our interview, Joan said that, “[In sessions] you still miss things. That’s why it’s wonderful to have the video because we never get to hear absolutely everything.” Clive and Paul noticed, too, how when they were involved in the process of creative music-making, they felt as though they had missed something. This is not a failure in perception; phenomenologically, there are no failures of perception:

I perceive correctly when my body has a precise hold on the spectacle, but the hold is never complete...To perceive is suddenly to commit to an entire future of experiences in a present that never...guarantees that future; to perceive is to believe in a world.
(Merleau-Ponty 2012:311)

The music therapist’s experience is like that of Merleau-Ponty’s orator: when the orator speaks, he invests himself so completely in his expression that there is no time to pause and reflect on what he is saying. It is only when the orator stops, when the spell is broken, that reflection can be taken up (Merleau-Ponty 2012:185). Each therapist in the room and the client is the orator at any given moment and sometimes all together, as music is a co-operative activity; unlike speaking, everyone is fully engaged in playing music at once. In pre-objective experience, each person has a partial hold on the present, and only in so far as they have thrown themselves into the flow of music. The therapist is as engaged as the client (or more so), and there are practical limitations of their experience when simultaneously listening and playing. Lynn commented:

Listening in such a way that whatever sound, movement, motion, or playing is reinterpreted, you take that in and you’re able to use yourself as a conduit for the music that comes out, to relate to that person. That certain kind of deep listening is the most important element required for this work. The problem is that you have to listen as you play. That’s why indexing is important.

Music therapists consciously tried to optimize their perception and receptivity of the client by being poised in the Creative Now. Therapists remarked on their concerted effort to “forget” their practice and training before a session, so that their music flowed from the situation, organically and creatively, reflecting what is present, and not blocking off their perception with pre-conceived notions of what should be. Nancy said, “There is this sense of being as prepared as you can be, you go home and practice the scales and modes, but when you’re in the room, you try to forget any kind of technical or cognitive process that you had planned.” The therapists “forget” in order to open themselves to receive as much information as possible, acknowledging the experiential magnitude of therapy. To “miss” something implies their bodies were unable to capture all the experiential information, and connotes a scientific attitude inherent to indexing. However, there is no failure here because the phenomenal body could be said to “miss” things all the time as experience is indeterminate, incomplete, and never transparent; we only grasp that to which we are attuned, given our unique embodied position in the world.

Phenomenologically, Nordoff-Robbins is a method of no-method, an approach with techniques that therapists use creatively. Music therapy and ethnographic fieldwork’s participant observation share a common ground; both demand that the professional actively participate with their informants, while they simultaneously document what is taking place personally and objectively in, for example, a shamanic ritual. Music therapists and anthropologists have recording media such as videotape as a means to compensate for the difficulty of objective observation while they are engaged experientially; it is a way to live the art and practice the science of their professions.

Unlike the musician, the music therapist is charged with guiding a client with the “right chords” toward greater development and social communication which requires him or her to

follow therapeutic progress objectively. The question is whether or not reflecting on the client's process must happen during the session, or if it can still be effective if done during indexing, outside the lived experience of the session. Straus (1958) distinguishes between sensory experience of the living body and sense data (or knowledge) that belongs to the objective body. In sensory experience, as Nancy observed, "during a session, no one knows what anyone else is hearing." Indeed, they cannot because although human experience is inherently accessible for others in the world, it is uniquely accessible in the first-person sense for the individual who lives the experience. "Sensory experiencing is mine; what I grasp there I grasp in relation to myself, to my existing, my becoming. It is defined by my present time, this moment in my unrepeatable existence, between birth and death" (Straus 1958:145). In sensory experiencing "something happens *to me* in the world" and there are no tests to prove or disprove my feeling that I was affected. Knowledge, on the other hand, is indifferent to our existence; in knowing, something merely happens in the world; it is for itself, not for me (Straus 1958:145).

