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LISTENING, IMPROVISATION, AND THE THERAPEUTIC RELATIONSHIP IN
MUSIC THERAPY: A SELF-INQUIRY

A THESIS

Submitted in partial fulfillment of the requirements
For the degree of Master of Science
in Music Therapy

by

JILL LUCENTE
Molloy College
Rockville Centre, NY
2011

MOLLOY COLLEGE

Listening, Improvisation, and the Therapeutic Relationship: A Self-Inquiry

by

Jill Lucente, MT-BC

A Master's Thesis Submitted to the Faculty of

Molloy College

In Partial Fulfillment of the Requirements

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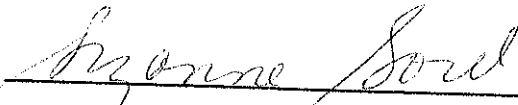
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Abstract

The purpose of this self-inquiry is to gain insight into the listening process I employ as a therapist through improvising with my clients, and also to better understand how the listening process influences the therapeutic relationship. Data was collected from two selected videotaped sessions of two clients (for a total of four videos). The sessions were transcribed and moments of improvisational music making were analyzed. Five areas were highlighted: client's responses, therapist's process, therapist's responses, therapist's reflection, and type of clinical listening. Adapted from Lee's six levels of clinical listening, four types of listening were identified: explorative listening, perceptive listening, grounded listening, and spiritual listening. Results demonstrate that listening during the session can be a different process than listening while reviewing session videos. In addition, the therapist's listening tendencies: explorative listening, perspective listening, and grounded listening are revealed. The influence of clinical listening on the therapeutic relationship has proved to be significant. The adaptation and application of these listening types are discussed, and conclusions and implications for training and practice are presented.

Key words: clinical listening, listening types, therapeutic relationship, listening in music therapy, improvisation.

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Table of Contents

	Page
ABSTRACT.....	iii
ACKNOWLEDGMENTS.....	iv
LIST OF TABLES.....	v
 LISTENING, IMPROVISATION, AND THE THERAPEUTIC RELATIONSHIP	
WHAT IS CLINICAL LISTENING?.....	1
My Clinical Experience	
Teamwork	
Significance of the Study	
Need for the Study	
REVIEW OF THE LITERATURE.....	8
An Exploration of Hearing, Listening, and Clinical Listening	
Simply Hearing	
The Act of Listening	
Listening to Music	
Clinical Listening	
Listening in Music Therapy	
Clinical Listening and Nordoff-Robbins Training	
Clinical Listening and Supervision	
Competencies and Clinical Listening	
AMTA Competencies	
NR Competencies	
Clinical Improvisation	
Research Questions	
Definition of Key Terms	
METHOD.....	22
RESULTS.....	26
Categories	
Research Question 1	
Listening Types	
Vignettes	
Research Question 2	
Research Question 3	
DISCUSSION.....	38
My Listening Process	

The Therapeutic Relationship
Influence of Listening Types on Therapeutic Relationship
Listening Tendencies
The Role of Supervision
The Role of Co-therapist

CONCLUSION.....43
 Summary
 Limitations
 Implications for MT Practice
 Implications for MT Education and Training
 Future Research

REFERENCES.....47

APPENDICES.....50
 Appendix A: IRB Approval Letter, Notification of Title Change,
 Consent Form, Letter of Permission
 Appendix B: Client Information
 Appendix C: Sample Data Analysis

Table	Page
1. Example of Explorative Listening: Charlie.....	29
2. Example of Explorative Listening: Samantha.....	30
3. Example of Perceptive Listening: Samantha.....	31
4. Example of Perceptive Listening: Charlie.....	32
5. Example of Grounded Listening: Charlie.....	33
6. Example of Grounded Listening: Samantha.....	34
7. Example of Spiritual Listening: Charlie.....	35

Listening, Improvisation, and the Therapeutic Relationship in Music Therapy

What is Clinical Listening?

How do I listen? What do I listen for? How do my interpretations, based on what I hear impact the therapeutic relationship? It was after a session with Samantha (pseudonym), a nine year-old- girl with autism and various developmental delays, when I began to reflect on how I generally listen to her musical responses during our sessions. I observed that her vocalizations became increasingly tonal and intentional. At the piano, I improvised a clear musical form that supported her vocalizations, while also creating enough space for her to extend her phrases. During these moments, I reflected on how I was listening to and interpreting her musical responses in ways that ultimately influenced my own musical responses. Interestingly enough, while reviewing the session footage as part of my documentation process, I noticed that she was imitating my melodic rhythm in her singing. I thought to myself, ‘Why was I not aware of this response in the moment?’ What musical responses was I listening to and “tuned in” to during this moment? How did I interpret her music? On what basis did I make these clinical decisions?’

As a new music therapy professional, the phenomenon of clinical listening continues to be a recurring theme in my work. During music therapy sessions with the children I work with, I ponder how I am listening and responding to their words and sounds; I consider how these musical interactions inform and shape the clinical work and the relationships that emerge through the therapeutic process, since I gain a better understanding of the child through a shared musical experience.

Based on my own clinical experiences, I believe that listening involves more than simply hearing a client's music. Listening is a complex process that requires the therapist to be emotionally connected and intuitive, while also sustaining both focus and intention in the clinical setting. Therefore, how we listen and what we listen for during music making in the clinical setting plays a significant role in the therapeutic process. In order to build a trusting client-therapist relationship that can grow over time, it is important to let the client know he or she is being heard. We show the client that he or she is being heard by intentionally listening with openness. I believe that developing and understanding this skill is a necessary component in engaging with our clients and formulating our own responses while making music. As I become more clinically experienced, I often consider how the act of listening can serve as a stepping stone to building a trusting client-therapist relationship. Specifically, I am increasingly curious as to what elements or features I am listening for in the music and how my interpretations and perceptions influence the developing relationship. As a clinician, I am constantly making interpretations based on what I hear, and thus I seek to discover and analyze my own "listening tendencies" in order to gain a deeper understanding of my clinical work.

While the context of this study stems from my initial curiosity of my own personal listening process, I am also motivated by my belief that as music therapists we have a responsibility to develop self-awareness, as this is an essential component to being an effective and empathic clinician on behalf of the clients with whom we make music. Research such as this study can serve an important role in linking theoretical ideas with clinical practice on the topic of listening.

My Clinical Experience

I am a board certified music therapist (MT-BC) working towards the Licensed Creative Arts Therapist-(LCAT) credential. September 2011, marked my fifth year at The Rebecca Center For Music Therapy; a music therapy clinic located on the Molloy College campus. In addition, I am currently completing my Nordoff-Robbins Level 1 Advanced Training at Molloy College.

The Rebecca Center for Music Therapy provides individual and small group music therapy services to children and adults with developmental challenges including Pervasive Developmental Delay (PDD), autism, Cerebral palsy, Down syndrome, and generalized learning disabilities. The Rebecca Center's mission is to use interactive music therapy interventions to facilitate relatedness, communication, and thinking. The session room contains a variety of instruments available for making music including percussive instruments, guitars, and piano. Pre-composed music and improvisational music is utilized based on the client's individual needs and preferences. Each therapy session is led by two music therapists and recorded using a digital video camera for documentation purposes. In addition, excerpts of sessions are later used for parent meetings, staff supervision, and presentations.

The Rebecca Center's philosophy is based on developmental theories of Dr. Stanley Greenspan and the Nordoff-Robbins approach to music therapy; focusing on the relationship through music and the client's ability to engage, relate, and communicate during interactive musical-play (Carpente, 2009). In the Nordoff-Robbins approach, the client plays music with no required skills as the therapist improvises music built around

his/her musical responses, movements, and emotional state. Carpenite (2009) asserts, "The purpose is to musically engage, match, support, and enhance whatever the child is offering, musically or non-musically, therein promoting relatedness, communication, socialization, and awareness within the music itself" (p. 12).

My approach to music therapy is humanistic, and more specifically, music-centered: "the achievement of experiences and expression specific and unique to music" (Aigen, 2005, p. 56). In this way of thinking, musical goals are clinical goals. This approach does not aim to utilize music merely as a "tool" to reach a goal, but what is achieved through musical experience is the goal of therapy. In my approach, improvisation is used as the means for connecting musically with my clients. Clinical improvisation will be further discussed in the review of the literature.

Teamwork

Reflective of the Nordoff-Robbins model, sessions at The Rebecca Center involve both the primary therapist who creates the music, and the co-therapist who facilitates the client in music making (Nordoff-Robbins, 2007). The relationship between the primary therapist and co-therapist is a unique one. Together, they assess the client and develop a treatment plan and clinical interventions. In addition, the primary therapist and co-therapist compose music for clients, review session footage, and document significant moments that occurred in the session through session indexing.

When working as a team in the session room, the primary therapist and co-therapist are aware of their roles as it pertains to the clinical process. At times, the co-therapist's role is an active one, supporting a client in instrumental play by modeling and

providing gestural cues. The co-therapist may also take on a role that is more passive, supporting the client with his or her proximity and presence.

