The Role of Music in Personal Therapy in Advanced Music Therapy Training: A Self-Inquiry

Jan Mark Casco

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THE ROLE OF MUSIC IN PERSONAL THERAPY IN
ADVANCED MUSIC THERAPY TRAINING: A SELF-INQUIRY

A Thesis

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

By
Jan Mark Casco
Molloy College
Rockville Centre, NY
2020
The Role of Music in Personal Therapy in
Advanced Music Therapy Training: A Self-Inquiry

By

Jan Mark Casco

A Master’s Thesis Submitted to the Faculty of
Molloy College

In Partial Fulfillment of the Requirements
For the Degree of
Masters of Science

August 2020
ROLE OF MUSIC IN PERSONAL THERAPY

MOLLOY COLLEGE

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Abstract

The purpose of this study is to explore the role of music through the similarities and differences of an Analytical Music Therapy (AMT) and Nordoff-Robbins Music Therapy (NRMT) trainee. The study employed a first-person research design and thematic analysis to assess three AMT and three NRMT personal therapy sessions. Music as well as the verbal interactions during the music therapy sessions were transcribed and analyzed. Five themes were constructed from the data, three similar themes and two different themes: (1) music as a place of meeting and the foundation of the therapeutic relationship, (2) using the voice to strengthen the therapeutic and musical relationship, (3) music making and meaning making, (4) collaboration in music making, (5) music as a referential meaning or an experience. The study indicated that the role of music in AMT and NRMT had many purposes for the researcher, such as, a representation of emotional content for the client. There were also differences between the role of music for AMT and NRMT, in which the therapeutic themes were addressed in different ways. The findings of this study bring up questions about integral thinking in music therapy practice as well as understanding the theoretical basis and traditional models of AMT and NRMT with an emphasis on the role of music. The data also indicates benefits of personal therapy as an advanced music therapy trainee. There is limited research comparing the experience of multiple advanced music therapy trainings.

Keywords: music therapy, Analytical Music Therapy, Nordoff-Robbins Music Therapy, improvisation, personal therapy, integral thinking
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The Role of Music

Personal Context

I am a non-classically trained violinist of over 20 years. While growing up as a musician I wanted to play notes that were not written on the page; I was drawn to the notes I was hearing, not seeing. Those were my first experiences of the power of music and the effect of one note. As musicianship evolved, I was exposed to more formal and classical training in order instruments such as voice, piano, and guitar. I found comfort utilizing improvisation in my music, such as adapting tempi, rhythm, and utilizing modulation. I have always felt comfortable playing improvised music both in music performance and in music therapy.

When I performed with my local church’s band, I always looked forward to our playing sessions and performance when our group members had the freedom to express and play however they wanted. I cherished those moments of freedom in the music whether it be notated from the sheet music or something that I heard in my head. I always felt something indescribably special in the feeling that came across the room through the audience and the band members. Through these experiences I have found that there may be something deeper to improvisation and how it reaches people.

Learning about clinical improvisation in music therapy was not what I had expected it to be because of my experiences utilizing improvisation as a performing musician. It was challenging to be in in the music during my first clinical improvisation, which elicited fear. Clinical improvisation is more than just being spontaneous and creating music without preparation. Clinical improvisation seemed different, and although the feeling may be similar, it still is very much different. Improvisation may be liberating for clients like the feeling I have
previously felt playing with my local church’s band, but I quickly realized there was a responsibility placed on me as a music therapist facilitating the improvisation.

Improvisation can be a liberating experience for music therapists and clients. Liberating like a bird taking flight; for me, improvising helps me drop the shackles and chains that I feel while making music. Instead of seeking the perfect note, I can just explore and be free. But there is a sense of uneasiness in leading an improvisation for myself as a new music therapist. My passion was sparked to find a deeper understanding of clinical improvisation. I am drawn to using improvisation in my clinical work, as I believe that it is a powerful tool for self-expression. Since my passion towards improvisation grew so strongly, I wanted to pursue advanced training in Nordoff-Robbins Music Therapy (NRMT) and Analytical Music Therapy (AMT). I wanted to understand the similarities and differences in my self-experiences as a trainee in NRMT and AMT.

When reflecting on my passion to deepen my clinical improvisation skills, I considered the role of music in improvisational models of music therapy. Improvisation as a music therapy method includes any experiences in which the client actively participates in improvisational music making with the music therapist and/or other clients: playing instruments, vocalizing, or sounding their bodies or other objects (Bruscia, 2014). Nordoff-Robbins Music Therapy (NRMT) and Analytical Music Therapy (AMT) are both approaches of music therapy that utilize improvisation as the primary method in the therapeutic experience. It is through improvisation that the client is accessed, expressed, and their challenges are worked through. Inherent in this process is the development of the therapeutic relationship through improvisation’s co-created music. NRMT and AMT practitioners co-create improvisations with their clients to form deep
rapport and relationship between music therapist and client (Cooper, 2012; Hadley, 1998a) but both trainings utilize improvisation in different ways.

Professional Context

In reviewing the literature, I found little comparing the role of music in NRMT and AMT (Hadley, 1998a, 1999). As a new music therapist, the role of the music in music therapy became an important topic to understand and explore. This study will further the understanding of the role of music and further develop clinical skills as a trainee in AMT and NRMT.

My curiosity for understanding the music and improvisation grew from my insecurity as a musician. I wanted to understand how creating music with my clients was bettering them and fostering our relationships (Gilboa et al., 2006). It only was fostered more as I had my internship experience at The Rebecca Center for Music Therapy at Molloy College. The Rebecca Center facilitates music therapy with an influence from NRMT and Developmental Individual-differences Relationship-based Floortime models. My first experiences with using improvisation in a clinical way was at The Rebecca Center. I found these initial experiences to be quite challenging; I lacked understanding in my play and found that I was creating music without listening to my clients. I began to understand that I was struggling to find my own meaning as a budding music therapy student. As improvisation became the primary clinical method I utilized in sessions, I learned to become freer and more poised in my music-making.

I was later exposed to AMT during an introductory course at Molloy College. The course was challenging because I began to draw similarities in general aspects of AMT and NRMT, such as the aspect of improvisation. But it did fuel my passion to understand more about the differences in the music created by AMT and NRMT practitioners. Improvisation loosely connects NRMT and AMT. Both use improvisation, but each models’ intent and use of
improvisation are different. I believe my curiosity was truly piqued as the students in my introduction to AMT course had a chance to debate about AMT being considered a “music-centered” approach and how that debate evolved in class. This debate involved understanding the differences between the philosophical lens and practical methodology of AMT vs other models of music therapy such as NRMT. My classmates and I interviewed a music-centered music therapist, one who is highly respected in his beliefs of music-centered music therapy; alongside this, the class was taught by a well-known AMT trainer. These experiences fueled my passion to understand how improvisation is utilized and the role of music in AMT and NRMT.

Need for the Study

A search of the literature comparing AMT and NRMT revealed only two studies (Cooper, 2012; Hadley, 1998a, 1998b, 1999). One of these studies were unpublished (Hadley 1998a,). No studies were found directly comparing the role of music in the improvisations of NRMT and AMT. It is my hope to provide a deeper understanding of the role of music, the music therapists, and the benefits and/or challenges of personal therapy as a trainee and through a comparison of the role of music in NRMT and AMT.

Research Question

This study intends to answer the following research question and subquestions:

1. What are the similarities and differences of my self-experiences in personal therapy as a trainee in Nordoff-Robbins Music Therapy and Analytical Music Therapy?
   a. What is the role of music in the improvisations of NRMT and AMT?
   b. What are the roles of the music therapists in NRMT and AMT?
   c. What are the benefits and/or challenges of personal therapy as a trainee?
Related Literature

According to Bruscia (2014) there are four music therapy methods: receptive, composition, re-creative, and improvisation. Each method is a different way in which clients can engage in music to facilitate the therapeutic process. In each of the four methods of music therapy there are multiple variations and different experiences that occur. Generally, in receptive music therapy methods the client encounters the music in a listening music experience, such as song discussion in a group or individual experience. In a composition method, the music therapist will utilize the imagination of the client to facilitate creation in a musical structure. This may include lyrical compositions or orchestrated music experiences and song writing. The clients take responsibility, organize, problem-solve, and communicate to create musical productions. In this method, therapeutic themes may emerge and be addressed (Gardstrom & Sorel, 2014). Re-creative methods entail the client’s reproduction of precomposed musical material. Clients can recreate music through utilizing their voice, through instrumental play, conducting or guiding the music, and/or putting on musical productions (Gardstrom & Sorel, 2014). Music stores memories and emotions in a specific way, through engaging in active music making, there is evidence that a client can engage and progress with therapeutic themes in the musical space (Erkkilä et al., 2019). Improvisational methods include any music experiences in which the client actively participates in spontaneous music making with the music therapist and/or other clients playing instruments, vocalizing, or sounding their bodies or other objects (Bruscia, 2014).