Knowing objectively what others "hear" takes a leap into the scientist's milieu, from the world of lived sensation to inanimate sense data. Sense data are always related to consciousness. Data can be wrong or missing, but sensory experience has no judgments. Once separated from the body as sense data, sensations are stripped of their worldly, personal, and corporeal qualities (Straus 1958:142). The empirical focus on knowledge, for Straus, abstracts us from our own vital existence and its conditions. Observers become interchangeable and the personal relation to things becomes hidden. Sensations become pure objects, general, and shared, rather than things as they appear to me in relation to myself and the world (Straus 1958:145). Indexing provides an objective perspective; all who watch the indexing video can agree on what was "heard" or "seen." This is evident in the ease with which anyone can understand what objectively transpired

in a session from the indexing notes. This makes indexing a very powerful training tool. Nancy believed she gained a great deal from indexing, saying:

I think that I've learned a lot from reviewing the sessions and the videos, learning to listen definitely benefits from having that opportunity, because there are certain things that you don't hear in the moment. Sometimes, I've done indexing without watching the video...that was one technique we learned in training, to index with just the audio input. That really helps the listening.

As a training tool, though, it is at an existential distance from the clinical encounter.

Indexing extracts the personal element of the sensory experience, negating the formula, “something happens *to me* in the world.” While this helps for training and agreement upon what transpired in a session and opens discussion for therapeutic approaches, it erases the fundamental being-to-being phenomenal experience on which the Nordoff-Robbins approach is based.

Listening in a categorical way trains the body to adopt a natural attitude, where objective qualities are “heard” as objective sensation for the ear. Further, it is not the perspective from any one of the music therapists – rather, it is the perspective of the filer. The objective qualities of what was “heard” are necessarily experienced differently during indexing than they were experienced phenomenally in the session.

It cannot be overstated that the phenomenal experience of the body is synaesthetic, indeterminate, and open. One hears with their whole body in the session. There is language that conveys the objective sense data, but what is missing is the language to describe what happens pre-objectively in the sensory experience of the Other and the ultimate restoration of communication. The field of the healing arts, in general, and the Nordoff-Robbins approach to music therapy in particular, would benefit from introducing into their lexicon concepts from phenomenology that better acknowledge the dilemmas of experience. There need to be words in the field that target the indeterminacy of the world and of experience, the taken-for-granted totality of our partial experience, and the paradoxes of being and having a body in the context of

the therapeutic milieu. With this linguistic set, music therapists would have another complement of tools for addressing the pre-objective and pre-reflective experience of transpersonal work.

While interpretation always casts experience *as* something, the language of phenomenology may help do justice to the experience and capture its fundamental structures.

Conclusion

The power of music to effect therapeutic transformation is undeniable, and as we have seen, the experiences of music therapists who perform healing with “hard to reach” clients are complex. Through the lens of phenomenology, this thesis has investigated the narratives of select Nordoff-Robbins music therapists and my own experience in the field to uncover many important aspects about the relationship between pre-objective and objective realms of experience in training for, and performance of, music therapy. The conclusions drawn from this research, its contribution to knowledge, and suggested future directions for investigation will be summarized below.

One of the most interesting findings of this research was the phenomenological basis for music therapists’ problem of language that describes their pre-objective experience. Immediate experience and perception are partial and indeterminate: any objectification (words, images, etc.) will be unsatisfactory in the sense that, for example, each verbalization introduces a transformation into a pre-verbal, pre-objective experience. Therapists seem to recognize that phenomenal experience is not transparent. In fact, they review session tapes (index) to catch what they “missed” during a session. It was not difficult to find objective language to talk about objects on the screen, but finding words for their original experience of their pre-objective contact with the world was problematic. Thus, therapists expressed their phenomenal experience through metaphor and poetics, a best approximation of their pre-objective experience.

From this research, important phenomenological structures of experience were found in music therapists’ training regimens. The interwoven experiences of listening (Chapter Four) and responding (Chapter Five) to clients begin as learned skills that therapists practiced until the skills were part of their embodied experience of the world. “Hard to reach” clients are limited in

their communicative and relationship abilities, thus music therapists' practice of learning to listen deeply was found to be a phenomenological problem of partiality and indeterminacy of perception. Therapists' "deep listening" was discovered to be a practice of synesthesia, a unified pre-objective experience of the world, which they described as an expanded or broadened attention. Moreover, therapists learned to be "poised in the Creative Now," an existential space they inhabited in sessions which opened them up to be more receptive and sensitive to the client's expressions and needs. This pre-objective mode of being in a session became an embodied habit of listening that the therapist took on as part of their being-in-the-world in general. Throwing themselves into the flow of the music, therapists listen (and respond) with clinical intentionality, a form of phenomenological intentionality that shapes the therapist's perceptions, interpretations, and actions toward the client. A unique modulation of the therapist's experience was their use of silence with clients, which was found to be a clinical tool for either staying in a pre-objective experience, or provoking the client to make an existential move from the pre-objective into the objective realm through an experience of musical expression.