The impression is that there are specific roles and that each team member is aware of his or her role and follows it. However, within these apparently clear parameters, there are an infinite variety of forms the actual clinical process may take depending partially on the degree to which the co-therapist is active in the particular instance (Turry & Marcus, 2005, p. 55).

The presence of the co-therapist is an important consideration when studying my ability to listen as the primary therapist. When reviewing video footage post session, the co-therapist may offer a different viewpoint in regards to client and therapist responses in music. She may perceive the musical experience differently, which could offer greater insight and understanding of my listening process. In addition, the co-therapist's responses and actions during the session may influence how I listen. For these reasons, the presence of the co-therapist is an important dynamic to consider when analyzing how I listen, as it pertains to my understanding of the work.

Significance of the Study

The concept of listening is significant to various fields such as music therapy music education, communication, psychology and counseling, musicology, and aesthetics. It is apparent that listening is a critical component for engaging in reciprocal interactions with others. While these fields utilize listening for different reasons, it seems that the recurrent theme is that listening is a pertinent part of building relationships and forming bonds with others.

In music therapy, listening is a required competency. Bruscia (2001) asserts, "...of the many diverse competencies required of a music therapist, listening is the most fundamental and unique to the discipline. It precedes shapes and monitors how the therapist responds to the client. Listening is the only way a therapist can understand what the client is accomplishing therapeutically in the improvisation" (p. 7).

A closer examination of listening in clinical improvisation through careful self-analysis can offer insight into the music therapist's listening process and interpretation of musical responses during co-active music making. This type of self-inquiry can benefit the clients as it can inform the therapist of his or her ability to listen and thus, enhance the therapeutic relationship. The therapist may become more self-aware which can result in a better understanding of the clients' needs. In addition, this self-inquiry is unique in that it is based on one therapist's perspective on the listening process.

Need for the Study

This self-inquiry study required research from various academic databases including: EbscoHost, PsycInfo, PsycArticles, ERIC (Educational Resources Information Center), and SAGE. In addition, an assortment of book publications was utilized as it pertained to my topic. My research revealed that there are six qualitative studies in music therapy (Aldridge, 2002; Arnason, 2003; Bruscia 2001; Cooper, 2010; Forinash, 1992; Sokira 2007) that are related to my topic.

In my research, I found twenty-five sources related to my topic. Four studies were scholarly articles, and one study was a doctoral dissertation. Interestingly, most of the studies that contributed to this research effort were qualitative rather than

quantitative. While it is evident that a body of significant qualitative research in the areas of listening techniques in improvisation has been undertaken, there seems to be a lack of self-inquiry studies that offer an in-depth analysis of the music therapist's listening process. The topic of listening constructs and improvisation analysis have been studied; however, the actual process of listening from the researcher's perspective has not been strongly presented in the research in the field of music therapy.

Throughout my coursework and attendance of conferences, as well as discussions with my colleagues, it became apparent to me that the therapist's listening process is an area of interest for many music therapists. More specifically, a particular area of interest that emerged centered on the interpretation of client's music-making during improvisation. My colleagues aim to discover how they interpret their client's music during improvisation and it is my hope that this study will be a valuable resource.

Thus, for these reasons, I chose to examine the topic through research as it offers the music therapist a deeper understanding of the listening process and its influence on the therapeutic relationship. While pre-composed music was utilized during sessions, I only analyzed listening while improvising, as this is my area of interest. I hope to gain insight into this aspect through exploration in my study. This may enhance the therapeutic relationship between me and my clients, while providing pertinent information to other music therapists. In addition, it is my hope that this research is informative and beneficial for music therapists and the clients with whom we share our music.

Review of the Literature

An Exploration of Hearing, Listening, and Clinical Listening

Throughout the literature, the concepts of hearing, listening, and clinical listening have been explored in various modalities. Some modalities include music therapy (Aldridge, 2002; Amir, 1995; Ansdell, 1995; Bruscia, 2001; Lee 2003; & Nordoff-Robbins, 2007), music education (Copland, 2002; Elliot 1995), communication (Schnell, 1995), psychology and counseling (Copeland and Shearon, 1994), ethnomusicology (Blacking, 1973) and aesthetics (Langer, 1942). There seems to be a common thread in the literature with respect to defining the act of listening: it is much more than just hearing the sounds or words of others, it is about actively and intentionally focusing on sounds for the purpose of deriving meaning from sounds that may inform the therapist of the client's strengths and needs.

When we hear sounds presented to us in our environment, we take them in and integrate them. We make sense of these sounds by applying meaning to them. This process is perceptual, as each person interprets sounds in the environment differently based on our individual differences. In other words, we can view listening as an interior and personal process, as well as an interactive process that requires us to actively focus on particular sounds and process what we are hearing moment by moment. As basic as this process is to many domains of human interaction, for musicians it takes on a heightened significance. As music therapists in the clinical setting, it is essential that we listen to and interpret the music we hear in order to gain a deeper understanding of our clients within the context of the therapeutic process. The various roles of hearing,

listening, and in particular, clinical listening will be further explored in the following review of the literature.

Simply Hearing

Kim (2003) defines hearing as a process that involves “the sensation and perception of the auditory system” (p. 16). She continues to explain that this process involves the collecting of sound waves through the ear. For instance, while reading a book, I may hear the faucet dripping water in the kitchen and the furnace clanking down the hall. I am hearing these sounds as merely background noises, and I perceive them simply as what they are: the faucet and the furnace. If I were to focus my attention on these sounds, I would be actively listening. Based on my individual experience, I may interpret them as having a rhythmic or melodic quality. At this point, these sounds are being organized and taking form as intellectual schemas or emotional and cognitive responses in my mind. This intentional organization of sound and subsequent interpretation occurs when I am not simply hearing, but *listening*.

The Act of Listening

Contrary to hearing, listening is a deliberate and focused action. Listening is a type of “doing” that requires us to tune into auditory stimuli, to interpret it, and to respond to it. Schnell (1995) emphasizes that listening is far more complex than hearing. When we are listening, we are interpreting the sounds we hear: “any act of listening is interpretive and, since we human beings are formed by different experiences, our interpretive processes will also vary” (p. 2). This implies that the act of listening is an individually-situated process. To be an effective listener, one must actively focus in order

to understand and provide feedback. Active listening also requires tuning into content (what is said) and feelings (how it is said) (Schnell, 1995). This suggests that active listening involves an emotional element and requires the therapist to listen beyond what is concrete and tune in to the meaning behind the content. These ideas are relevant as listening and interpreting is central to this study.

Listening to music. Researchers from a range of different perspectives describe listening to music as a pleasurable and individualized experience (Copland, 2002; Elliot, 1995; Kim, 2003). Kim (2003) describes music as having a natural and instinctive quality that humans are drawn to. Musical preference and how someone experiences music is based on the individual. We listen to music for various reasons and with various attendant cognitive and emotional expectations. Copland (2002) explains that some may listen to music and experience it on a sensuous plane (listening for the sheer pleasure of sound), expressive plane (listening for the emotional content), and the musical plane (listening to the musical constructs and elements). Based on the individual, these “listening planes” may vary. Elliot (1995) explains, “music listening requires us to interpret construct auditory information in relation to personal understandings and beliefs” (p. 81). Furthermore, Elliot defines certain specific qualities of “listenership” making this process a domain of human endeavor. He places listenership as one component that makes up the larger idea of “musicing,” a term he popularized to represent music as a dynamic interactive process and not an inert subject. In a similar way, we are not solely passive when we listen, we are creatively engaged, and actively making sense of the sounds we hear based on our individualized experiences.

As humans, we tend to relate to music that has developed a cultural meaning for us. This is apparent in musical traditions that are passed down through generations. For example, we may be deeply familiar and emotionally connected with a nursery rhyme or a favorite song that we were exposed to during childhood. The ethnomusicologist John Blacking (1973) discusses the importance of listening in regards to ensuring the continuity of music tradition across various cultures. He asserts, "Music is a cultural tradition that can be shared and transmitted, it cannot exist unless at least some human beings possess, or have developed, a capacity for structured listening" (p. 10). This notion offers a glimpse into the bigger picture of the significance of listening: that such processes and the meanings derived from them are always contained in particular cultural settings, with their own definitions, expectations, and inherited sets of meanings.

Langer (1942) also describes the individual understanding of meanings in the music we listen to: "The imagination that responds to music is personal and associative and logical...because no assignment of meaning is conventional, none is permanent beyond the sound that passes; yet the brief association was a flash of understanding" (pp. 206-207). When exploring the concept of listening to music, it is important to consider individual beliefs and understanding, as it will impact how each person perceives music. This notion is essential when listening in a clinical setting, because the "flash of understanding" can only be identified and developed in the client-therapist relationship through a balance of empathy and musical sensitivity. While Blacking's views regarding music as an inherited cultural tradition is relevant, this study focuses on self inquiry of one individual listening during spontaneous music making. Although

clinical work in music therapy is itself a particular cultural setting with accompanying definitions, expectations, and inherited sets of meanings, a deeper examination of questions along those lines is not at the heart of the present research.