Improvisation in Music Therapy

The word improvisation may suggest inventive, composed in the moment music. In music therapy, clinical improvisation focuses on music experiences where the client engages in
spontaneous music making with the music therapist and/or other clients. This may include vocalizing, playing an instrument, or any objects in general including one’s body. Clinical improvisation in music therapy can be defined as the free or guided extemporaneous use of music, undertaken by the music therapist and/or client, using a range of tuned and untuned instruments and voice to maintain or improve health and meet clinical goals (Bruscia, 1987; Gardstrom & Sorel, 2014).

Clinical goals can be an aim or a desired outcome of music therapy (Bruscia, 2014). Clinical goals can be musical goals. These can be targeted through improvised music. Bruscia (1987) highlights the benefits of analyzing a client’s improvised emotional expressions for assessment and treatment via the Improvisation Assessment Profiles (IAPs). The product of the client’s music making may take precedence in analysis and interpretation of meanings. Through the analysis and interpretation of a client’s music, clinical goals can be crafted. A client’s music-making may serve as a temporary release of emotional energy, or catharsis, as a representation of the client’s inner emotional world, or as a reflection of the way he expresses aspects of personality and emotional experiences (Bruscia, 1987).

In clinical improvisation, the music therapist is in a creative moment with the client facilitating a different state of being wherein the music therapist can address clients’ emotional states and physical needs. Bilboa, Bodner, and Amir (2006) found that emotions were successfully communicated and decoded through clinical improvisations. The general level of emotional communicability indicated a strong rate of accuracy at communicating the emotions, indicating that music therapists can successfully convey emotions through music. The expertise or musicianship of the improviser was not a factor in the successful conveyance of emotions through music.
In NRMT and AMT there are differences between the ways in which wellness and health, pathology, and the nature of therapy are conceptualized. This demonstrates that an integration of the two models may be inappropriate because the fundamental premises underlying the two models are conceptually incompatible (Hadley, 1999).

Hadley (1999) compares NRMT (referred to as Creative Music Therapy at the time of publication) and AMT through three main categories: intrapersonal (dealing with inner parts of the person/self); interpersonal (relationships with others); and, transpersonal (extending beyond or transcending the personal). In reference to the intrapersonal, NRMT believe that it is through the organization and integration of the ego functions, and the structuring and mastery of skills, that a person gains a greater freedom in expressiveness and, thus, is better able to communicate the self (Hadley, 1999). Intrapersonal wellness and health in AMT is viewed as an individual requires insight and understanding and not just expression of feelings and redirection of energy (Hadley, 1999). Interpersonally, NRMT built their model of therapy on the ability to interact with and relate to others in central to the notion of wellness, interaction is the context in which the self is shaped and developed, and there is a universal potential for interaction and relationship through music (Hadley, 1999). In regards to how interpersonal relationships are viewed in AMT, Priestley believed that we can achieve interpersonal freedom when we are not hindered by rigid defense mechanisms (Hadley, 1999). Furthermore, the transpersonal category in NRMT was viewed as being swept up by the musical experience and reaching heights and depths not recognized in other situations, the client feels something beyond his or her boundaries (Hadley, 1999). In AMT, transpersonal thoughts were not directly used, but Priestley described a phenomenon called “the ineffable” (Priestley, 1994, p. 321) which referred to the music becoming greater than the client and the therapist and the music held the musicians in a grander
space (Hadley, 1999).

**Nordoff-Robbins Music Therapy**

NRMT focuses on active music making and being in the musical space; the current practice of this approach was founded by Paul Nordoff and Clive Robbins (Aigen, 2005a; Mahoney, 2016). Living in the music is the idea of the client and music therapist being present in the music as co-creators in the music. NRMT is an interactive approach to music therapy; in its essence, the work is a “process of using musical forces to activate what it is which animates, literally giving life, one’s flesh, thus giving spirit, essence, or self greater contact with the body...the world of material things in which the body moves and interacts” (Aigen, 1998, p. 317). Hadley (2003) believes that one’s experiences in life influence one’s work and that one’s work influences life experiences. Primary themes of NRMT include working relationships, mastery, independence, and freedom. Hadley (2003) found significant aspects of Clive Robbins’ life that may have led him to deem these themes important in therapy.

In NRMT, the music therapist attempts to access and direct the transpersonal forces in music (Nordoff et al., 2007; Turry, 1998). Transpersonal deals with states or areas of consciousness beyond the limits of personal identity (Kasprow & Scotton, 1999). When the music therapist engages with the client in music, the music that is created reaches beyond the client’s present self to elicit developmental potentials and assists in the integration of the personality in a way unique to music (Turry, 1998). Non-referential improvisations are those in which the client improvises without reference to anything other than the sounds or music, referential improvisations are those in which the client improvises to portray a nonmusical reference, such as an event, feeling, image or relationship (Bruscia, 1987). A client’s musical responses serve as contributions to the musical space where therapeutic themes may be drawn.
from as well as expressions of self. In NRMT the improvisations are non-referential and the 
client’s musical responses serve as the primary source of data for assessment and evaluation 
(Bruscia, 1987; Guerrero et al., 2014; Scheiby, 2014).

**Music Child**

The music child can be defined as the individualized musicality inborn in each child 
which responds to musical experience, finds it meaningful and engaging, remembers music, and 
enjoys some form of musical expression (Nordoff et al., 2007). A focus of NRMT is musical 
aesthetic. Aigen (2005a) explains how the source of clinical music does not lie in the music 
therapist’s conscious implementation of techniques to work towards specific goals, but rather 
focusing the session about the goals. The music therapist imagines general directions in which 
the “music child” is progressing in relation to the rest of the client’s being (Aigen, 2005a, p. 16). 
The music child is seen as more than a metaphor, representing a constellation of human 
capacities that plays a vital role in human development (Aigen, 2005a; Nordoff, Robbins, & 
Marcus, 2007).

The concept of the music child can refer both to clients and music therapists. Kim (2010) 
incorporated the concept of the music child in her study of Korean female NRMT Trainees’ path 
of actualizing their unique musicality, or “musical individuation” (p. 353). The discovery of the 
participant’s own music child was highlighted as the experiences of feeling oneself freely, 
awakened, and discovering one’s strengths, abilities, or “something valuable” (p. 358). This 
discovery illuminated the trainees’ self-awareness, acceptance, integration, and actualization 
regarding their identities as musicians, music therapists, and people.

NRMT is considered a music-centered approach in which clinical intention is 
communicated directly through the use of the elements of music (Aigen, 2005b). In this
approach, the focus of intervention is on how a variety of musical elements and their musical qualities are employed to reach and meet clients in clinical situations. So, in NRMT training, trainees develop musical resources and a personal relationship with music to work effectively with a client. NRMT trainees are encouraged to learn how to offer their personal and unique musicianship in therapeutic sessions.

**Therapeutic Relationship**

The interpersonal concept of wellness is intimately linked to the organizing of the inner self (music child) and the integration of the ego functions such as thinking, feeling and willing. In NRMT, music therapists believed that a person gains greater freedom in expressiveness in music, specifically improvisation, and is then better able to communicate (Hadley, 1999). Interpersonal concepts of wellness are linked to the ability to interact with and relate to others freely. Nordoff and Robbins believed that within the “music child” was the innate potential for interaction with others and communication of the self through music. Through improvisational music experiences, Nordoff and Robbins believed that there is an innate potential for interaction and relationship (Hadley, 1999).

In NRMT, the relationship is primarily worked through in the music. When issues arise verbally, the issues are typically redirected back to allow the music to help resolve them (Hadley, 1998b). Dynamically, the music therapist’s role is to facilitate and support the development of a client-music relationship by showing reverence and respect for the client; working through the various kinds of relationships that develop with the client; accepting and working through the client’s resistiveness; creating and using music that will therapeutically engage the client; using music for clinical rather than personal, expressive purposes; and continually furthering the client’s own musical-personal development (Aigen, 1998; Bruscia, 1987; Hadley, 1998a).
Resistiveness is a term Nordoff and Robbins used to define when a client would be avoidant in music (Nordoff et al., 2007). The growth process in NRMT is described in terms of changes in the client-therapist and client-music relationships (Aigen, 1998). Through the clinically improvised music, the therapeutic relationship is developed thus providing another role of music.

**Analytical Music Therapy**

AMT was borne from psychoanalysis and focuses on bringing the unconscious to the conscious through music (Priestley & Eschen, 2002). Hadley (2001) found that there were five central themes emerging from her experiences of AMT: “energy (represented psychodynamically as the id), expectations (represented psychodynamically as the superego), awareness (represented psychodynamically as the ego), fulfillment, and involvement” (p. 126). Priestley (1975) described AMT as a way of exploring the unconscious through the expression of sound. These expressions of sound are a way of getting to know oneself, possibly as a greater self than one had realized existed. Priestley (1975) also asserts that AMT’s purpose is to free the maximum amount of energy for use in the achievement of the client’s greater life aim.