Music therapists' training in clinical improvisation centered upon the ultimate problem of creativity in music therapy and its phenomenological structures. It was found that in sessions, music therapists negotiated between structure and freedom, between determinacy and indeterminacy. In improvisation, the creative act was a unified movement and flow of expression between the pre-objective and objective realms of experience. The therapists' intuition and inspiration combined with spontaneous gesture in a single existential thrust into the world. The gesture, figurative in nature, was a co-created expression with the client, born out of the pre-objective, fundamentally social realm of experience in which therapist and client lived. The

musical gesture communicates both the therapists' clinical intention to help and their empathy and desire to understand and meet the client in music.

Further findings include the phenomenological structures of the objectivity and subjectivity debate among music therapists. While some therapists held that music is an aesthetic object that is universally meaningful, others maintained that it was the therapist's personal delivery that gave the expression meaning. Phenomenologically, it was found that music is an objectification of lived experience and as an object it can belong to the anonymous world; however, the object is only meaningful to someone when it is taken up and articulated in terms of the person's own subjective embodied position in the world. When music is co-created in a social relationship, it is less the product (the object), more the process (the existential shift between pre-objective and objective experience) that matters for therapeutic transformation.

In the performance of healing (Chapter Six), the therapists' phenomenological experiences of meeting the client, the Other, in music were examined. The goal of music therapy is to overcome the client's disorder of communication and make it possible for them to engage in social relationships ("we-relations"). In the therapeutic milieu, music framed the experience as play which had the effect of re-ordering the client's disordered pre-objective experience of the world: interlocking their experience of time, changing their experience of space, and introducing new possibilities for self-expression and communication with the therapist. Music, as a pathic sense, demanded the attention of everyone in the room. It had a powerful effect on reaching the "hard to reach" client and drawing them back toward the social world.

Another prominent finding with regard to the performance of healing was the therapist's need to gauge when to approach the client musically and when to withdraw, as in silence mentioned above; a game of searching for and finding the clients in the pre-objective realm was

ongoing. The client, too, cycled through approaches and withdrawals on their way to social relationship. The therapists conceptualized rejection as resistiveness, a communication of pre-objective experience of the world. As communication, it could be objectified and worked with, effecting therapeutic transformation between the pre-objective and objective realms of experience. The phenomenal experience of “meeting” the client in music was felt existentially by therapists as a slipping into the Other’s subjective experience of the world, and sharing in the client’s perspective without abdicating their own. In moments of the “real thing” or meeting in music, therapists and clients explored their new roles in reciprocal social communication.

Contribution to the Field and Future Directions for Research

This research has built upon literature on performance and healing from the fields of anthropology and music therapy. It has contributed a new theoretical perspective to the study of healers’ training and experiences by applying a theoretical perspective that is rooted in the phenomenology of embodiment and intersubjectivity. Indeed, the research was gathered predominantly from participant observation, whether as a co-therapist, when transcribing lecture videos, or participating in the Center’s daily activities. Interviews were the source of the narratives, but a great deal about music therapists’ experiences was learned from my experience of being with them. My engagement in the therapeutic milieu grounded the theoretical analysis and the presentation of this research in lived experience, rather than in abbreviated surveys and the like, which keeps it closer to the life-world of the therapists with whom I worked.

For the field of music therapy, this research provides a new approach to investigating the phenomena of healing, as well as the experiential structures of music therapists’ work. Here, metaphor and poetics are tethered to a strong theoretical framework, which clinician-researchers

in the field can continue to use and build upon. Light has been shed on a number of existential and experiential problems for music therapists, such as the lack of language to talk about the phenomenal experience of training, healing, and being with a client in therapy. It has also offered insight into the problem of creativity, upon which improvisational music therapy relies.

This thesis endeavours to serve as a reference document that provides the field of music therapy in general, and Nordoff-Robbins music therapy in particular, a distinctive language to adopt and integrate into their training courses and everyday practice. The language of phenomenology has been shown throughout this investigation to be capable of describing and making sense of experiential phenomena that resist academic explication. It is intended that the understanding of phenomenal structures of experience – indeterminacy, pre-objectivity, and synaesthesia – become part of music therapists' self-reflective practice and future research in the field of music therapy and healing arts.