Clinical listening. Listening should be both intuitive and purposeful in the clinical setting, since it is a necessary component to understanding our clients' responses, as well as our own musical choices. Lee (2003) defines clinical listening as "the art of the therapist's attunement to the client's sounds, listening to reality and beyond; listening to every nuance from the client's first utterances to the final sounds as the session ends" (p. 87).

In the counseling literature, Copeland and Shearon (1994) explain that listening is "a combination of hearing, seeing, expressing, and feeling. The process of listening is of such significance that it can be termed a cornerstone of an effective helping relationship" (p. 14). The authors further explain that trust, empathy, and respect are essential to the therapeutic relationship and require listening skill. These concepts are fundamental to being an effective music therapist.

Listening in music therapy. As music therapists, we utilize our listening skills in order to understand, interpret, and respond to clients during music making. Bruscia (2001) developed listening techniques when listening to a recorded improvisation: *free open listening*, *focused open listening* (musical or clinical aspects of improvisation), and *positioned listening* (empathic, complementary, and reactive). Bruscia emphasizes the importance of listening and describes it as "the only way a therapist can understand what the client is accomplishing therapeutically in the improvisation, and as such, is the prime

requisite for assessment, treatment, and evaluation” (p. 7). A more complete examination of Bruscia’s four modes of listening will follow.

Free open listening can be described as allowing the music to lead the entire listening experience. This may require shifting focus as the music changes, but ultimately this technique requires the therapist to let go of the “how” and “what” of listening, and simply be open to the sounds. *Focused open listening* is listening with a level of focus on a particular musical element, while still grounded in being open to allow for a shift of focus while listening. *Positioned listening* allows the music therapist to listen empathically, to focus and attempt to identify with what the client may be experiencing musically, and complimentary: this technique that allows the therapist to explore personal reactions and professional reactions in the role of the therapist when the analyzing improvisations. *Reactive listening* allows the music therapist to remove him or herself from the improvisation and reflect on the music making (Bruscia, 2001).

Similar to Bruscia, Aldridge (2002) emphasizes the distinction between hearing: the fact of simply perceiving sounds with listening which is a concentrated, focused, and more personal matter. She characterizes listening as an emotional, as well as perceptual and cognitive act. We may be hearing our client’s music, but when listening we are actively making an effort to hear. In her study, Aldridge (2002) analyzed recordings of improvisations between the therapist and the client. She reviewed the excerpts and interpreted the client’s musical responses while offering modes of listening similar to Bruscia’s listening techniques: empirical listening, open listening, and focused listening. Aldridge defines *empirical listening* as “immediate, direct, close, and includes thoughts

and feelings aroused during or after the improvisation” (p. 3). The immediate perception of what we hear in the moment is connected to the phenomenon of experience. *Open listening* requires “listening freely” and being intuitive while listening back to session recordings. During this time, we are emotionally removed and can identify significant moments that were perhaps colored by empirical listening during the session (p. 6). *Focused listening* is interpretive and focuses on particular events in the improvisation. This involves analyzing the session and honing in on the significant moments of the session in order to gain more insight. Aldridge concluded that, as music therapists, listening demands flexibility, and how we experience our clients through music is essential to the therapeutic process. Furthermore, listening and making sense of what we perceive can lead us to insight and knowledge (Aldridge, 2002).

In relation to listening constructs, two specific kinds of listening can be identified, as described by Amir (1995): *external listening* (being open to the music and present with the music), and *internal listening* (being with oneself and listening to messages from within). *External listening* requires the music therapist to be completely present and concentrated on listening to the client’s music, moment-to-moment. *Internal listening* is actively being open to one’s inner sounds and gaining intuitive knowledge of the self (Amir 1995). Amir expresses the importance of these two kinds of listening working together during the music making process, and all listening is geared towards the client.

On the other hand, Lee (2003) developed hierarchal modes of listening: *surface listening*, identifying the therapeutic relationship and musical form; *instinctive listening*,

further identifying and interpreting musical form and the relationship; *critical listening*, identifying musical resources; *complex listening*, identifying and interpreting further musical resources; *integrated listening*, identifying connections between musical and therapeutic; and *listening beyond*, identifying the incorporeal nature of the music and relationship. Lee suggests that awareness of these levels can help the therapist gain a better understanding of an improvisation.

While there are similarities between the modes of listening developed by these researchers, there are also differences. Lee (2003), Aldridge (2002), and Bruscia (2001) offered hierarchal types of listening, while Amir (1995) described two types of listening that are to be integrated simultaneously. These researchers demonstrated that modes of listening can provide the therapist with a framework for understanding and interpreting client responses during clinical improvisation.

Since clinical listening in music therapy involves listening with intent as it relates to developing a relationship with another person, developing a high degree of skill in the domain of clinical listening lies at the crux of improvisational work in the music therapy session. As Bruscia (2001) states, "Musical improvisation is a sound-centered art form...it is ear-oriented-hearing and listening are at the very core of the experience" (p. 7). Hence, it is necessary to examine more deeply clinical improvisation as it relates to the act of listening.

Clinical listening and Nordoff-Robbins training. In the Nordoff-Robbins approach to music therapy, listening is an essential component to understanding the client and developing a mutual musical relationship. Aigen (2005) explains, "Musicing with

other people involves listening intently to them and responding in a way that reflects the listening...the quality of the music is directly related to the listening skills of the people creating it" (p. 83). The essence of the Nordoff-Robbins training is developing the skills to observe the client as musical in all facets of his or her being. For example, a client walks into the room with a heavy, slow gait while tapping the wall. This activity is perceived as musical and the therapist's music is built around the client's responses and reactions to his or her music.

Turry (2001) discusses the idea of the therapist being "Poised in the Creative Now." This refers to "a state of balanced receptive alertness on the part of the therapist. In this state of readiness, listening is a creative, musical act" (p. 352). He further explains that the therapist is willing and open to respond to the client and enter into a mutual musical relationship. The Creative Now is a place for both the therapist and client as they create music together with the possibility of discovering untapped potentials (p. 352). Thus, developing acute listening skills is a significant aspect of the Nordoff-Robbins training.

Clinical listening and supervision. The supervisory relationship in Nordoff-Robbins music therapy is built upon the idea that when listening to trainees, "the focus is not on advice giving, but rather on trying to understand what they need in order to take the next step as aspiring therapists" (Turry, 2001, p. 360). During the course of my supervision, I continued to develop my listening skills and learned to be more "tuned in" to my client's music. Through this mentoring process, my supervisor has played an important role as a model and guide.

The development of listening skills is an essential part of the supervision process as well. A key part of supervision in Nordoff-Robbins training involves reviewing session footage with the supervisor in order to gain a deeper understanding of the clinical process. Playing music with the supervisor is another common element of supervision. Turry (2001) discusses music making between trainee and supervisor: "It can help trainees to discover how they feel about the client, and how these feelings are affecting the specific ways in which they are responding to the client musically. Focusing on the trainee's musical response to the client may give the trainee insight into the client" (p. 365).

Competencies and Clinical Listening

While this is a unique study based on one music therapist's perspective, it is important to examine the advanced competencies related to clinical listening.

American Music Therapy Association (AMTA) advanced competencies. The American Music Therapy Association requires that board certified music therapists adhere to the professional competencies. The following advanced competencies are related to clinical listening: (4.4) Understand the dynamics and processes of therapy from a variety of theoretical perspectives. (4.7) Utilize advanced music therapy methods (e.g., listening, improvising, performing, composing) within one or more theoretical frameworks to assess and evaluate clients' strengths, needs, and progress. (4.13) Respond to the dynamics of musical and interpersonal relationships that emerge at different stages in the therapy process. (7.2) Compose music, including songs, in various styles to meet specific therapeutic objectives. (7.3) Provide spontaneous musical support for client

improvisation. (7.4) Improvise in a variety of musical styles. (7.5) Utilize a wide variety of improvisatory techniques for therapeutic purposes. (7.9) Apply advanced skills in the clinical use of at least two of the following: keyboard, voice, guitar and/or percussion. (8.1) Utilize self awareness and insight to deepen the client's process in music therapy. (8.4) Use personal reflection (e.g., journaling, artistic involvement, meditation, other spiritual pursuits). (8.7) Selectively modify music therapy approaches based on knowledge of the roles and meanings of music in various cultures. (American Music Therapy Association, 2009).

Nordoff-Robbins competencies. In addition to being equipped with strong musicianship skills, clinical applications in the Nordoff-Robbins approach include actively listening and being "poised" to listen musically (Turry, 2001). The therapist is required to trust the music and be able to improvise with mutuality and clinical focus. Another competency requires the therapist to be aware of the musical tendencies of the client and the personal musical qualities and tendencies of the therapist. The ability to understand and articulate the therapeutic process and the client-therapist relationship dynamic is significantly important. Furthermore, understanding self- exploration in the examination of the therapy process is essential (Turry, 2001).