AMT involves reciprocal improvisatory duets between the client and music therapist in addition to verbal discussion. The improvisations give the music therapist a more active role in analyzing and working through unconscious feelings when compared to the passive role taken by the verbal analyst (Bruscia, 1987). In AMT, the client’s improvising is often stimulated and guided by feelings, ideas, images, fantasies, memories, events, and situations which the client or therapist has identified as an issue needing therapeutic investigation. Improvisations are titled and are programmatic or referential in nature in that the music symbolizes or refers to something outside of itself (Bruscia, 1987).

*Inner Child*
The concept of the inner child is a complicated entity not fully explained in the literature. Priestley (1994) stated that in AMT the music therapist is always partly working with the child the client once was; the inner child is referred to as incommunicable or repressed, a spiritual world which is difficult to enter from the outer world. Priestley (1994) believed that music is a bridge where an individual can reach this inner world. That is why this free expression is so vital for music therapy (Priestley, 1975). By utilizing improvised musical experiences, AMT practitioners nurture the inner child and hope to bring the unconscious to the present state of consciousness.

**Therapeutic Relationship**

In AMT, the intrapersonal concept of self is shaped by the psychodynamic structural model consisting of the “moral” super-ego, the “thinking” ego, and the “instinctual” id (Hadley, 1999, p. 8). Priestley believed that wellness requires insight and understanding, not just expression of feelings and redirection of energy (Hadley, 1999). Interpersonal concepts manifesting in AMT are similar to NRMT wherein people relating to and communicating with others is central to wellness (Bruscia, 1987). Priestley (1975) believed that clients can achieve interpersonal freedom when they are not hindered by rigid defense mechanisms. Priestley described moments when during improvisations “the music changes quality and begins to hold the therapeutic couple” (Hadley, 1999, p. 11-12). The idea that music changes quality and holds the therapeutic relationship is an important aspect of improvisation in AMT. The improvised music can help free a client in musical expression to foster the relationship between client and music therapist.

In AMT, practitioners analyze the dynamics of the therapist-client relationship through psychodynamic constructs of the working alliance, transference, and countertransference.
(Bruscia, 1987). The working alliance is referred to as a rational relationship that the client forms with the music therapist in order to accomplish the goals of therapy (Bruscia, 1987; Hadley 1998a).

**Self-Experience in Therapy**

Bruscia (2012) defines self-experience as an umbrella term for the wide range of teaching practices used in education, training, and supervision of music therapists. Self-experience emphasizes the importance of the learner engaging in the practice of therapy. The learner becomes either the client or the therapist. By engaging in this practice, the music therapists learn how to manage respective processes, a mutual understanding can occur between the music therapists and the population that they serve. While engaging in self-experience for educational purposes, this idea can come with attending personal therapy. Through personal therapy, similar sentiments can occur such as learning how to respect the process of a client. Personal therapy can serve as a self-experience.

**Personal Therapy As Self-Experience**

Personal therapy can be defined as a systematic process of intervention in which participants “participate genuinely as clients in private individual or group sessions that are facilitated consistently by a credentialed therapist and that aim at cognitive, emotional, intuitional, and/or behavioral exploration and change” (Gardstrom & Jackson, 2012, p. 183). It is becoming common practice in psychotherapy-based training for students to undergo personal therapy in many counseling and allied health professions because it can enhance a student’s understanding of the client’s experiences as well as promote positive engagements and encourage lifelong development (Edwards, 2018).

**Personal Therapy in Music Therapy Advanced Trainings.** Many of the advanced
training programs in music therapy encourage personal therapy in the advanced training. For example, in the AMT training program at Molloy College a minimum of forty-eight (48) sessions are required at entry-level. Additionally, the NRMT training at Molloy College requires a minimum of ten (10) personal experiences in NRMT. These requirements can offer rich experiences for trainees and students to understand the client’s experience in therapy in addition to developing clinical skills.

Students and trainees develop a deeper sense of empathy towards the clients through personal therapy (Gardstrom & Jackson, 2012). Empathy is a key component to clinicians in psychotherapeutic work. Without a deeper understanding of our clients the therapeutic relationship may struggle to develop. Depending on the theoretical orientation of a clinician, if there is no relationship, there is no therapy (Yalom, 2003).

Transference is an important aspect to music therapy students’ clinical development (Bruscia 2012; Murphy 2012; Scheiby 2012a; Schulman-Fagan, 2012). Some practitioners implore researchers to study more in depth transferential work and suggest forms of self-experience to delve deeper in understanding of transference (Scheiby, 2012a; Sorel, 2012). Scheiby (2012a) recommended music therapy students receive music psychotherapeutic self-experiential training so that they can deal with and understand the phenomenon of transference and how it presents itself in clinical situations. Students also develop understanding with when and how to help the client to gain insight regarding the content of the transference on the basis of musical content and interactions in the sessions (Scheiby, 2012).

Transference has two important features: repetition of the past and distortion of the present. The client repeatedly experiences the same feelings, drives, attitudes, fantasies, and defense from the past that were originally aimed at a significant figure in childhood, while
distorting the present by unconsciously and inappropriate displacing these feelings onto the music therapist (Bruscia, 1987; 1998). Transferences can be either positive or negative. Positive transferences are warm, loving feelings which can provide the impetus to therapeutic change. Positive transferences also need to be worked through and can also impede the work in some ways, especially because they hook into countertransferences of the therapist perhaps being fed by a kind of idolization and feeling loved and important to the client (S. Hadley, personal communication, May 6, 2020). Negative transferences are feelings of resentment, hate, anger, hostility towards the therapist which are manifested in various kinds of resistances and aggression. It is important to work through negative transferences, otherwise the client is likely to terminate therapy (Kernberg, 2016).

In NRMT, transference and countertransference are not applied terms when conceptualizing client-therapist interaction. This is primarily because some NRMT practitioners believe that these concepts result from a reductionist philosophy minimizing the importance of the aesthetic power of music and musical interaction, thus placing an artificial barrier between the music makers (Turry, 1999).

In contrast, transference and countertransference heavily informs the work in AMT. Transference helps the patient gain insight to help them through the stages of: “a) understanding how and why she acted as she did emotionally in the past; b) how she is acting in the present (without being able to change); and c) how she is about to act” (Priestley, 1994). Positive transference refers to an urge a client has to face challenges in their lives because of the strength of the therapeutic relationship; it also gives them the courage to face the painful emotions that are repressed. Negative transference refers to doubting, or disliking, of the therapist. Another form of negative transference is sexual transference, the client desiring the therapist sexually.
Priestley (1994) distinguishes between two different countertransferences, c-countertransference, and e-countertransference. C-countertransference refers to the therapist identifying with one of the patient’s introjects (Priestley, 1994). E-countertransference refers to a therapist becoming aware of the sympathetic resonance of some of the client’s feelings through their own emotional and/or somatic awareness (Priestley, 1994). These psychodynamic constructs inform AMT practitioner’s work and how they interpret the relationship between client and therapist.

**Summary**

There is a limited number of sources comparing AMT and NRMT experiences. AMT and NRMT appear to draw upon contrasting theories, engage musically with clients in different ways, using verbal processing with other intention, and draw upon different musical aesthetic (Meadows & Wimpenny, 2017). AMT and NRMT trainees go through immense growth and development throughout their trainings which tie to their experiences in NRMT and AMT. Through the exploration of both trainings, this study looks to contribute to the music therapy literature and find mutuality and differences between both models.
Method

This study explored my self-process as an AMT and NRMT trainee; focusing on the role of music throughout the self-experience in my personal therapy portions of their respective trainings. How I experienced the music and what its role was in my personal therapy provided data for the study. This study employed a first-person research design that focused on the role of music of the participant-researcher. The primary data sources consist of the video and audio recordings of three personal AMT and NRMT sessions and my logged journals after each therapy session. I attended the AMT and NRMT personal therapy sessions. I video and audio recorded the sessions and wrote in a journal my personal reactions and feelings after each session. After each music therapy session, the session was transcribed. The transcription involved any music and verbal interactions that happened during the music therapy session. Each session was analyzed for themes based on my personal experience.