For anthropology, this research also contributes a good theoretical platform from which to explore shamanic healing rituals and performances in other cultures and settings. It offers a starting template through which earlier literature can be revisited in terms of relations to the Other, indeterminacy, pre-objectivity, and objectivity. Improvisational music therapy as a way to creatively build a relationship with an Other in music shares many features with ethnographic fieldwork; the method of no-method that characterizes participant observation may be better understood in relation to this thesis's findings. This study is one of the first of its kind, articulating universal structures of human experience in terms of the particular experiences of a certain group. Though this thesis focused on the experiences of Nordoff-Robbins music therapists, the theoretical approach can be applied more broadly to other groups and practices.

Future research could conceivably focus on the problems of creativity and language in music therapy. To address the creativity and the creative act more closely, such a study would have to include researchers working as primary therapists, training and performing improvisation so that they could feel the experience for themselves and be more engaged participant observers. This would lead to more nuanced research questions and to uncovering more subtle problems to which phenomenology could be applied. The second issue to address more closely in future research is the practice of indexing and the act of objectifying (in images and words) the pre-objective contact with the world. This practice is unique to Nordoff-Robbins and could be a dissertation unto itself because of its phenomenological complexity. To accomplish these goals, the researcher must participate with a higher level of expertise on piano (the main improvisational instrument) and must commit to a longer period of fieldwork.

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Appendix A

November 9, 2012

Session 6

- 00:00 S enters and goes to the bass end of piano. He looks at J when she sings her name. He plays clusters, single tones. He watches J at times as she plays. Is he copying J or is J copying him? He smiles a little.
- 02:40 S shows interest in J's glissandi, tries to do it. He sometimes jumps as he plays. He tries glissandi, but can't. He shares the keyboard space with J. He repeats a note in the lower bass. He looks at the edges of the keys, goes to the floor to explore the pedals.
- 04:50 J: *Where, oh where, is S?* We get the 2 drums. As soon as J starts to play piano he comes over, plays in the treble. He plays a lovely melody! Some fast spurts of playing. Slow melody (starts with descending Cm arpeggio). He stops to listen.
- 07:40 S goes behind the piano. He lets M take his hand to tap the drum a few times, then returns to play in the treble. He smiles when J plays strong clusters with him. He plays triplets to J's melody.
- 09:20 Music stops. J asks him if he wants more, makes the sign. S also makes the sign, plays more, smiles at M. Jumps a little, seems happy. Plays high in the treble. S jumps—J follows his tempo.
- 11:50 S leaves the piano, taps the drum as he goes past. Plays wc briefly, piano bass briefly. Jumps back to the piano, looks at M when she offers him a mallet.
- 13:30 He stays at the side of the piano—J sings *uh, oh*. He plays in the bass, watches the key depress.
- 14:40* S vocalizes, looks directly at J. J is not playing piano, but vocalizing. S goes behind the piano, vocalizes more. Comes back to the bass, then treble. Runs in place.
- 15:45* J plays *Twinkle*. He listens, stares at M as she sings and taps the drum. He stands quite still as J plays and sings the song. He plays in the high treble. He stares at M as she sings on *la*.
- 18:05* S plays the tonic in the bass! J leaves pauses—he fills in on the piano, not with words.
- 19:15* S wanders. J gets the wc, plays and stops. This captures his interest. At first he watches from afar, then comes closer. He vocalizes. J plays/sings (dominant to tonic), stops.
- 20:42* S smiles and comes over to play the chimes with J. J repeats plays/sings, stop many times. S remains interested. Calm, focused energy. J prompts him to say or sign *play or more* but he doesn't.
- 23:52 S goes over to the drums and plays with his hands for a few seconds. He returns to the wc. J resumes the game and he remains interested.
- 25:15* S helps J catch the wc to stop. He vocalizes when J stops the wc.
- 26:00 S loses interest in the wc. J gets the guitar. S vocalizes, sits on the floor with J and strums. J improvises a GB song. He seems very comfortable. He tries to turn the pegs. We sing GB to everyone. S lies on the floor. He yawns. He moves his lips for *bye*. He moves his head from side to side (self-stim).
- 29:12 S lets J take his hands. He seems tired, unfocused.
- 29:48 When J asks him if it's time to open the door, he makes a sound of protest. J walks him to the door.
- 30:35 END