Clinical Improvisation

Following the foregoing survey of listening in musical and clinical literature, it is important to specifically consider listening as it pertains to improvisation. Analysis of improvisations and the development of listening themes have been explored in the research (Arnason, 2003; Bruscia, 1987; Cooper, 2010; Forinash, 1992). Bruscia (1987)

defines improvisation as being "...inventive, spontaneous, extemporaneous, resourceful, and...involves creating and playing simultaneously" (p. 5). He continues to explain that improvisation is a creative activity that involves inventing or arranging in the moment. Improvisation requires the therapist to be musically spontaneous and flexible. Ansdell (1995) referred to improvisation as demanding creativity, awareness, listening, and being physically and emotionally present. To be an effective improviser in the clinical setting it is imperative that the therapist embodies these characteristics.

Forinash (1992) conducted a phenomenological study where she interviewed eight Nordoff-Robbins music therapists (three of the eight therapists were co-directors of the clinic) in order to gain insight into their experience while improvising. Each participant chose a videotape to be reviewed with the researcher. The video-viewing meeting was recorded and later transcribed. Some of the many themes that emerged through analyzing the interviews were feelings of vulnerability (stripping of defenses and letting go), pressure (knowing that the session is being videotaped can put pressure on the therapist), the unknown (uncertainty about the outcome), intuition (a sense of knowing which direction to proceed), self (to believe and trust the self), and the therapist's music biography (awareness of therapist's musical background to use as natural resources). Forinash concludes that gaining a deeper understanding of the therapist's experience while improvising could be an avenue to explore more fully in future research, therefore the findings in this study could serve as a guideline to training music therapists.

From the above research, it is clear that the lived experience of improvised music making, as well as analyzing session footage, embodies an emotional component.

during an improvisation, therapists' perceptions of the clients within the musical experience, and therapists' perceptions about music while improvising. Based on the themes and sub-themes that emerged, she found that to truly listen is an essential aspect of the improvisational experience and, for some, it is as vital as breathing (Cooper 2010). She explains, "one therapist suggests a client's 'being heard' by the therapist...creates deeper possibilities for connection in the relationship and...is perhaps one of the transformative elements in Nordoff-Robbins Music Therapy" (p. 109).

While it is evident in the related literature that listening constructs have been developed, and that listening techniques are avenues that can be explored regarding a clinical improvisation, there appears to be a lack of self-analysis or self-inquiry studies that focus on the therapist's listening process using highly-developed constructs. The present study aims to examine more closely the elusive act of listening that music therapists describe as being central to the music making process. By doing so, I hope to explore my own listening perspectives. When the client offers a response to the music, the music therapist can gain a better understanding of the client through a shared musical experience. Thus, the decision to explore this topic through qualitative and descriptive research might reveal to the therapist a deeper understanding of the listening process and its influence on the therapeutic relationship.

Research Questions

The purpose of this self-inquiry study is to gain a deeper understanding of the therapist's listening process while improvising with clients. The following research question will be explored in the study: 1) What types of listening are utilized in sessions?

2) How similar and/or different is my listening process during and after sessions? 3) How does listening in improvisation influence the therapeutic relationship?

Definitions of Key Terms

The following key terms are adapted from Bruscia (1987):

- **Clinical Listening:** actively listening with focus and clinical intent to someone or something within the context of the therapeutic relationship.
- **Clinical Improvisation:** the spontaneous, creative, and inventive use of music during music-making. Clinical improvisation requires the therapist to be creative, flexible, and physically and emotionally present.
- **Therapeutic Relationship:** the bond between client and therapist that is built on respect, trust, and empathy. The therapeutic relationship develops over time and can be enhanced by the reciprocal musical interactions between the client and therapist.

Method

Participants

With consideration to the first-person research design, I am the participant as well as the researcher (Bruscia 2001). For this self-inquiry study, I conducted research on myself and my listening process while making music with clients in music therapy. The selection criteria for the session recordings are as follows:

- 1) One client was male, and one client was female. Both of them have a diagnosis of being developmentally delayed.

2) The clients have been receiving music therapy services by the researcher for at least three months or longer to ensure that both a trusting therapeutic relationship and clinical goals have been established,

3) The clients' parent or guardian signed a consent form.

The most recent session videos were selected for this study based on gender (one female, and one male), diagnosis, and length of time in music therapy. Signed release forms by the parents are on file for every client who is enrolled in our program. These release forms give permission for the session footage to be used for research and educational purposes.

The researcher obtained approval from the Institutional Review Board (IRB) at Molloy College. A letter of permission was signed by the director of The Rebecca Center. In addition, audio/visual consent forms were signed by the parents or guardians of the participants (See Appendix A).

Client Background Information

Charlie (pseudonym) is an energetic and enthusiastic five-year-old boy. He is diagnosed with PDD, language delays, and sensory processing difficulties. He has been receiving individual music therapy services since October, 2010. Samantha (pseudonym) is a joyful and musically sensitive nine-year-old girl. She is diagnosed with autism and developmental delays. She is non-verbal and has sensory processing difficulties.

Samantha has been receiving individual music therapy services since October, 2010. (See Appendix B).

Design

This study is first-person research (Bruscia, 2005; Varela and Shear, 1999) which utilizes clinical retrospection. First-person research is clearly defined by Bruscia (2005) as “the researcher or participants gather information from themselves, using processes such as introspection, retrospection, self-perception, self-observation, self-reflection, self-inquiry, and so forth (p. 379).” This qualitative method was suitable for examining my research questions.

Data Procedures

1) Numerous sessions from each of the two clients were digitally recorded using a Flip HD video camera set on a tripod that was positioned in the therapy room.

2) In addition, I took notes (e.g., personal reactions, observation, any events in relation to the session) before and after the sessions.

Materials

Materials that were used included: a Flip Ultra HD video camera, desktop computer to play back video recordings, and Microsoft Word to document session events.

Data Analysis

When analyzing the data, two kinds of listening constructs were utilized. As I analyzed listening types during sessions, I adapted from Lee’s six levels of clinical listening (Lee, 2003). This provided a framework for my interpretations and also inspired me to develop my own types of listening based on my findings. In addition, I utilized Bruscia’s listening techniques, Bruscia (2001), as a resource while I was reviewing my session videos and identifying the types of clinical listening since it was developed with

that retrospective view. The following data analysis steps have been adapted from Sokira (2007):

- 1) Two session videos from each client (a total of 4 videos) were selected to be analyzed for this study.
- 2) Each session video was viewed several times.
- 3) Each session video was transcribed, documenting moment-to-moment account of the musical and non-musical events of the session.
- 4) The session transcription was also reviewed several times.
- 5) The transcript was culled: any items that were redundant and irrelevant to the topic were eliminated. For example, pre-composed music was eliminated as I aimed to analyze improvisation only.
- 6) The transcript was then segmented and interpretive coding was utilized: therapist's responses (musical, non-musical,), client's responses (musical, non-musical), therapist's process, therapist's reflection, and clinical listening type. In addition, relevant factors from the notes that I took before and after the sessions were also included.
- 7) Following the segmenting process, the codes were categorized into salient points based on the research questions and themes were identified.
- 8) The original transcripts and the themes were reviewed for consistency.

Ensuring Integrity

To ensure integrity, I shared the session transcripts and categories with the clinical supervisor and the co-therapist ensuring trustworthiness of research findings and

to assist me in uncovering information that I may not be aware of. In addition, I compared any new insight or information with the original videos to ensure relevance.

Results

The purpose of this study was to understand my clinical listening and how it informs and enhances the therapeutic relationship. The following discussion of the research findings will be framed around three research questions: 1) What types of listening are utilized in sessions? 2) How similar and/or different is my listening process during and after sessions? 3) How does listening in improvisation influence the therapeutic relationship?

Adapted from Sokira (2007), the preliminary stage of the data analysis utilized interpretive coding that highlighted five areas categorized as follows: client's responses, therapist's process, therapist's responses, therapist's reflection, and type of clinical listening. These areas clearly outlined the data and assisted me in understanding my clinical listening skills during musical improvisation in sessions.

The categorization of the areas also assisted me in identifying types of clinical listening. For the clinical listening type category, I utilized Lee's six levels of clinical listening (Lee, 2003) as a resource in order to establish these types of listening which are more specifically targeted toward the aims of this study. The adaptation and application of this approach will be further discussed later in the section.

Five Categories:

Client's responses. Client's responses refer to musical (M) and non-musical (NM) responses offered by the client. Musical responses include vocal response,

instrumental response, musical movement, and embody musical elements such as melody, harmony, rhythm, tempo, pitch, dynamics, timbre, and the development of musical themes. Non-musical responses include interpersonal responses (e.g., facial affect) and non-verbal responses (e.g., gestures and verbal responses).

Therapist's process. This category consists of my internal process in regards to the therapeutic dynamic that is unfolding during musical play. In addition, I am interpreting client's responses, mood, and emotional state while taking note of my own thoughts and feelings in the moment. My interpretations also consist of interpreting the client's mood and emotional state, and his or her musical responses based on the level of listening utilized. I am also observing the quality of the client's responses to determine if his or her responses are intentional (purposeful) or reflexive (an automatic response).