Participants

As this is a first-person research study, I was the participant-researcher analyzing my experiences as a client receiving personal therapy in Nordoff-Robbins Music Therapy and Analytical Music Therapy. The NRMT and AMT therapists were recommended by supervisors in the respective trainings. Criteria such as being trained specifically in NRMT and AMT was a necessity. To protect the rights of the music therapists, the study was reviewed and approved by the Institutional Review Board of Molloy College (Appendix A). The AMT and NRMT practitioners were available for in-person sessions of 60 minutes. Both practitioners have been practicing for at least 5 years. Two music therapists were selected that fit the selection criteria (Table 1).
Table 1

Demographic Information of Music Therapists

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Ethnicity/Race</th>
<th>Education (Advanced Trainings)</th>
<th>Years of Clinical Experience</th>
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<td></td>
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<td>● AMT Certification</td>
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<td>● LCAT</td>
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<td></td>
<td>● LCSW-R</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Vocal Psychotherapy</td>
<td></td>
</tr>
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I collected data from three in-person sessions of AMT and NRMT, each. The sessions were for one hour each, addressing different therapeutic themes, utilizing music, instruments and experiences (Table 2).
Table 2

Session Dates and Information

<table>
<thead>
<tr>
<th>First Session</th>
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<th>Third Session</th>
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<td>Date: March 6, 2020</td>
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<td>- No Direction</td>
<td>- Loss</td>
</tr>
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<td>- Managing Expectations</td>
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<td>- Singing Bowl</td>
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</tbody>
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**Design**

The study implemented aspects of heuristic inquiry to examine the experience of myself in personal therapy as a NRMT and AMT trainee. The purpose of this study is to understand the similarities and differences of my personal therapy as a trainee of NRMT and AMT as well as the role of improvisation in both models of music therapy. Data consisted of sessions that were video and audio recorded of my personal therapy sessions. The primary data was the music created in the therapy sessions that was stored on a password encrypted external hard drive. The data was analyzed through thematic analysis focusing on the improvisations created by the NRMT and AMT clinicians. In this study, the focus was primarily on comparing and contrasting the two models based on the experience of the trainee and the role the music had. Data was
analyzed through the transcriptions created by the researcher. Transcriptions contained a thorough studying of the audio and video recordings in which I transcribed the music created in session and documented the verbal dialogues between the music therapist and myself. A journal was kept after each session to reflect about my experience in therapy to draw more themes, compare how the therapeutic and musical relationships were developed through the music.

**Data-Collection Procedures**

I set up individual appointment times for personal therapy with the AMT and NRMT music therapists. Data was collected from three sessions of NRMT and AMT each. The sessions were 60 minutes to have consistency between the two sessions. As the client receiving therapy, I arrived promptly to each session and participated in both therapies with hopes of finding a deeper understanding of self. The AMT and NRMT sessions took place at the respective private clinic spaces. Permission forms for NRMT (Appendix B) and AMT (Appendix C) were drafted and audio/video (Appendix D) consent was received. The music therapy sessions were transcribed electronically with both musical and verbal interactions between the music therapist and the trainee. Through the data themes were drawn and analyzed.

**Biases and Assumptions**

I believe it is important to highlight my cultural background as this may influence my experience or analysis of the data. I am a first generation Filipino-American. Both my parents were born in the Philippines and I was raised in a traditional Filipino household. I find that there are significant cultural influences in the music that I create and the music that I prefer. Music is an important aspect to the Filipino culture as many Filipinos are gifted musicians and many pursue music as a career. Growing up, my family would often hold large family gatherings in which many of my relatives would attend and in one of the rooms of the house would be either
karaoke or general musicing. In this musicing I often found myself watching from the outskirts as I was regarded as a lackluster musician growing up in my family. Many of my relatives either took voice, piano, guitar or violin lessons, I was not interested in private lessons but I played throughout my scholastic journey. I would try to join the musicing but I was not comfortable joining in a song that I was unfamiliar with and I did not dare to play in an improvisation without knowing the key or other musical elements. I struggled to be in the music with my family.

As a practicing music therapist, the influences of my musical culture effect how I create music and how it influences my ear as an improviser. I have been previously told by my family members and other Filipino musicians that there seems to be a preference to “sentimental” and “thoughtful” music, which I happen to identify with.

I have not received personal therapy in any form in the past decade. When I last received therapy, it was talk therapy over ten years ago. I do support the idea of going to therapy but it had not been something prioritized through my education and training. I acknowledge that this may create some negative thoughts about attending therapy that may come out in my music as resistance.

In my training as a music therapist, the majority of my supervisors have been trained from Molloy College and practice from a humanistic and music-centered theoretical stance. I have taken introductory courses in AMT and NRMT prior to officially entering the advanced training. I find that I prefer AMT techniques with clients that can engage in verbal dialogue and NRMT with clients who have challenges engaging in verbal dialogue. Furthermore, a majority of my supervisors have been trained in either NRMT or AMT, which may lead to bias or preference in relation to a previous supervisor. There were no dual relationships with my personal therapists, but as my trainings continued; I developed a liking to a certain model of training
because of my relationships with my professors and their respective trainings. Personal therapy sessions are a requirement for both trainings; I acknowledge that the educational requirements may influence my session attendance, meaning I felt educational obligations to attend my personal therapy at times even though I was feeling some resistance.

It is my belief that in a typical AMT session the therapist will utilize improvisation to refer to an important figure or symbol in my life such as a family member or current stresses and the music will represent those references. It is the job of the therapist to facilitate my process and find deeper understanding of these challenges that I was having. My thoughts on a typical NRMT session are that it will involve creative freedom and the NRMT clinician will actively create the music around my musicing.

Improvisation is also a preferred musical experience for me. I enjoy listening to improvisation and playing in free improvisation rather than a referential improvisation. This may limit my freedom in playing in either session. While I have a sense of freedom being in a non-referential improvisation, being in a completely free open-ended improvisation may be a challenge. I find comfort in strict rhythm; free rhythm structures are challenging to me. These musical tendencies may pose a challenge to me while I transcribe and try to understand the music made in my sessions.

I am under the impression that the role of music is to facilitate the therapeutic relationship and that the music creates a relationship between the client and the therapist. I also believe that music is the agent of change in music therapy sessions. These theoretical locations may influence the way that I hear the music in the recordings.
Data Analysis

The music therapy sessions were transcribed with both musical and verbal interactions between the music therapist and myself. The sessions were analyzed through a process of inductive thematic analysis which would leave room for themes to emerge during the review of the music therapy sessions as there were not preexisting codes for the data to fall into (Braun & Clarke, 2006). This analysis consists of six steps:

1. Become familiar with the recordings and data, transcribe the music therapy sessions, and get a general sense of the musical experiences
2. Generate initial codes
3. Search for themes
4. Review themes
5. Define and name themes
6. Produce the report

The themes drawn from the sessions were analyzed from each session, NRMT and AMT and then compared. The data demonstrated how music is utilized in each model; as well as understanding what the role of music is in each model, the role of the therapists and the benefits and challenges of personal therapy as a trainee.
Results

The intention of this study is to understand the similarities and differences of my personal experience as an AMT and NRMT trainee receiving personal music therapy with an emphasis on the role of music in the music therapy sessions. The study aims to develop a deeper understanding of the benefits and challenges of receiving personal therapy while being an advanced music therapy trainee.

Session Summaries

The session summaries included in this section follow the initial in-person intake sessions with the AMT and NRMT practitioners. I met with both music therapists at separate offices where they held private music therapy sessions. Both music therapists had unique setups and office space.

Analytical Music Therapy

The room of the AMT practitioner was clean and set up with a few options for me to sit in. The environment seemed warm and inviting with an array of instruments to choose from, various percussion instruments ranging from melodic to non-melodic, a guitar, keyboard, violin, and large drums as well. The instruments were placed in bins waiting to be played on the table. The space seemed safe, a place where therapy will happen. We sat with the table to the side of us while we faced each other. This seemed to be the typical format going forward. It felt different to be receiving therapy as it has been quite some time, but overall, I felt excited and motivated to continue my therapy journey with my AMT practitioner.

AMT Session 1. As I walked into the room, we exchanged greetings and pleasantries. Once we sat in the spots where we sat during the intake session, we engaged in a ten-minute silence. During the silence I saw the therapist mirroring my body language and entraining to my
breath rate. I broke the silence sharing that I felt guarded in that moment. The AMT practitioner suggested exploring this thought of “guarded” musically. The music had limited range, in which the AMT practitioner primarily filled the role of supporter. The musical themes were identified based on my therapeutic needs. I chose to play a steel tongue drum because I enjoyed the warm sound. My therapist shifted between the keyboard, stirring xylophone and vocalizing. She referred to her keyboard play to have “ghost notes” while supporting my musicing because my playing was so soft. Ghost notes were referring to her pushing keys down on the keyboard but no sound was coming out of some of the keys that were being pushed. We shifted to the opposite end, the AMT practitioner modeled a splitting technique, of feeling “grounded.” I continued to play the steel tongue drum for comfort but played with more structure. After verbal processing both experiences, the AMT practitioner suggested exploring the “grounded” feeling further and supported an experience while I explored my voice while playing a singing bowl.

**AMT Session 2.** This session began in just under ten minutes of silence. I broke the silence because I was trying to find the pitch of the automatic heater. I was thinking that I had no direction to my therapeutic process as a client. I broke the silence with no musical prompt and the therapist joined in my musicing as I explored the xylophone. The music I began to create sounded otherworldly, utilizing the whole tone scale. I began playing with my fingers on the xylophone, the music therapist offered me mallets to play with. She played the steel tongue drum while I continued to explore the xylophone. As this musical experience began to move to an ending cadence, both of us commented on how we ended on an F# together without any notification. My therapist’s instrument did not have pitches labeled, but we both ended on the same pitch. When we ended on the same note, the AMT therapist smiled. I titled this improvisation, “What pitch?” We verbally processed about the musical experience and I shared
that I was just “taking in the instruments.” We continued to discuss as I shared my personal
process of having a challenging time differentiating between “aggressive” and “assertive.” We
implemented the splitting technique and explored the two thematic ideas. During verbal
processing I equated “aggressive” to one-sided play, and “assertive” to co-creative playing in
music. While leaving the session, I thanked my therapist, and she offered that I should thank
myself for “putting in the work.”

**AMT Session 3.** This session occurred during a different time from our typically
scheduled sessions. When I arrived I shared that “I’m here.” I shared about feeling challenges of
being overwhelmed. The music therapist asked me what the other polarity of “overwhelmed” is,
and I shared the idea, “balanced.” We implemented a splitting technique. I played the keyboard
during overwhelmed, an instrument I do not typically choose to play in any context. The music
therapist supported my play on a xylophone. I played in a broad range on the piano, with large
gaps in my left and right hand, while my therapist mirrored the intervals I was playing. I kept a
tritone interval in either of my hands as I explored chromatic movement in the other voices in the
piano. The AMT practitioner sang back to me “feeling overwhelmed”. While continuing to
explore the feeling of “overwhelmed,” I played a chromatic descending bass motif repeating
while exploring tritones and other two chord shapes in my right hand. The music therapist sang
to me “where is this going?” The lyric was powerful and brought awareness to this feeling, in
which I stopped playing. We then shifted to exploring an improvisation of “balanced.” I played
the steel tongue drum initially playing only, then eventually initiating syllabic singing. The AMT
practitioner sang back, “Everything is balanced.” As we reached the cadence we ended together
in tempo. During verbal processing I shared about these feelings manifesting because the timing
of the session was around the anniversary of a loved one’s passing.
Nordoff-Robbins Music Therapy

The room for my NRMT practitioner was warm and dimly lit with warm colors. The room felt inviting to me. The room was covered in instruments ranging from various world instruments, melodic and non-melodic percussion, a guitar, a keyboard, hand puppets, stereo systems. Initially, the space seemed overwhelming. However, after sitting at the couch, facing the NRMT practitioner who was sitting in a rolling chair, it seemed safe. During sessions, there was a table with instruments in between the therapist and I, this seemed to create a safety for me, like I had some sort of barrier or guard. Overall, the space felt welcoming and safe to engage in our therapeutic journey.

NRMT Session 1. This was the session following my intake session. The session initially started discussing some extra intake information such as my personal resources with coping, if I have a strong support system and intrapersonal relationship. The NRMT practitioner offered a miniature steel tongue drum for me to play while she played a singing bowl as we vocally toned. The experience was uplifting for me as I felt that I was not caught in thought as much. I felt that I was expressing how I was feeling through my voice. After the musical experience we verbally processed. I shared how the absence of thought while musicking is a unique experience for me. I shared that I felt present during the musical experience.

NRMT Session 2. This we engaged in music rather quickly as opposed to talking. This improvisation was structured in a turn taking based experience. Initially, improvisation started with the music therapist initiating a vocal line to imitate. Partway through the experience, the music therapist suggested that we do not have to be taking turns; and could overlap our vocalizations. We created music while playing a tubano and conga drum while vocalizing. The tempo shifts felt intentional and meaningful, as the music seamlessly continuously adapted. The
music making lasted about fifteen minutes. The music sounded like tribal chanting with a mixture of legato tones and short staccato vocalizations. We engaged in verbal processing after the music had ended on its own. We spoke about what that experience was like for me; I shared that I felt like my music was enough like I was a co-collaborator in the music.

**NRMT Session 3.** In this session I shared about my experiences struggling with the loss of a loved one. The NRMT practitioner ensured that this space was for my nourishment. I shared about struggling with my voice, words, and feeling free. We transitioned to the keyboard to engage in a vocal holding experience. I sat on the keyboard bench while the therapist sat in her rolling chair and played the keyboard. I sat with access to the keyboard, but chose to vocalize only. The chords were suggested to me, and I ended up choosing moving from a C major 7 chord to a F major 7 chord. The NRMT practitioner entrained to my breathing continuing to play the shift between the C major 7 chord and the F major 7 chord. She encouraged me to vocalize on an exhale, when I did, I exhaled on G.

We continued to vocalize on syllables, I felt a sense of freedom exploring my voice the low and high parts of my vocal range. A melodic motif was created between the music therapist and I. It was a descending line following the fifths of the music. The music therapist supported me while I sang the melodic motif. Our voices were held by the two chords on the keyboard. In the music we would shift from singing in unison and countermelodies. We sang for about ten minutes. After the experience I shared about having images of wings, open skies, clouds, and of flying. I thought the experience could be summed up by the words “peace” and “freedom.” The music therapist offered the thought - which I agreed with - that experiences that “deliver peace during [my] hectic schedule can be meaningful and important.”
Therapeutic Themes

The therapeutic themes worked on during my sessions were all derived from thoughts shared in session and challenges that I had brought up (Table 2). In both AMT and NRMT, the therapists sought out themes to frame the session, primarily working from what I was offering. In my AMT experience, the therapist used some of the therapeutic themes as references for our improvisations. In my NRMT experience, the therapist did not refer to the theme, but offered musical experiences to facilitate discussion and approach my challenges. Challenges such as feelings of self-doubt and loud negative thoughts, we worked on these by engaging in a musical way in a structured improvisational experience and not directly referring to these issues.

The Role of the Therapist

The therapists’ roles in AMT and NRMT showed similarities and differences. In both of my therapeutic experiences, the music therapist’s role was person-centered, humanistic, holistic, and non-directive. Both therapists were music-centered practitioners that worked with the thoughts that I shared in session. They facilitated music and verbal experiences. They both worked as supporters and collaborators in music making. Both therapists seemed to facilitate sessions through a music-centered lens, meaning that the music making was the primary form of therapy, where the therapeutic work was occurring.

A difference between the two models was that the AMT practitioner often mirrored and reflected my body language and affect; this was a way of bringing awareness of my actions. The NRMT practitioner did not mirror my physicality or body language, but served as a supporter and reflector while musicking. Another difference is in philosophical intent between the AMT and NRMT practitioners. This showed up in the verbal dialogue and processing. For example, when engaging in the verbal processing with my AMT practitioner, the music therapist would try
to emphasize symbols such as how I was playing the drum and how that could represent an internal struggle that I was perhaps hiding or avoiding. With the NRMT practitioner, the music therapist would speak about the issues, but refer to the musical space as a place away from the issues to nourish my troubles and feelings with the music. Both therapists were integral, but the AMT practitioner worked primarily psychodynamically while the NRMT practitioner worked primarily humanistically.

**The Role of Improvisation and Music**

The role of improvisation and music was significantly different in my therapeutic experiences. Bruscia (1987) refers to free improvisation as an improvisation in which the music therapist does not impose any rules, this allows the client to let go on a musical instrument. In my AMT experience, the music was free improvisation or referential improvisation, there was a reference point or a feeling to reflect on, however, the music was purely free as led by me, the client. Structured improvisation refers to the music therapist observing and presenting thoughts and music catered specifically to meet the client’s ongoing needs (Bruscia, 1987). In my experience with NRMT, the music was also improvised, however, it was structured and non-referential, at times similar experiences were brought back, such as the singing bowl and vocal toning experiences.

Improvisation is an important aspect to both AMT and NRMT as it facilitates bypassing some obstacles for the client and allows them to express freely connected to the moment. Pre-composed music, receptive or recreative, would not allow for the therapists and me to connect as authentically in the musical space as it may create more distance between therapist and myself. The distance could be created by either the therapist or myself hiding in the music by masking
authentic reactions as well as encouraging other and extra thoughts that may not be related to the relationship between client and therapist.

The role of improvisation in AMT is to access the unconscious, symbols, images, the unknown for the client. Through genuine free improvisation created by the client, the unconscious material manifests in the music in which the client and therapist can then discuss, verbalize and analyze those musical experiences.

The role of improvisation in NRMT is to create music in the here-and-now in the present moment bypassing the client’s pre-existing pathology and other conditions. Through this improvisation, structured by the music therapist, it creates moments for the client to express themself freely to connect to the music and the therapist.