Therapist's responses. The therapist's responses category may include musical and non-musical responses. In addition, my interventions may include (but are not limited to): vocally and/or instrumentally reflecting a musical phrase, meeting the client's vocal or instrumental response on piano or guitar, creating silence in the music, and/or leaving space in the music for the client to respond by filling in or punctuating the musical phrase. I may also respond verbally, or through gesture and facial affect.

Therapist's reflection. This category consists of my own personal reactions, co-therapist reactions and/or issues, and supervisor reflections/comments. In this category, I am reflecting on musical interventions and significant events that occur. Here, I am reflecting on my responses and the client's responses in retrospect.

Clinical listening type. From Lee's six levels of clinical listening, I derived four levels of listening better suited to the purposes of this study: Explorative Listening, Perceptive Listening, Grounded Listening, and Spiritual Listening. These types assisted me in organizing the data and were established since they relate more closely to my findings. Definitions and case examples of these types are clearly outlined below as they pertain to my research question.

Research Question 1

What types of listening are utilized in sessions? As stated above, I derived four types of listening for purposes of this study: explorative listening, perceptive listening, grounded listening, and spiritual listening. These listening types can best be described through clinical case examples of Charlie (pseudonym), a six-year-old boy with PDD, and Samantha (pseudonym), a nine-year-old girl with autism and developmental delays (See Appendix C).

Explorative listening. Explorative listening refers to listening and responding with openness to the musical elements (melody, harmony, tempo, dynamics, rhythm, timbre, etc) through which the therapist and client can begin to develop a musical connection and mutual understanding of one another. The therapist is taking into account the client's mood and emotional state. The therapist is listening and musically supporting by responding to the client and providing the opportunity for him or her to be musically expressive. Musicing is explorative in that the client and therapist are beginning to explore music making together and finding a musical connection.

Vignette 1: Charlie enters the music room singing "Oh dear, oh dear" as he walks toward me at the piano. He is singing in pitch as I play in the key of C Major in the Blues style, (a style that he seems to relate to as evidenced by his expressive singing when it is played). To support Charlie's phrase, I create a steady pulse with my left hand, playing octaves in the bass and I sustain the I7 chord in my right hand. I vocally respond "Oh dear, is it time to say hello?" Charlie climbs up on my lap and gives me a hug. I respond by singing "We'll give a hug to say hello."

Table 1

Example of Explorative Listening: Charlie

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
C walks into the room singing "Oh dear, oh dear." He walks to J at the piano (M-vocal)	I want to incorporate what he is offering and connect with his phrase. I want to acknowledge what he is saying and doing. He seems to be showing affection.	J sings, "Oh dear, is it time to say hello?" (M-vocal)	In retrospect I am wondering why he initiated a hug. Is he demonstrating affection? Is he feeling unsafe and looking for security?	Explorative

Vignette 2: I am at the piano and I can hear Samantha vocalizing as she is walking down the hallway. I listen and pick up on her pitch. On the piano, I begin to play in the key of Eb as she is singing a Bb tone. As she enters the room, she sings with a staccato-like phrase and I reflect this in my melody by changing my articulation. My tempo is in 4/4, matching her strides as she walks to her chair. She sings "ee ah, ee ah, ee ah" and I reflect this melodic rhythm on an interval of a fifth (Eb-Bb).

Table 2

Example of Explorative Listening: Samantha

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
S is vocalizing "ee ah" in the hallway in pitch to the music that I'm playing on the piano. (M- vocal/pitch)	I can hear S in the hallway. She can hear the music and perhaps, this motivates her and she is eager to come into the room. Her vocalizations have a staccato-like quality. She is vocalizing on the tonic in the key of Eb	I change my articulation on the piano to reflect her staccato-like vocalizations. I am playing in 4/4 in the key of Eb. (M-instrumental, melody, rhythm)	Supervisor Comment: "Listen to the quality of her singing. She is singing a lot, the music can be "airy" leaving more space"	Explorative

The above vignettes are descriptive examples of explorative listening. In the case of Charlie, I am supporting his expression by sustaining chords and leaving space in the music to let him know I am listening to him. In the case of Samantha, I am reflecting her pitch and rhythm to acknowledge her expression. With both Samantha and Charlie, I am listening with openness to gain a better understanding of their emotional state and to find a way to musically connect with them.

Perceptive listening. Perceptive listening refers to the therapist acutely listening and interpreting client responses during musical play. The therapist perceives the sounds as both client and therapist are listening and musicing with each other in a back and forth manner. With this type, musical form is identified and themes may emerge in the musical moment that stem from the therapist/client interaction. Since these themes can be recalled

in later sessions, this level forms a musical accompaniment to the unfolding clinical relationship.

Vignette 3: I create a call and response singing "ee ah, ee ah," and I leave space in the music. Samantha stops beating the drum and responds to my call with a vocal response of her own "eeyaya, eeyaya, eeyaya, eeyaya." She continues drumbeating in an allegro tempo. I respond to her musical response by singing a new phrase and meeting her tempo. She smiles, and we simultaneously return to the main theme "ee ah, ee ah."

Table 3

Example of Perceptive Listening: Samantha

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
S stops beating S sings a descending melody line in Eb "eeyaya, eeyaya, eeyaya" and then follows this with allegro beating for ½ measure of music. (M-vocal/instrumental)	Her responses are communicative and musical. She is initiating new tones and by increasing the tempo, she may be telling me that she wants to play faster and this excites her.	J pauses the music J creates a call and response, by reflecting the movement of her vocal line on different tones and then meeting her increased tempo on piano. (M-vocal/tempo)	I am playing in a steady tempo, and she initiated a faster tempo. I can interpret this as her excitement, and her desire to move the music.	Perceptive

Vignette 4: After a sustained musical experience of drum playing, Charlie looks at me and says "goodbye?" I respond by singing "It's not time to say goodbye yet!" Charlie gets upset as evidenced by fussing and repeating "goodbye." I sense that he is ready to leave and perhaps playing for a sustained period of time took a significant amount of energy from him. I acknowledge this and sing, "We'll do a little bit of drumming to say goodbye." The co-therapist models on the drum, and Charlie imitates her beat patterns as the therapist sings, "It's time to say goodbye."

Table 4

Example of Perceptive Listening: Charlie

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
C stops beating the drum, looks at J and verbalizes "goodbye?" (NM-Verbal)	I'm sensing that he is tired, and sustaining his playing may have taken a lot of energy. I want to acknowledge this and help provide closure to the session.	J sings, " We'll do a little bit of drumming to say goodbye" playing half steps in the melody on (melody: E-Eb) (M-vocal)	In retrospect, he was finished playing and I was challenging him to continue. Being sensitive to his mood is important.	Perceptive

The above examples display perceptive listening. My sensitivity to Charlie's needs and perception that he is finished making music is important information that surfaced from being perceptive. This theme of client transition to drumming becomes a shared understanding that we can use in future sessions as well. The back and forth musical conversation that occurred in Samantha's session required listening and interpreting her responses. When Samantha initiated an increase in tempo, it informed me that perhaps she is experiencing the music in a different way that she may find exciting and stimulating. She has developed the resources to initiate musical changes and I perceive this as an opportunity for the music to evolve and support her to offer a new musical experience.

Grounded listening. Grounded listening is a more in depth type of listening. Here, the therapist moves beyond perceiving various musical elements and begins to listen with clinical focus and an understanding of the client's strengths and needs. The therapist has clear musical direction as it pertains to the client's therapeutic goals. The therapeutic relationship is established and both client and therapist are musically "working" together as goals and objectives are established.

Vignette 5: Charlie is holding two horns (E and A). I initiate a new theme in e minor and sing, "What can we do in the music room today?" Charlie looks up at me. I continue, "We can blow the horn!" Charlie blows the horn and walks away. I create tension in the music by playing a diminished chord and sing "blow!" Charlie turns around with a smile and continues to blow the horn.

Table 5

Example of Grounded Listening: Charlie

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
When J creates theme and leaves space for C, C blows the horn (E) one time. (M-instrumental)	We are working on helping C sustain his playing for a longer period of time. I wanted to create a short dissonant phrase that allowed him to respond.	J continues the theme and plays a short phrase using diminished chord to "call" C back into the musical interaction. (M-harmony/instrumental)	Creating short phrases with clear musical direction helps C sustain interactions. Supervisor comment: "clear theme helps C and you stay engaged in mutual playing for longer"	Grounded

Vignette 6: I play a three beat pattern on the piano as Samantha continues a steady tempo on the drum. I am playing in the key of D minor. She extends her phrase by repeating the three beat pattern. I want to help her continue to be more flexible in playing, so I continue to play a three beat pattern (ti-ti, ta) on various ascending melody tones. A call and response between the piano and drum occur. Samantha completes the phrase by initiating a tremolo as I meet her tremolo on the piano on the V7 chord.