**The Role of Verbal Processing**

Verbal processing was a significant portion in my therapeutic experiences. Verbal processing, meaning any moment where my therapist and I were not actively musicking. Both therapies referenced the music we created. In my AMT experience, the music sometimes was a reference to prior relationships and transferential experiences, either referring to a therapeutic theme that had come up, or challenges that I was facing that day. In my NRMT sessions, I found that the verbal processing was focused on the here-and-now and my present feelings in the moment. For example, in AMT sessions the therapist would utilize the verbal space to analyze the moment but then apply it to bringing unconscious feelings to my present awareness. This was different in NRMT as the verbal processing was more directed to how I currently felt at that moment. In the NRMT sessions we did not analyze defense mechanisms or obstacles, but how I could be nourished from the musical experiences. Both AMT and NRMT used verbal processing to redirect back into the musical space.
Thematic Results

While generating codes and searching for themes from each AMT and NRMT sessions, there seemed to be shared themes and not shared themes. These themes that were occurring in the data helped to organize and understand my experience in the sessions. The following themes were created for similarities and differences.

Similarities

Theme 1: Music as a Place of Meeting and the Foundation of the Therapeutic Relationship. Throughout my sessions in NRMT and AMT the music and atmosphere of the sessions were held together by music. There were several moments where I felt an authentic connection between my therapists and myself. These moments were specifically musical moments. I was expressing a feeling or thought and it was being understood, supported, and collaborated with in the musical space. I felt that in this musical space, an authentic meeting between myself and my therapist was occurring. These experiences were the basis of our therapeutic relationship.

Example 1. In session 2 of my AMT personal therapy sessions, we were exploring a free improvisation named, “What pitch?” My therapist and I connected by ending on the same note although she was playing a steel tongue drum where the pitches were not labeled, and I was playing a xylophone (Figure 1). The musical framework was based around the whole tone scale. This music was created by me, reflecting my sense of feeling uncomfortable and having no direction with a strong feeling of uncertainty as it was only my third time meeting the music therapist and I unconsciously had a feeling of discomfort and unknown. However, this ending on the same note was a point of contact where we both acknowledged that we had found each other in a challenging idiom as there is so much tonal pull.
Example 2. During session 1 of my NRMT sessions, I felt introspectively connected to the music. I did not have to think about how I was feeling to relate to the musical space being created around me with the singing bowl and the steel tongue drum. I felt present in the moment. The musical space was a space not only for me to relate to myself and the music, but to connect with my therapist in a way that was unique, not through verbal interactions. The singing bowl played by the NRMT practitioner was a drone tone which held my musical expression (Figure 2). This musical experience became a foundation to future contact with the music therapist.
Theme 2: Using the Voice to Strengthen the Therapeutic and Musical Relationship.

There were several instances during my personal therapy sessions when I engaged in vocalization and the communication between myself and the therapists became clearer. I felt I was saying something, not with words, but within the music. While I was expressing something, I believed that the therapists were understanding what I was sharing and supporting my expressions.

Example 1. In AMT session 3 while exploring the emotion “balanced” the music therapist and I began singing together. Our voices mixed and the music felt more collaborative (Figure 3). I recall this feeling being novel as we did not vocalize together often; here, it felt easy and comfortable, strengthening our bond as client and therapist. When engaging in vocal play
with the music therapist, I felt a deeper connection to the music and to her. I felt that I began to understand the therapeutic process and her role as a supporter.

**Figure 3**

*Vocal Play During “Balance” Improvisation*

*Example 2.* Throughout NRMT session 2, vocalizing with the therapist was a common musical meeting place. Through the vocalizations during the turn taking drum experience, the therapist and I were able to connect and strengthen our relationship within the musical space. This is demonstrated by the transition from imitative turn taking to free vocal exploration (Figure 4). Throughout the free vocal exploration, I felt supported while vocalizing although I did not have a modelled sequence to follow or imitate.
Explorative Vocal Play NRMT Session 2

Therapist

Client

Congas

Tubano

Theme 3: Music Making and Meaning Making. Music is multidimensional, in the therapy sessions, the music was the therapy for me. I was able to express my thoughts and feelings in the music. While expressing my thoughts in the music, the musical ideas seemed to be coming from a place of creative freedom, a place in between active thinking and reflex. In these moments, music making became the meaning and understanding of my personal process. It was as if the music was translating my expressions and thoughts to the therapists.

Example 1. In AMT session 3, during the “overwhelmed” improvisation, my music was creating a world that the therapist was understanding. Through this understanding, she vocalized “feeling overwhelmed” (Figure 5). The music I was playing was scattered and free, evoking and inspiring my therapist to vocalize. The music seemed to compel her to support my play by vocalizing. This demonstrates the experience that she was having listening to my play as I was not vocalizing or sharing any thoughts, purely in the music.
Example 2. In NRMT session 1, while exploring vocal toning, the therapist was able to recognize and hear the gentleness and hesitancy in my nervousness of attending therapy. While in the music the therapist continued to sing and support my vocalizations. After the experience, the therapist shared that she heard the gentleness in my voice and feeling the warmth from becoming more comfortable in playing (Figure 6). In the moment I was navigating how I was feeling and trying to express that in the music. I was trying to share that I felt safe and invited while trying to come out of my shell.
Differences

**Theme 4: Collaboration in Music Making.** Experiencing freedom while making music with my therapists was an important aspect of my therapeutic process. At times throughout my experiences I felt like there was an expectation on me, that I had to do something in a particular way. While engaging in free or structured improvisation with the AMT and NRMT practitioners I was able to have a sense of freedom to express my feelings and thoughts. I felt there were more obstacles in my way to express my authentic self when I did not have this sense of freedom. The sense of freedom was emphasized in improvisational music making with the therapists, but in different ways. As a client in AMT, the music was my own, I sensed a feeling of ownership while creating the music, it was an expression of myself being supported by the therapist. In NRMT, I felt that the music being expressed was a collaboration between myself and the therapist, and that we both had equal say in the expression.

**Example 1.** In AMT session 1, I recall not feeling a sense of freedom in my thoughts and play. It felt like I was supposed to play a certain way, the idea of a free improvisation did not translate to my personal process. I felt constricted at times and was not sure how to work through this challenging process (Figure 7). Since there was a lack of freedom and understanding, I felt more obstacles blocking me from experiencing the contact and meeting of the therapist in the
ROLE OF MUSIC IN PERSONAL THERAPY

Session. Due to the framework of AMT and it being a fairly novel experience for me, the therapist assigned roles of me being the musical creator and her being the supporter. This brought up anxiety and discomfort in me as I felt a lot of pressure to create the music, in a way, blocking my sense of freedom, although I was given free reign to play, perhaps too much freedom.

**Figure 7**

*Journal Excerpt Session 1 AMT*

Example 2. In NRMT session 1, I felt like a collaborator in improvisational music making (Figure 8). The experience of creating music together, not specifically on my own felt more comfortable to me. I was more inclined to explore since the way my therapist framed the musical experience, not assigning roles, but offering a way to make music. I did not have to initiate the music, but I was able to listen and focus on making music with someone else. This brought up the sense of freedom for me.
Theme 5: Music as a Referential Meaning or an Experience. Both therapists seemed to facilitate the therapy following music-centered models. However, both utilized music as an experience differently. This speaks to the classic models of AMT and NRMT in which the philosophical intent of the therapy is different. The intent differs due to the differences between psychodynamic psychology and humanistic psychology.

Example 1. In all AMT sessions we often referred back to the music as representations and symbols to my personal experiences. Through verbal processing, we discussed how the music I created were manifestations of my therapeutic needs. My therapeutic needs were being expressed through my music, such as working on feelings of “guardedness” and “balance.” Through musicking I was able to process my experience cognitively and begin to understand what obstacles are in my way (Figure 9). The music created was a representation of my experiences and the challenges that I am working through, my therapeutic themes.
Example 2. In my NRMT experiences the music was often seen as an experience and not a representation. During verbal processing with the NRMT practitioner, we often discussed about my experience in the moment; for example, “what was that like for you?” We did not speak about my music being a representation of previous experiences. The music was primarily the experience and therapeutic intervention and if there was verbal processing after, it was regarding my present state at that time. The music that we created was the therapeutic experience.

In NRMT session 3, after the vocal holding experience, the music therapist and I discussed feelings of peace and freedom. In an experience where I had full control of the musical framework and no parameters to reflect on, but just be as present in the musical space I can be. I shared feelings of feeling weightless and having no bounds, like flying. The music indicated this as I explored my voice’s low range and high range. The musical motif created through collaboration with the intertwining of our voices with the keyboard holding and supporting the voices (Figure 10). The articulation of the melody indicated the lightness and weightless feeling that I wanted to express. During verbal processing, the music therapist and I discussed how an experience of being in control during times of not having much control can be meaningful and
beneficial to my process. An experience where I am in control of and know what to expect can be easy, light, weightless, and unburdening.

Figure 10

Creating a Melodic Motif
Discussion

This study examines the similarities and differences of my self-experiences in personal therapy as a trainee in Analytical Music Therapy and Nordoff-Robbins Music Therapy, focusing on the role of music in my therapy sessions. The data was analyzed utilizing an inductive thematic analysis (Braune & Clarke, 2006). Themes were drawn and synthesized from three NRMT personal therapy sessions and three AMT personal therapy sessions. I utilized the session transcriptions, my journals and the music as my primary source of data. In my self-experience, the following themes were constructed: (1) music as a place of meeting and the foundation of the therapeutic relationship, (2) using the voice to strengthen the therapeutic and musical relationship, (3) music making and meaning making, (4) collaboration in music making, (5) music as a referential meaning or an experience.