Table 6

Example of Grounded Listening: Samantha

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
<p>J initiates 3 beat pattern on the piano.</p> <p>S reflects J's 3 beat pattern (ti ti, ta) and continues a basic beat (M-instrumental/rhythm)</p>	<p>S demonstrates sensitivity to rhythm. We are working on helping her be more flexible in her drum playing, and also working on her motor planning. This ability to reflect a complex rhythm shows her potential. I do not want to mirror her playing, but create space for her to beat freely.</p>	<p>J plays a 3 beat melodic pattern (C-A-A') and leaves space for S to continue beating. (M-melody/rhythm)</p>	<p>Co-therapist as a factor:</p> <p>In retrospect, G playing along simultaneously with S may have been too much support for S. I think she was capable of sustaining her complex rhythms on her own.</p>	<p>Grounded</p>

As described above, this level of listening is grounded in musically “working” together. By creating a musical structure with clear direction and therapeutic goals in mind, Samantha was encouraged to work on her motor planning through musical play. In order to assist Charlie to increase the duration of his musical interactions, I needed to listen with clinical focus.

Spiritual listening. Spiritual listening refers to listening beyond the sounds and silences in the music. The aesthetic nature of the musical moment, or expressing or communicating beyond spoken language, is made manifest in shared insights. In addition, transcendent “peak experiences” may occur.

Vignette 7: There is a moment of silence in the music. Charlie reaches for the co-therapist's hands and a dance ensues. There is something delicate and sweet about this dance, so I create a clear and simple waltz-like melody on the piano to accompany the dancing. As Charlie swings his arms side-to-side, I open my hands on the keys to create a grand and celebratory sound. For a few moments, there are no lyrics, just music and movement. Charlie, the co-therapist, and I are smiling and engaged in the musical experience.

Table 7

Example of Spiritual Listening: Charlie

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
C initiates interaction with H by reaching his hands up to her (NM-gestural/affect).	C is allowing H to dance with him. He is laughing and smiling. Musically, I feel connected to C and to H. I feel present in the moment and there seems to be a flow to the musical interactions	J creates a theme in $\frac{3}{4}$ (waltz-like) in I, iv, ii, V, I. in the key of C Major. J plays melody notes beginning on high E, then a creative leap an octave higher. (M-meter/melody)	Watching back, this moment seemed connected between the music and C, and the relationship was apparent	Spiritual

During this moment, the aesthetic nature of the music seemed to capture us as we connected musically beyond words. The music painted a portrait of the in-the-moment musical experience, and brought Charlie's movements to life. Here, I felt I was fully and creatively present. Truly inspired moments such as this example can be related to "break throughs" in therapy, when the client and therapist's true potentials are reached.

Research Question 2

How similar and/or different is my listening process during and after sessions? Based on my research findings, listening to clients during sessions is a different process than listening while watching session videos. During a session, there is a constant flow of listening and responding between the client and therapist. The musical relationship is evolving in the moment-to-moment interactions. In viewing the session video, I had the opportunity to examine the session from a different point of view. By removing myself from the actual moment, the entire musical landscape of the session can be viewed and the therapeutic dynamics can be observed with an acute awareness.

The key difference between my listening process during and after sessions is that after sessions, I am emotionally removed from the moment and can gain a new perspective. Aldridge (2002) describes this as *open listening*, and suggests that this technique allows us to identify significant moments that were perhaps blurred by the immediate perception of what we hear (p. 6). An excerpt of a session with Samantha can best display how my listening process is different during and after sessions:

I am improvising a melody on piano in Eb Major (ta,ta,ti-ti-ti,ta) to accompany Samantha as she walks down the hall to the music room. I can hear her vocalizing and matching pitch, often singing the tonic and the IV. As she approaches the music room, she is singing "Ee,ee, ee-ee-ee,ah." I continue to reflect her tones in the melody by alternating between Eb and Bb while sustaining a steady pulse.

During the session, my focus was on Samantha's pitch and framing her vocalizations by matching her tones. However, when reviewing the session footage, I noticed that rhythm was a component I had initially overlooked. I presented a melodic rhythm (ta,ta,ti-ti-ti,ta) and she responded by repeating this melodic rhythm. This was a response that became clear while watching the session footage. Further exploration of this will be addressed in the discussion section.

Research Question 3

How does listening in improvisation influence the therapeutic relationship?

Bruscia (2001) asserts, "Listening is the only way a therapist can understand what the client is accomplishing therapeutically in the improvisation, and as such, is the prime requisite for assessment, treatment, and evaluation" (p. 7). This idea is crucial to developing an understanding of the impact of listening on the therapeutic relationship and the clinical focus of therapy. Through the process of analyzing the types of listening and

how they relate to my work, I was able to gain a better understanding of how these listening perspectives influence the therapeutic relationship. An example of this can best be described from an excerpt of a session with Charlie:

Charlie has a difficult time engaging in sustained music making with me. Charlie is standing in front of the floor tom and the cymbal. He beats 2 forceful beats on the drum and begins to walk away. I reflect 2 beats on the guitar and extend the phrase in the Spanish idiom to provide rhythmic grounding. Charlie turns around and watches me as I accent the down beat and create a short rhythmic phrase. Charlie moves closer to the drum and strikes 2 beats again. I meet his playing and he continues to play. We are now playing simultaneously. Charlie continues a basic beat on the drum and we play simultaneously for 3 measures of music.

The depth of my listening in sessions ultimately guides the direction of the improvisation and influences the client's responses. Charlie was able to sustain his beating because I was listening to, and interpreting his musical response. A more in depth analysis of this vignette will be discussed in the following section.

In summary, the establishment of the listening types provided me with a framework for understanding how I listen and interpret my client's responses during music making. The results revealed notable differences while listening during and after sessions. Furthermore, my findings helped me gain more insight into the impact of listening on the relationship between myself, my clients, and the music.

Discussion

In this section, I will elaborate on my findings, and discuss my common listening patterns, the role of supervision, and how each type of listening influences the therapeutic relationship.

My Listening Process

In the above vignette of my session with Samantha, I gained valuable information while watching the videotaped session. I discovered that she was offering a musical response that I was not in-tuned to in the moment. While my attention was not initially focused on Samantha's sensitivity to rhythm during the session, this example supports my belief that reviewing session footage is a valuable resource and an integral part of the clinical work, as it can reveal subtleties in the musical experience that may not be clearly heard or seen in the moment. These subtleties may offer significant information as it pertains to the clinical process.

In addition, reviewing session footage also provided me with an opportunity to contemplate the possible reasons as to *why* I may not have been in-tune to Samantha's rhythmic response. Why was I focused on matching her pitch? What was my clinical intention in that moment? Is matching pitch my listening tendency? By asking myself these types of questions, I can essentially "check in" and understand the process more fully. Furthermore, reviewing the session footage can serve as a learning tool to help me enhance my listening skills during the session in the moment-to-moment musical interactions.

The Therapeutic Relationship

As described in the above vignette, Charlie sustained his drum beating when I musically responded to him. By listening to the quality and essence of his strong, but short beating, I was able to use this information to musically “call” him into an interaction by reflecting the dynamics of his playing. It was important for me to listen to how he was playing so that I could capture its quality and essentially show him “I hear you. I’m with you,” and also to gain a better understanding of his emotional state and what he may be communicating.

Schnell’s (1995) concept of listening to the content (what is said), and feelings (how it’s said) to ensure understanding can be related to the vignette of my session with Charlie. I interpreted his beating as a desire to want to play, but an uncertainty to continue. This uncertainty could be due to his sensory needs, and perhaps he was having difficulty processing the musical stimuli. Another reason for his apparent hesitancy could be due to the unpredictable nature of the music being presented, as Charlie will often leave a musical interaction if the music is unfamiliar to him.

I reflected his two beats on guitar to show him that I was listening to him, and present in moment to make music with him. He recognized that I reflected his beating, and he took the initiative to come back to the drum to play. He looked at me, and I looked at him and smiled. There seemed to be an unspoken understanding between the two of us as we engaged in simultaneous music making. By empathizing with Charlie, he was able to trust me. I believe that this motivated him to join in playing with me, demonstrating that empathy and trust are significant factors in developing a therapeutic relationship in music.

Watching the videotape of this session, I was able to see how this moment served as the foundation for the musical connection that emerged during the improvisation. For example, Charlie made a musical statement, and I demonstrated that his statement was heard by reflecting his rhythm and dynamics. His musical response was accepted and he was encouraged to be in a shared musical experience. As an observer of the session footage, I could view the process as it unfolded and was able to gain a better understanding of the direction of the therapy with Charlie.

Influence of Listening Type on Therapeutic Relationship

Explorative listening. Through my research, I've discovered that explorative listening is an important type of listening as it creates an opportunity for the client and therapist to explore each other's music with sensitivity and openness. While explorative listening does not necessarily have an initial clinical focus, this type allows for the therapist to learn about the client and to begin developing a relationship through music. Before the therapist can establish musical goals, it is important to listen to the client fully and musically without prior expectations.

Perspective listening. Perspective listening requires the therapist to begin interpreting client responses. This is essential to developing a therapeutic relationship, as it will guide the therapist in understanding the client through music making. By listening and responding in a reciprocal manner, both the client and therapist can begin to form a musical connection.