Thematic analysis provided insight to process the data of my personal therapy sessions. A touchstone of NRMT is the quality of the relationship in the music (Ansdell, 1995). The musical relationship is instinctual but more sensitive than the verbal relationship - meaning that the musical relationship relies on feeling rather than cognition (Priestley, 1975). The therapeutic relationship is discussed thoroughly in NRMT and AMT (Birnbaum, 2014; Purdon, 2002). This is evident in themes one and two. Through this contact and meeting in the musical space, the relationship between therapist and client flourish.

Meeting in music made connecting and creating a relationship with my music therapists flourish. I had a space in which I was able to express freely and to showcase my feelings. In the musical space the client is able to express their thoughts and be able to feel like they are a part of something greater. The relationship between client and therapist is important to any
ROLE OF MUSIC IN PERSONAL THERAPY

psychotherapeutic session and developing the musical relationship interpersonally and intrapersonally is a key component to music therapy (Gardstrom & Jackson, 2012).

When reviewing the data, there are common aspects of music psychotherapy, (e.g., empathy, and person-centered approaches). In both models of music therapy, I felt that the music was a vehicle that was used to empathize with me. Empathy was seen in example 1 in theme 3, when my AMT therapist sang “feeling overwhelmed” I felt in those moments that it was more than just a reflection, but an embodiment of how I was feeling. The lyrics directly related to how I was playing and demonstrated how the music therapist empathized with my experience (Turry, 2006). Utilizing improvisational techniques to elicit and empathize with the client in music is a core feature in music therapy (Bruscia, 1987; Nordoff, Robbins & Marcus, 2007; Priestley & Eschen, 2002).

There are many roles that music can serve. The music created was a representation of my feelings. The sessions were a space filled with music for the therapist and myself to be the most authentic. Some writers show evidence that even spoken words can be viewed as musical experiences (Lindblad, 2016; Nelligan & McCaffrey, 2020; Nolan 2005), although it is noted multiple times by Priestley (1975, 1994) that it is challenging to bridge the music to the spoken word. The idea of bridging music, word, and the whole session as music relates to themes 3, 4, and 5. Although the role of music was different in comparison between AMT and NRMT, the general idea of music-centered practice was apparent in both (Aigen, 2005b). Carpente & Aigen (2019) speak about emphasizing the therapist and client’s musicality to produce the greatest benefit, that the emphasis is not about achieving “extrinsic, nonmusical benefit, but because of what music specifically and uniquely provides” (p. 255). I believe that this sentiment of
emphasizing the therapist and client’s musicality is both intrinsic to AMT and NRMT, but may be more emphasized in NRMT practice.

In both my AMT and NRMT personal experiences, it seemed like both therapists functioned as music-centered music therapists (Aigen, 2005b; Carpente & Aigen, 2019). In my AMT sessions, the music therapist focused on my expression in the music, facilitating freedom in unstructured, free improvisation (theme 4, example 1). In my NRMT sessions, the music therapist focused similarly on my expressive experiences in music, focusing on collaborating within a structured improvisation (theme 5, example 2).

Prior to this research, I thought there would be large differences in the approaches of my AMT and NRMT therapists; they are theoretically (e.g. psychodynamic vs humanistic, referential vs non-referential improvisation), but in my personal experience there seemed to be some overlap. I believed that the approach of both therapists did not line up with the traditional models of AMT and NRMT, and were instead more integral. For example (theme 3, example 2), the NRMT practitioner at times would refer to my music and at times refer to it as a point of reference at times alluding to psychodynamic techniques as opposed to the traditional model of NRMT which aligns more with humanistic/existential thought. The AMT practitioner would also speak about creating music in the here-and-now without thought and reference, alluding to humanistic/existential constructs. This is not to refute that the AMT practitioner was not primarily working with a psychodynamic philosophy and the NRMT practitioner primarily worked with a humanistic/existential philosophy. Bruscia (2014) states that an “integral therapist works the way a client needs him to work, not the way the therapist has already decided to work” (p. 260).
The idea of meaning making is discovered when trying to find a deeper understanding of the role of music. Meaning making refers to three aspects of music therapy, outcome, process, and communication (Bruscia, 2000; Keith, 2007). When searching for my meaning, I found it in the music. Although I had only met the music therapists a total of four times each, I was able to draw some insight, self-understanding, and self-awareness in the musical space with both my AMT and NRMT practitioners. For example, in theme 3, I felt that the music was the therapy for me. I felt freedom and I was able to access parts of myself to understand and work on the feelings of being overwhelmed (theme 3, example 1) and identifying myself as a gentle person (theme 3, example 2). Through this insight and self-awareness, I felt that I was beginning to understand myself to a deeper extent, this all occurred through the music and because of the music. This can be seen in Nordoff and Robbins’ case material with their client Audrey how the music was able to anchor her and provide her “psychological awareness” (Aigen, 2012). Scheiby (2012b) also refers to the act of improvised music leading to intrapersonal and interpersonal dialogues which can provide the basis for self-transformation and growth.

Interestingly, through comparison of both self-experiences the themes relate to earlier findings emphasizing philosophical differences between AMT and NRMT (Hadley, 1999). This brings up a difficult challenge for myself as the philosophical differences of the original models of AMT and NRMT do not seem compatible. At times it was difficult to distinguish the philosophical influence of the NRMT practitioner due to her different educational backgrounds including Vocal Psychotherapy. This difficulty of understanding the philosophical influence was most likely due to the small amount of sessions that I was able to spend with the music therapists. I believe that this brings up the idea that in today’s cultural expansion the idea of
“being integral” (Bruscia, 2014, p. 260) is extremely important, therapists need to adapt to their clients to deliver care.

The idea of being integral appealed to my therapeutic process. I felt more connected and comfortable with my music therapists as I felt I was able to relate to different aspects of their backgrounds in experience and training and the way that they were working with me. As there are a multitude of approaches and a diverse range of practices in music therapy, an integral approach seemed to be most effective in my process. The role of music is integral, music is in fact integral and perhaps that is what made my therapeutic process so effective (Lee, 2015). The music was able to help me develop and produce a wealth of knowledge for myself and through understanding AMT and NRMT. Albeit challenging at times as confusion settled at times trying to understand the differences in AMT and NRMT. Overall, I believe that what resonated with my therapeutic process the most was feeling a sense of connection and relation in the music. I felt that both AMT and NRMT provided that feeling to me, but in different ways as I described in previous sections.

**Benefits and Challenges of Personal Therapy as a Trainee**

The educational benefit for the trainee to engage in personal therapy related to the training can provide experience related to empathizing with clients and finding an increase in self-awareness. The trainee can develop a deeper understanding of the client’s experience as well as immersion into the model they are learning (Gardstrom & Jackson, 2012; Murphy, 2012; Scheiby 2012a; Shulman-Fagen, 2012; Sorel, 2012). These experiences can benefit the trainee as they can develop openness to the model and a vast array of experiences in regards to the client-therapist relationship. Some techniques such as splitting, and musically supporting a client (e.g. traditional AMT model, and traditional NRMT model) are better understood and grasped through
personal experience as opposed to didactic learning. Through personal therapy theoretical ideas can become meaningful to the trainee (Wiseman & Shefler, 2001). This is demonstrated through multiple splitting techniques (AMT session 1, 2, and 3) that I engaged in during my AMT sessions as well as collaborative equal partnership in my NRMT sessions (Theme 4, example 2).

An important factor of pursuing this research was the effects of personal therapy as a trainee. The study benefits music therapy educators and promotes personal therapy experiences. Personal therapy can have negative and positive effects on a future therapist (Malikiosi-Loizos, 2013). It can facilitate personal development and a deeper understanding of oneself while also presenting challenges. Through these self-experiences, the trainee can become aware of challenges and obstacles that may interfere with them while practicing such as transference content (Hadley, 1998b). At times the challenge was trying to differentiate the experiences due to integral work and meeting my needs as a client. However, the challenge pushed me to look deeper into my experiences to understand the differences between the models.

Limitations

Since this study was grounded in my self-experiences in personal therapy, as a heuristic first person study, it is interpretive. It was vital for my understanding of each model; however, the themes may not be relevant to other’s experiences. These experiences belonged only to myself. We cannot make these experiences generalizable to AMT and NRMT because each person’s experience will be unique and special in each therapeutic approach. This also applies to how the AMT and NRMT practitioners were, as the representation of the models were catered specifically to my needs as the client.

Also, I only collected data for three sessions of each therapy. Perhaps if there were time to collect more data the study could be deeper and richer and could lead to different conclusions.
Due to the desire of in-person sessions and the COVID pandemic, in-person sessions were placed on pause and I was unable to collect more data. In addition to having less data, there was less time to develop the therapeutic relationship between myself and the therapists. I also held the role of researcher and client-participant in this study. This is both a positive thing for exploring heuristic experiences in music therapy, and a limitation due to the bias.

Another challenge was locating an AMT practitioner for in person sessions. In my area there happened to be more available NRMT practitioners but I wanted to keep similar conditions between the two sessions. While researching, there were more AMT practitioners available for online sessions, and there were less NRMT practitioners available for online sessions as that was believed to be challenging to create synchronous music online.

Furthermore, the way that the AMT and NRMT advanced trainings are structured, I had been more immersed in the NRMT training because I had weekly class so my expectations about the music and music therapy may have influenced my findings and results. This immersion in the NRMT model influenced my relationship with music. My relationship with music continued to change throughout this project as I continued my training in both AMT and NRMT, creating constant shifts with how I wanted to create music and what kind of music I wanted to support me.

**Implications for Music Therapy Practice**

The findings of this study can help other and future trainees continue to develop their own personal beliefs and understanding of AMT or NRMT, or music therapy as a whole. Themes were established to describe the essence of music therapy experience in the models of AMT and NRMT. This research is particularly significant as it provides a raw experience of a trainee’s perspective taking two advanced trainings in music therapy. To my knowledge, this
study joins two other studies, one in which is over 25 years old, comparing the experience of multiple advanced music therapy trainings (Cooper, 2012; Hadley, 1998a, 1998b, 1999).

The data in this study may point to an exploration into ways in which AMT and NRMT may be becoming more closely aligned in their approaches, integrating aspects of other approach in each to inform future educational training for AMT and NRMT trainees. This can also facilitate further understanding in music therapy education and training for future trainees (S. Kim, personal communication, May 6, 2020). I would recommend future researchers to continue to explore integral music therapy work and how music therapy education can implement it. To all music therapists, supervisors, and educators, I believe we need to continue to find a way to honor the traditional models in education, but also facilitate the students’ process in learning and with the traditional model and integral thinking.

**Recommendations for Further Research**

Going forward, there is a need for further exploration and immersion into self-experience. This study also emphasizes the importance of integral therapy work and the deeper understanding of the client-therapist relationship. Future research is necessary to continue understanding the relationship between the role of music in the therapeutic relationship and the benefits and/or challenges of personal therapy as a trainee in music therapy.

It is recommended to do a similar study with more sessions to review and collect data, this would give a deeper understanding of the differences between AMT and NRMT. This may also lead to a deeper understanding of integral music therapy practice. This study alludes to integral approaches to music therapy being effective to the client’s experience. Perhaps continuing to explore integral music therapy work can be beneficial for the future of the field. I
think it is important to raise the question, is it possible to integrate ideas and techniques from multiple frameworks and theories in order to better serve the client?

**Conclusion**

The purpose of this study was to compare my self-experiences of personal therapy in AMT and NRMT in order to discover a deeper meaning of the role of music in AMT and NRMT. In this study, themes were developed based on my self-experiences in AMT and NRMT to demonstrate the role of music in my personal experience of AMT and NRMT, also comparing the similarities and differences of the experiences. My experiences offered insight to my understanding of the AMT and NRMT models and my perspective of music therapy. Overall, this study shows similarities and differences to a trainees’ self-experience in personal therapy during their advanced training in music therapy.
References


*Psychotherapy: Theory, Research, Practice, Training, 38*(2), 129–141.

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Appendix A

IRB Approval Letter

Institutional Review Board
1000 Hempstead Avenue
Rockville Centre, NY 11571
www.molloy.edu

Tel. 516.323.3711

Date: January 6, 2020
To: Dr. Seung-A Kim and Jan Casco
From: Patricia Eckardt, Ph.D., RN, FAAN
Chair, Molloy College Institutional Review Board

SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXEMPT STATUS
Study Title: The Role of Music in Personal Therapy in Advanced Music Therapy Training: A Self-Inquiry
Approved: January 6, 2020
Approval No: 10030119-0106

Dear Dr. Kim and Mr. Casco:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is exempt.

It is considered an EXEMPT category 45 CFR 46.104(1) per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects.

As per 45 CFR 46.115(b) and 21 CFR 56.115(b) require that all IRB records be retained for at least 3 years, and records relating to research which is conducted be retained for at least 3 years after completion of the research.
Please note that as Principal Investigator (PI), it is your responsibility to be CITI Certified in both the Responsible Conduct of Research and Human Subjects Research and to submit the evidence in order to conduct your research.

Remember, all consents and recruitment flyers for any research protocol need to have Molloy IRB dated stamps of approval. To obtain the official stamp, please contact Ms. Gina Nedelka (gnedelka@molloy.edu) to arrange a time to meet with her in her office in Kellenberg-Room 009. You will bring one clean consent (of each consent and/or assent) and any recruitment flyers to the meeting with Ms. Nedelka for IRB dated stamp of approval. You then make copies of stamped materials and use those copies for recruiting and consenting.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

This acknowledgement expires within three years-unless there is a change to the protocol.

However, the IRB requires an annual ongoing report of your exempt protocol (the application for ongoing/continuing review) is available on the IRB web page.

If there is a proposed change to the protocol, it is the responsibility of the Principal Investigator to inform the Molloy College IRB of any requested changes before implementation. A change in the research may change the project from EXEMPT status and requires prior communication with the IRB.

Sincerely,

Patricia A. Eckardt, PhD, RN, FAAN
Chair, Molloy College Institutional Review Board
Professor, Barbara H. Hagan School of Nursing
peckardt@molloy.edu
Appendix B

Letter of Permission Form (Nordoff-Robbins Music Therapy)

Appendix B: Letter of Permission Form (Nordoff-Robbins Music Therapy)

A Letter of Permission Form

Title: THE ROLE OF MUSIC IN PERSONAL THERAPY IN ADVANCED MUSIC THERAPY TRAINING: A SELF-INQUIRY

Researcher: Jan Mark Casco, MT-BC, Master's Degree Student
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Advisor: Seung-A Kim, Ph.D., LCAT, MT-BC
Associate Professor of Music Therapy, Molloy College
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The following research project is part of the Molloy College Graduate Music Therapy Program: MUS 5510/03 (Thesis: Music Therapy). My research involves understanding the unique experience of a Nordoff Robbins Music Therapy and Analytical Music Therapy trainee's self-experience. The session protocol will be two sessions of Nordoff-Robbins Music Therapy with ________. These sessions will be analyzed and corroborated to uncover themes about the trainer's self-experience. This project will be conducted at the private practice of ________. This course is a requirement for graduation. Approval is contingent upon ________ in accordance with the Molloy College Review Board procedures.

Nordoff-Robbins Music Therapy Clinician ____________________________ Date: ____________________________

Researcher Signature ____________________________ Date: ____________________________
Appendix C

Letter of Permission Form (Analytical Music Therapy)

Title: THE ROLE OF MUSIC IN PERSONAL THERAPY IN ADVANCED MUSIC THERAPY TRAINING: A SELF-INQUIRY

Researcher: Jame Mark Casco, MT-BC, Master's Degree Student
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Advisor: Seung-A Kim, Ph.D., LCAT, MT-BC
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Director of Undergraduate Music Therapy
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The following research project is part of the Molloy College Graduate Music Therapy Program: MUS 551/03 (Thesis: Music Therapy). My research involves understanding the unique experience of a Nordoff Robbins Music Therapy and Analytical Music Therapy trained self-experience. The session protocol will be two sessions of Analytical Music Therapy with . These sessions will be analyzed and corroborated to uncover themes about the trainee’s self-experience. This project will be conducted at the private practice of .
This course is a requirement for graduation. Approval is contingent upon ________ in accordance with the Molloy College Review Board procedures.

Analytical Music Therapy Clinician

__________________________ Date: ____________________

Researcher Signature

__________________________ Date: ____________________
Appendix D

Permission to Audio/Video Record

Student Researcher:
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Advisor:
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I, ____________________________________________, give Jan Mark Casco permission to video record their self-experience music therapy sessions. The recordings will be used for research purposes. I have already given written consent for my participate in this research project. At no time will my name, personal information, or contact information be used.

I understand that I will be video recorded during my scheduled two 60-minute music therapy sessions with the researcher. I give permission for the recording to be used from January 2020 to July 2020. I understand the video recordings will be archived for training purposes after the study is completed.

I understand that I can withdraw my permission at any time. Upon my request, the recordings will be erased and removed immediately. If I want more information about the recordings, or if I have questions or concerns at any time, I can contact the investigators at the top of this page.

I understand that my signature below indicates my voluntary consent to be video taped. I understand that I will be given a copy of this signed form.

Please send this form to the researcher by TBD at the following e-mail address: casco1@liuons.molloy.edu. Thank you for your participation.

Music Therapist's Signature ___________________________ Date ________________