Grounded listening. Grounded listening lies at the crux of the therapeutic relationship, as the therapist and client form a musical connection and begin to work

toward targeting musical goals and objectives. Grounded listening is what sets music therapy apart from other music-related modalities, as this type of listening has therapeutic aims. The clinical focus that is inherent with this type of listening influences the musical relationship by providing direction and a framework for therapy.

Spiritual listening. Spiritual listening can enhance the therapeutic relationship beyond goals and objectives. The human connection that is innate in the act of music making can strengthen the bond between client and therapist. The aesthetic nature of music in and of itself can be a spiritual experience when shared with another person. Both client and therapist can take with them a moment of experiencing a musical connection beyond words.

Listening Tendencies

I have discovered that the listening types are not necessarily hierarchal. Over the course of a session, I found myself listening differently based on the moment-to moment musical exchanges that occur. The types of listening are intertwined with the musical relationship, and these are ever changing throughout the musical experience. This required me to shift my focus when necessary to tune into certain aspects of the music.

Throughout this research experience, I have learned that my most common tendency is to interpret my client's music and reflect his or her responses which are related to explorative type and perceptive type of listening. I am often reflecting responses to let my clients know that he or she has been heard. Another common listening type I utilize often is the grounded type, musically "working" with my clients in regards to goals and objectives. It became apparent through this research that I have

minimal moments of “peak experiences,” and I do not always find a spiritual connection with my clients during music making.

As I continue to develop my listening skills as a clinician, I seek to understand possible reasons for my listening tendencies. Often times, my own insecurities interrupt my ability to listen as this distracts me from being focused in the “here and now.” There are moments when I do not trust my own insights and musical capabilities and this may prevent me from listening on a deeper level and potentially having “peak experiences” in music. This research allowed me to see my tendencies more clearly and encouraged me to seek out resources that will guide me to enhance my listening skills.

The Role of Supervision

Supervision is a valuable resource that is pertinent to my growth as a music therapist. It was helpful for me to receive supervision throughout this study for many reasons. Firstly, it provided me with an opportunity to receive another perspective that assisted me in uncovering aspects of my clinical work of which I was not aware. Several supervision meetings involved reviewing session footage and dialoguing about the clinical process, my interpretations, and musical interventions. In addition, music-making with a supervisor during our meetings has enhanced my observation skills, musical skills, and assisted me in developing a keen sense of listening to and interpreting the music.

Supervision provided me with support and encouragement throughout my research. My research findings supported my belief that it is essential to consider supervision as part of ongoing development as a therapist. Supervision proved to be a

significant component to my growth as a clinician and will continue to be a part of my responsibility as a clinician.

The Role of Co-therapist

The role of the co-therapist was an important contribution to my research. I have discovered that the co-therapist's presence in the session influenced my listening process in some ways. At times, the co-therapist helped to enhance my listening by offering cues and/or by musically reflecting the client's response during moments when I was unable to decipher the client's response. In these instances, the co-therapist's close proximity to the client assisted me in listening.

In addition, there were moments when we demonstrated differences in what we observed and how we listened when making music with our clients. A times, the co-therapist would unintentionally interrupt my listening by initiating singing or instrumental play while I was focused on another aspect of the client's music. By closely examining the session footage, I was able to dialogue with the co-therapist in regards to specific moments of listening in order to understand our clinical rationale and view of the therapy.

Conclusion

Summary

The purpose of this study was to gain insight into my listening process during improvisation, to understand its influence on the therapeutic relationship. As the researcher and subject of the study, I analyzed four session videos of one male client with pervasive developmental delay, and one female client with autism. Sessions were

transcribed and culled into five categories: client's responses, therapist's process, therapist's responses, therapist's reflection, and clinical listening type. I established four types of listening based on the data: explorative listening, perceptive listening, grounded listening, and spiritual listening. Finally, common themes and listening tendencies emerged.

Limitations

Within this study, there are limitations to be addressed. First, the video session sample was too small. By analyzing numerous session videos, a wider range of possible themes could have emerged and more data could have been collected. In addition, the selection of session footage was not chosen at random, as I was aware of which sessions I was going to analyze prior to the session taking place. This could have influenced my listening process during the session and while analyzing the session footage.

Implications for MT Practice

Arnason (2003) asserts, "Music therapists must learn skills for listening at different levels of experience. The art and discipline of informed listening evolves through constant practice" (p. 134). While the findings of this study were specific to one therapist, the topic of analyzing how a therapist listens is an area that can be explored by other music therapists. By gaining an understanding of listening patterns, therapists can potentially enhance their clinical skills and gain insight into the clinical process. The experience of developing an awareness of oneself as a music therapist is significant and imperative in music therapy work.

Implications for MT Education and Training

It is important for students to develop self-awareness and an understanding of listening as part of the clinical process. This study can serve as a guide to students in training. The method used in this study can be applicable to analyzing sessions and help the student explore the musical relationships between clients and therapists. The types of listening that I have developed are a useful adaptation of Lee's work, as it allows for this study to be replicated in music therapy training sites.

Future Research

Bruscia (1998) defines countertransference as, "a therapist [interacting] with a client in ways that resemble relationship patterns in either the therapist's life or the client's life" (p.52). The presence of countertransference can influence the therapist's ability to listen. Turry (1998) suggests "[it] is important for the therapist to become conscious of the habitual musical patterns he may have in order to be able to discern them from possible countertransference reactions" (p. 166). Future research could examine the influence of countertransference on listening and improvisation, as well as its implications within the therapeutic relationship. The concept of countertransference is a significant consideration when analyzing the dynamics of the client and therapist relationship within the context of music-making.

Other opportunities for research could include an archival study on listening in music therapy that could allow for a wider range of findings. In addition, this study could be replicated in various music therapy training sites both in and out of Nordoff-Robbins approach. Replicating this study can assist other music therapist's in gaining insight into

his or her own listening process. This type of study can and help a music therapist discover the type(s) of listening he or she tend to use less or more frequently.

Listening is an essential component to developing a musical and therapeutic relationship with our clients. Throughout this study, I have grown and become more self-aware. I have learned that understanding how I listen is a life-long process. This study has reinforced the idea that I will always be learning and striving to understand my clients and myself within the context of the musical relationship. With each new experience, comes another opportunity to listen and grow.

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APPENDIX A

IRB Approval Letter, Notification of Title Change, Consent Form, & Letter of Permission.



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1000 Hempstead Ave., PO Box 5002, Rockville Centre, NY 11571-5002
www.molloy.edu

Date: January 25, 2011
To: Jill Lucente
From: Lillian Bozak-DeLeo, Ph.D.
Chair, Molloy College Institutional Review Board

I am pleased to inform you that your proposal, "The Therapist's Listening Process in Clinical Improvisation" has been approved by the Molloy IRB. You may proceed with your project.

Good luck with your research.

Lillian Bozak-DeLeo, Ph.D.

Thesis Title Change

Jill Lucente

Sent: Thursday, August 11, 2011 11:26 AM

To: Lillian Bozak-DeLeo

Cc: Seung-A Kim

Hello Dr. Bozak,

I am writing to inform you of the change in title of my Master's Thesis: "Listening, Improvisation, and the Therapeutic Relationship: A Self-Inquiry"

Thank you.

Best,
Jill Lucente

Jill Lucente, MT-BC
Music Therapist-Board Certified
Program Coordinator

The Rebecca Center For Music Therapy at Molloy College
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Music Department
T: 516.678.5000 ext 6192
F: 516.255.4823

Title: Listening, Improvisation, and the Therapeutic Relationship in Music
Therapy: A Self-Inquiry

Researcher: Jill Lucente, MT-BC
Molloy College
516-678-5000 ext. 6983

Advisor: Seung-A Kim, PhD, AMT, LCAT, MT-BC
Assistant Professor/ Music Department, Molloy College
1000 Hempstead Avenue
Rockville Centre, NY 11570
516-678-5000 ext. 6348

CONSENT FORM

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the reviewing of session video as part of the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my child's name will not in any way be identified. I understand that additional information about the study results will be provided, at its conclusion, upon my request. I know that my child is free to withdraw from having sessions reviewed for this study without penalty at any time.

The above information has been provided to me (check one)

In writing Orally

Name of Child: _____

Signature of parent/guardian: _____ Date: _____

Signature of researcher: _____ Date: _____



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Music Department
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Title: Listening, Improvisation, and the Therapeutic Relationship: A Self-Inquiry

Researcher: Jill Lucente, MT-BC
Molloy College
516-678-5000 ext. 6983

Advisor: Seung-A Kim, PhD, AMT, LCAT, MT-BC
Assistant Professor/ Music Department
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A LETTER OF PERMISSION FORM

The following research project is part of the Molloy College Graduate Music Therapy Program: MUS 540 (Thesis: Music Therapy). My research involves examining how a deeper understanding of the therapist's listening process informs improvisation and enhances the therapeutic relationship. The researcher will be the source of data and session videos will be analyzed.

This project will be conducted with Jill Lucente at The Rebecca Center For Music Therapy at Molloy College.

This course is a requirement for graduation. Approval is contingent upon the Executive Director in accordance with the Molloy College Review Board procedures.

Executive Director Signature: [Signature]

Researcher Signature: [Signature]

Date: 12/13/2010

Client Information

Client: Samantha

Music Therapist(s): Jill Lucente, MT-BC, & Gabriela Ortiz, MT-BC.

Music Therapy Goals:

- Goal 1: Samantha will engage within the rhythm for 5-6 measures with intent to relate two times per session.
- Goal 2: Samantha will intentionally relate to the dynamics (*p,f*) during musical play two times per session.
- Goal 3: Samantha will initiate musical ideas/s with the intent to engage and relate to the therapist one time per session.
- Goal 4: Samantha will engage in call-and-response musical play while referencing the therapist for 1-2 measures one time per session.

Session Date: 4-7-2011

Session Number: 26

Session Summary:

Samantha walked into the room, vocalizing in tonality and smiling. Samantha typically sings 3rd or 5th however today she was singing leaps of a 6th tonally and intentionally related to the music. A new theme emerged today, "Samantha is beating the drum!" in the Middle Eastern mode. Samantha initiated syncopated rhythms on the drum and imitating therapist's rhythms on the drum in an intentionally related manner for up to 4 measures of music. Her vocalizations sound more like approximations of words in recent weeks. She is intentionally trying to communicate. When therapist sings her name, she looks up and smiles/giggles. This allows Samantha to develop awareness of self and her role in the musical relationship.

Session Date: 4-14-2011

Session Number: 27

Session Summary:

Samantha entered the room today vocalizing in the key of Eb and reflected the therapist's melodic rhythm and initiated an interaction with the therapist by coming over to her and clapping her hands together. Samantha's range of in her vocalizations continues to expand as she is singing a wider range of tones and vowel sounds. Today, her vocalizations seemed purposeful and intentional as evidenced by the emotional interest she displayed during piano playing.

Client: Charlie

Music Therapist(s): Jill Lucente, MT-BC, & Heejin Chung, M.Ed., MA, KCMT, NRMT

Music Therapy Goals:

- Goal 1: Christian will maintain regulation during musical play for 3-4 measures, two times per session.
- Goal 2: Christian will engage within the rhythm for 3-4 measures with the intent.
- Goal 3: Christian will engage in simultaneous musical play while referencing the therapist for 3-4 measures, one time per session.
- Goal 4: Christian will engage in call-and-response within the context of musical play while referencing the therapist for 1-2 measures, one time per session.

Session Date: 4-29-2011

Session Number: 23

Session Summary:

Charlie is able to remain engaged in an interaction for longer periods of time. Today the grounding bass of the horn theme seemed to help him sustain his interactions. He seems to initiate verbal interactions with the therapists and each session he offers a new phrase or idea. Today was the first time we saw sustained drum playing (up to 2 measures of music) and simultaneous musical play. He seems to be more open to the therapists helping him find ways to communicate when he is upset (wanting to say goodbye) as he will often regulate himself and attempt to verbalize what he wants to the therapists. Providing Charlie with clear musical form helps him to understand musical dialoguing.

Session Date: 5-6-2011

Session Number: 24

Session Summary:

Charlie has been expressing some anxiousness when transitioning to the room as evidenced by repeating the phrase "Oh dear." This could be related to the fact that he is gradually developing the capacity to engage in sustain interactions and this could be a new experience for him. Continue to monitor this and provide him with the musical support he needs. Charlie demonstrated sustained engagement today through music and movement and a brief moment of sustained drum playing. He seems to be more willing to engage in new experiences.

Sample Data Analysis

Table B1.

Client's Responses	Therapist's Process	Therapist's Responses	Reflection	Listening Type
C walks into the room singing "Oh dear, oh dear." He walks to J at the piano. (M-vocal)	I want to incorporate what he is offering and connect with his phrase. I want to acknowledge what he is saying and doing. He seems to be showing affection.	J sings, "Oh dear, is it time to say hello?" (M-vocal)	In retrospect I am wondering why he initiated a hug. Is he demonstrating affection? Is he feeling unsafe and looking for security?	Explorative
J sings "hello _" leaving space for C to finish the phrase. He initiates names and says "Charlie." (M-vocal)	I want to leave this open for him to respond.	J sings "Hello Charlie, Hello" (M-vocal)	He is initiating more. Perhaps I can offer less support and give him more of an opportunity to express.	Explorative
C uses his elbow to play clusters in the middle register of the piano. H taps the cymbal in rhythm. (M-instrumental)	It seems that C wants to play, but how he is playing makes me wonder if this is an intentional response.	J creates a walking bass line in the blues style to reflect C's playing. H continues to tap the rhythm on the cymbal. (M-instrumental/Rhythm)	In retrospect, I interpret his response seems as musical and intentional.	Perceptive
C looks at H and says "welcome back" H smiles and says "welcome back." A brief dialogue begins here. C looks to H and gives her a kiss on the cheek. (NM-verbal response/gesture).	Here, I felt that the music and the dialoguing had a nice momentum and flow. It was natural and I feel that the music supported the conversation between H and C.	J continues in the blues style singing with H "welcome back" and creates form, leaving space for H and C's dialogue (M-instrumental/vocal)	I think this was an intentional expression of affection towards H. Maybe he feels connected and understood? I felt connected here and really appreciated this moment.	Perceptive
C reaches on top of the piano and picks up 2 horns (E & A). When J creates a theme in E minor and leaves	We are working on helping C sustain his playing for a longer period of time. I wanted to create a short dissonant phrase that allowed him to	J continues the theme and plays a short phrase using a diminished chord to "call" C back into the musical interaction. (M-harmony-	Creating short phrases with clear musical direction helps C sustain interactions.	Grounded

<p>space for C, C blows the horn (E) one time (M-instrumental)</p>	<p>respond.</p>	<p>instrumental).</p>	<p>Supervisor comment: "clear theme helps C and you stay engaged in mutual playing for longer."</p>	
<p>C stops blowing the horns, but is looking down at them. H sings "How many horns do you have?" (melody notes: EE,F,G,GAG) I see 1 ___ C fills in with "2." C then initiates and new idea and says "eyes." (M-vocal) (NM-verbal response)</p>	<p>I think C is relating counting to body parts which is something he has initiated with us in previous sessions. Maybe he needs something familiar.</p>	<p>J changes the music to the key of CMajor reflecting H's melody and the playful mood. (M-rhythm/melody).</p>	<p>This seems is meaningful to him and maybe on some level it is his way of relating and being present in music.</p>	<p>Perceptive</p>
<p>C initiates interaction with H by reaching his hands up to her. (NM-gestural/affect)</p>	<p>C is allowing H to dance with him. He is laughing and smiling. Musically, I feel connected to C and to H. I feel present in the moment and there seems to be a flow of musical interactions.</p>	<p>J creates a theme in ¼ (waltz) in I, iv, ii, V, I in the key of CM. J plays melody notes beginning on high E, then a creative leap an octave higher. (M-meter/melody)</p>	<p>Watching back, there seemed to be a connection between the music, the therapists, and C. The relationship is apparent here.</p>	<p>Spiritual</p>
<p>C walks over to the guitar and says "guitar." J picks up the guitar as C gets up from his chair and walks closer to the drums. (NM-verbal/gesture)</p>	<p>Here, I want to bring him into a simultaneous musical-play and into a meaningful interaction that he can experience.</p>	<p>J begins a new theme in the Spanish idiom in an andante tempo to create rhythmic grounding for C. (M-tempo/rhythm).</p>	<p>He is initiating an idea here, and he seems to be responsive to this idiom.</p>	<p>Grounded</p>
<p>C sustains a basic beat on the drum with for 1 ½ measures of music, and then stops. He looks over at J. (M-instrumental/gesture/interpersonal)</p>	<p>C's moments of shared interactions are typically fleeting. I want to give him the experience of engaging with another through music-making.</p>	<p>J begins to play in a syncopated rhythm, and then matches C's beating to help him sustain. When C looks at J, she smiles at him. (M-rhythm/gesture/interpersonal)</p>	<p>This was a significant moment. He engages with me in music and then looks at me. Perhaps this was a meaningful moment of accomplishment for him?</p>	<p>Grounded</p>

APPENDIX A

IRB Approval Letter, Notification of Title Change, Consent Form, & Letter of Permission.



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1000 Hempstead Ave., PO Box 5002, Rockville Centre, NY 11571-5002
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Date: January 25, 2011
To: Jill Lucente
From: Lillian Bozak-DeLeo, Ph.D.
Chair, Molloy College Institutional Review Board

I am pleased to inform you that your proposal, "The Therapist's Listening Process in Clinical Improvisation" has been approved by the Molloy IRB. You may proceed with your project.

Good luck with your research.

Lillian Bozak-DeLeo, Ph.D.

Thesis Title Change
Jill Lucente
Sent: Thursday, August 11, 2011 11:26 AM
To: Lillian Bozak-DeLeo
Cc: Seung-A Kim

Hello Dr. Bozak,

I am writing to inform you of the change in title of my Master's Thesis: "Listening, Improvisation, and the Therapeutic Relationship: A Self-Inquiry"

Thank you.

Best,
Jill Lucente

Jill Lucente, MT-BC
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